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WHO: Past, Present and Future

The evolution of human rights in World Health Organization policy and the future of human rights through global health governance

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ABSTRACT

The World Health Organization (WHO) was intended to serve at the forefront of efforts to realize human rights to advance global health, and yet this promise of a rights-based approach to health has long been threatened by political constraints in international relations, organizational resistance to legal discourses, and medical ambivalence toward human rights. Through legal research on international treaty obligations, historical research in the WHO organizational archives, and interview research with global health stakeholders, this research examines WHO's contributions to (and, in many cases, negligence of) the rights-based approach to health. Based upon such research, this article analyzes the evolving role of WHO in the development and implementation of human rights for global health, reviews the current state of human rights leadership in the WHO Secretariat, and looks to future institutions to reclaim the mantle of human rights as a normative framework for global health governance.

Introduction

Looking to human rights under international law as a basis for public health, this article analyzes the evolving operationalization of a rights-based approach to health in the World Health Organization (WHO). This research traces WHO's early leadership in developing international legal obligations, squandered opportunities to implement a rights-based approach to health, failed effort to employ rights-based language for primary health care, and rediscovery of human rights protections in response to the HIV/AIDS pandemic. With WHO now attempting a more systematic mainstreaming of health-related rights, an initiative given new focus under the current reform process, it is necessary to examine the enduring challenges to human rights in WHO policy. By tracing the past neglect of human rights in international health and analyzing the present obstacles to human rights in the WHO Secretariat, the authors look to the future of human rights in global health governance, highlighting an expansion of the rights-based approach to health through WHO's international legal authorities, global

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health pubic-private partnerships, and the proposed Framework Convention on Global Health.

Health & human rights

By addressing threats to public health as 'rights violations,' international law has offered global standards by which to frame government responsibilities and evaluate health policies, shifting the debate from political aspiration to legal accountability. Out of the horrors of the Second World War, the contemporary origins of WHO's human rights authority encompass human rights under international law as a basis for public health, structured by the United Nations Charter, given meaning in the WHO Constitution, and proclaimed through a Universal Declaration of Human Rights.

Developing international human rights law for health through the United Nations (UN), the 1945 UN Charter elevated human rights as one of the principal purposes of the postwar international system. With the UN seeking to 'make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all,'[1] states worked within the UN system to establish human rights as a formal legal basis to assess and adjudicate principles of justice.[2] Concurrently elevating health within the UN, state representatives established WHO as the UN's first specialized agency, with the Constitution of the World Health Organization (WHO Constitution) serving as the first international treaty to conceptualize a unique human right to health.[3]

Through the preamble of the 1946 WHO Constitution, states framed international health cooperation under the unprecedented declaration that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being,' defining health positively to include 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.'[4] Established by medical representatives at the postwar International Health Conference, this preambular language further declared that 'governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.' Under such far-reaching rights and responsibilities, even if too vague to offer any meaningful operationalization, the WHO Constitution was seen to 'represent the broadest and most liberal concept of international responsibility for health ever officially promulgated'[5] and encompass the aspirations of the medical community to build a healthy world out of the ashes of the Second World War.[6]

Drawing on the negotiations for a WHO Constitution, states proclaimed a 1948 Universal Declaration of Human Rights (UDHR), framing within it a set of interrelated social welfare rights by which:

> *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widow-hood, old age or other lack of livelihood in circumstances beyond his control.*[7]

Including both the fulfilment of necessary medical care and the realization of underlying determinants of health, this expansive vision reflected budding national welfare policies and prevailing social medicine discourses as a basis for public health systems.[8]

Evolution of human rights in WHO governance

With both the UDHR and WHO coming into existence, there was great promise that these two institutions would complement each other, with WHO—like all UN specialized agencies—serving to support human rights in its policies and programs. Yet in spite of this promise and early WHO support for advancing a human rights basis for its work, the WHO Secretariat intentionally neglected human rights discourse during crucial years in the development and implementation of health-related rights, projecting itself as a technical organization above 'legal rights' and squandering opportunities for WHO leadership in the evolution of rights-based approaches to health.

WHO in the development of the right to health

As states worked through the UN Commission on Human Rights to develop human rights treaty law, WHO was set to play a defining role in translating the aspirational public health language of the 1948 UDHR into the binding legal obligations of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR). Although WHO served this vital human rights leadership role in the first five years of its existence, the political constraints of the Cold War led WHO to reposition itself in international health as a purely technical organization, focussing on medical intervention and disease eradication to the detriment of rights advancement. Where WHO neglected human rights development, it did so to the detriment of public health. When WHO sought to reclaim the language of human rights in the 1970s in the pursuit of its 'Health for All' strategy, its past neglect of human rights norms left it without the legal obligations necessary to implement primary health care pursuant to the Declaration of Alma-Ata.

WHO's early years were marked by the Secretariat's active role in drafting human rights treaty law and its cooperative work with other UN agencies to expand human rights frameworks for public health. Working with state representatives in the early 1950s, WHO Director-General Brock Chisholm welcomed 'opportunities to co-operate with the [UN] Commission on Human Rights in drafting international conventions, recommendations and standards with a view to ensuring the enjoyment of the right to health,' recognizing that 'the whole programme approved by the World Health Assembly represents a concerted effort on the part of the Member States to ensure the right to health.'[9] In pressing the Commission on Human Rights in its development of health obligations, the WHO Secretariat successfully suggested in 1951 that the right to health reflect state commitments in the WHO Constitution, emphasizing (1) a positive definition of health promotion, (2) the importance of social measures as underlying determinants of health, (3) governmental

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responsibility for health provision, and (4) the role of health ministries in creating systems for the public's health.[10] While these WHO proposals survived early objections from the Cold War Superpowers, with vigorous debates among state representatives in both the WHO Executive Board and the UN Commission on Human Rights on the expansiveness of such public health commitments,[11] WHO's influential contributions to the development of human rights for public health were explicitly rejected following a 1953 shift in WHO's Secretariat leadership and reform of WHO's health priorities.

As the UN sought to codify a right to health in the ICESCR and extend rights to determinants of health, WHO abandoned the evolution of human rights, turning its attention to technical assistance through its regional offices.[12] Under the leadership of Director-General Marcolino Gomes Candau, the WHO Secretariat repeatedly declared throughout the late 1950s and early 1960s that it was not 'entrusted with safeguarding legal rights,'[13] and as explained by WHO's chief legal officer, 'a programme based on the notion of priorities has given way to one based on the needs of the countries themselves, expressed through their requests for advice and assistance.'[14] With the United States objecting to WHO's advancement of the right to health (while making clear WHO's increasing dependence on U.S. funding), WHO (1) declined to participate in the proceedings of the Commission on Human Rights,[15] (2) requested that the UN Secretariat not include a section on health in its human rights summaries,[16] and (3) did not contest the 1966 ICESCR's limited codification of a right to health.[17] Without the legal staff necessary to engage with international legal developments,[18] the WHO Secretariat sought only to lessen its UN responsibilities to implement the right to health,[19] hampering health advocates in their efforts to elaborate the scope and content of human rights.[20] Given the WHO Secretariat's abdication of responsibility for health rights, the UN's 1968 review of international human rights efforts includes only a vague generalities on the right to health and enumerates the human rights activities taken by every UN specialized agency except WHO.[21]

After twenty years shunning human rights law, the WHO Secretariat sought to re-engage human rights language as a moral foundation and political catalyst upon which to advance its failed 'Health For All' strategy. Concurrent with an expansion of human rights advocacy networks in the early 1970s,[22] Director-General Halfdan Mahler sought to expand WHO's influence in international health by redefining its health goals to reflect human rights standards. Supported by developing nations in the World Health Assembly,[23] the WHO Secretariat engaged its legal office in human rights debates in the 1970s – at the Commission on Human Rights, in human rights seminars, and as a voice for policy reform.[24] In addressing determinants of health through 'primary health care,' the WHO Secretariat would adopt human rights discourse to advocate for the national and international redistributions that would allow people to lead socially and economically satisfying lives.[25] Embedded in the 1978 Declaration of Alma-Ata, this socio-economic approach to health reasserted the WHO Constitution's proclamation that health 'is a fundamental human right,'[26] creating a rights-based vision for what many at the time considered 'the onset of the health revolution.'[27] However, despite presenting a nominally rights-based framework for advancing public health,[28] WHO's previous neglect of human rights law would prove fatal to the goals of the Health for All Strategy.[24] Without UN treaty frameworks to guide primary health care,[29] the Declaration of Alma-Ata presented no obligations on states, with scholars noting in its aftermath that 'inadequate national commitment to the 'Health for All' strategy is at some level a reflection of the ineffectiveness of WHO's strategy of securing national dedication to the right to health.'[30]

Rediscovering human rights in responding to the HIV/AIDS pandemic

Yet as states stepped back from implementing the right to health through primary health care, such rights-based standards endured in WHO's evolving approach to public health, reconceptualized in the international response to HIV/AIDS. With governments responding to the emergent threat of AIDS in the early 1980s through traditional public health policies—including compulsory testing, named reporting, travel restrictions, and coercive isolation or quarantine—civil and political rights were seen to respond to intrusive public health infringements on individual liberty and to serve as a bond among HIV-positive activists.[31] In this period of burgeoning fear and advocacy, Jonathan Mann's vocal leadership of the WHO Secretariat's Global Programme on AIDS (GPA) in the late 1980s marked a turning point in the operationalization of individual human rights in public health policy, applying human rights to focus on the individual behaviours leading to HIV transmission.[32] With these prevention efforts grounded in individual autonomy for health, WHO's rights-based approach to AIDS found support among transnational networks of non-governmental advocates and UN human rights officers, working closely with the WHO Secretariat to understand the risks for transmission, educate the public on prevention, and slow the spread of HIV.

Although human rights scholarship had long recognized the infringement of individual rights as permissible—even necessary—to protect the public's health, the GPA viewed respect for individual rights as a precondition for the public's health in the context of HIV prevention and control. The GPA conceptualized civil and political rights claims in opposition to restrictive public health measures, examining human rights violations as a key driver in the spread of the disease[33] and operationalizing human rights in WHO programming through strategies to combat HIV discrimination, promote health equity, and encourage individual responsibility.[34] Through this rights-based framework, the WHO Secretariat shifted HIV/AIDS policy away from both the biomedical framing of international health rights and the individualistic framing of neoliberal health policy.[35] In partnership with the UN human rights system and with the support of Director-General Mahler, the GPA sought to 'bring together the various organizations, particularly those organizations of the UN system and related organizations involved in human rights to discuss the relationship between AIDS, discrimination, and human rights.'[36] Confirming WHO's leadership role in applying interconnected human rights to address intersectoral determinants of HIV, the UN General Assembly

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directed all UN agencies to assist in WHO's efforts, resolving 'to ensure…a co-ordinated response by the United Nations system to the AIDS pandemic.'[37]

Tying together the efforts of international institutions, national governments, and non-governmental organizations under a universal framework for action, WHO's 1987 Global Strategy for the Prevention and Control of AIDS (Global Strategy) solidified human rights principles in preventing HIV transmission and reducing the impact of the pandemic. The Global Strategy focused on principles of non-discrimination and equitable access to care, stressing the need for public health programs to respect and protect human rights as a means to achieve the individual behaviour change necessary to reduce HIV transmission.[38] Through this Global Strategy, civil and political rights framed the HIV/AIDS response, serving as a normative basis for the development of international guidelines, national policies, and non-governmental action. In upholding WHO's rights-based authority to ensure global collaboration against this unprecedented threat, the World Health Assembly reaffirmed in May 1988 that 'respect for human rights and dignity of HIV-infected people, people with AIDS and members of population groups is vital to the success of national AIDS prevention and control programs and of the Global Strategy.'[39] Although the election of Director-General Hiroshi Nakajima came to diminish the GPA's ability to promote a rights-based approach to health—leading Jonathan Mann to resign in protest, stymieing WHO authority for human rights, and leaving WHO's AIDS programs in a state of disarray[40]—this Secretariat focus on rights-based approaches to health would persist even as WHO lost programmatic authority for the HIV/AIDS response.[41]

Enduring human rights challenges in the WHO Secretariat

Moving beyond HIV/AIDS and encompassing a range of health-related rights, WHO has considered a more systematic application of civil, cultural, economic, political, and social rights to an array of public health challenges. With the end of the Cold War, a political space opened in the 1990s for human rights discourse in international relations, with the UN embracing human rights as a basis for global governance and WHO looking to women's rights and children's rights in advancing distinct health priorities.[42] In mainstreaming human rights across the work of the WHO Secretariat, WHO has sought to frame health as a human right, employing this framework with mixed success to elevate rights-based approaches in WHO programs, frame state responsibilities under international law, and support WHO authority for global health.

Mandating a cross-cutting approach to human rights, UN Secretary-General Kofi Annan called on specialized agencies in 1997 to 'mainstream' human rights in all programs, policies and activities.[43] Under Director-General Gro Harlem Brundtland, WHO took up this UN call,[44] seeking to realize human rights in global health and reestablish WHO as 'the world's health conscience.'[45] Under the auspices that every state was party to at least one human rights treaty recognizing health-related human rights, the WHO Secretariat sought to incorporate human rights into its public health efforts, hiring a human rights advisor to integrate the rights-based approach in the design, implementation, and monitoring and evaluation of all policies and programs of the Secretariat Headquarters.[46] Originating out of an office on 'Globalization, Cross-Sectoral Policies, and Human Rights,' the Secretariat began in 1999 to implement this cross-cutting approach to human rights, incorporating human rights standards in WHO's 2000 World Health Report on health systems[47] and supporting public health standards in the UN's 2000 General Comment on the human right to health.[48]

Defining a rights-based approach to WHO governance, the WHO Secretariat sought to apply international legal standards to assess the availability, accessibility, acceptability, and quality of health systems.[49] As a policy framework to mainstream rights throughout the Secretariat, WHO's human rights advisor began in 1999 to draft a WHO Strategy on Health and Human Rights to solidify the place of human rights within WHO,[50] building Secretariat support among WHO clusters through a series of Informal Consultations on Health and Human Rights.[51] In echoes of past human rights debates, however, internal Secretariat disagreement hindered the development of any formal human rights strategy, as program officers and country offices questioned the ramifications of 'political goals' in a 'medical organization.' Notwithstanding such medical intransigence to human rights, this 2001–2002 Secretariat debate led in the ensuing years to a visible presence for human rights officers in the Secretariat,[52] WHO support for the appointment of a UN Special Rapporteur on the Right to Health,[53] and the development of a WHO human rights publication series.[54] With the 2003 creation of a small Health & Human Rights Team inside the Office of the Director-General, establishing a focal point for consideration of international human rights law, the WHO Secretariat reengaged with the UN human rights system and collaborated with organizations, academics, and advocates at the intersection of health and human rights.[55] However, with Director-General Brundtland leaving WHO in July 2003, Director-General Lee Jong-wook moved away from efforts to mainstream human rights throughout the Secretariat, and through a series of restructurings, the Health & Human Rights Team would be reduced to only two permanent members (along with temporary Junior Professional Officers), who would be transitioned across Secretariat departments.

Situated initially in the Department of Ethics, Trade, Human Rights and Health Law, the Health & Human Rights Team originally worked in this technical department to ensure the application of international law across the Secretariat, seeking:

> *To advance the Right to Health in international law and international development processes through advocacy, input to UN mechanisms and development of indicators;*
>
> *To strengthen WHO's capacity to adopt a human rights-based approach in its work through policy development, research and training; and*
>
> *To support governments to adopt a human rights-based approach in health development through development of tools, training and projects.*[56]

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From a staff of only three, the Team grew again to include the human rights advisor, two human rights officers, and two Junior Professional Officers – supported, as with all Secretariat work, by a larger staff of temporary unpaid interns. Shifting thereafter to the Department of Ethics, Equity, Trade and Human Rights, the Health & Human Rights Team focused increasingly from 2004 to 2010 on human rights capacity building: supporting collaborating partners in 2005 to develop an e-learning course on Health & Human Rights, enlisting interns in 2006 to produce an informational video for Human Rights Day, 'Health – My Right,' and working with the UN Office of the High Commissioner for Human Rights in 2010 to develop an information sheet on 'A Human Rights-Based Approach to Health.'[57] As mainstreaming began to take hold in the Secretariat, the Health and Human Rights Team found internal support in its rights-based efforts from human rights focal points within select program clusters and technical officer collaborations with the UN Special Rapporteur on the Right to Health.[58]

These efforts to incorporate human rights law in the work of the WHO Headquarters came to be replicated through the Secretariat's regional offices, with select regional offices strengthening rights-based governance through the mainstreaming of human rights. Within the Pan American Health Organization (PAHO, or the WHO Regional Office for the Americas, AMRO), the regional human rights advisor has developed a series of yearlong collaborations to mainstream human rights in various technical offices and build rights-based capacity within national offices.[59] Drawing upon steadfast regional support for human rights,[60] PAHO member states incorporated human rights as a guiding principle of the 2008–2012 PAHO Strategic Plan[61] and adopted a 2010 Resolution on Health and Human Rights to mainstream human rights in national health ministries and PAHO technical programmes.[62] Similarly seen in the WHO Regional Office for Africa (AFRO), the regional human rights office seeks to provide technical assistance to states to mainstream human rights in national health programmes. With the right to health enshrined in the African Charter on Human and People's Rights and the national constitutions of all but six African states, AFRO member states adopted a 2012 Resolution on Health and Human Rights to strengthen legal and institutional measures to promote human rights, with the Regional Director supported in developing tools to assist member states in strengthening human rights capacities and designing rights-based health policies.[63] Even where the states of the WHO Eastern Mediterranean Region (EMRO) have shown less state support for human rights, the regional human rights advisor nevertheless has held consultancies for national health ministries to build capacity for operationalizing the right to health in national policies and programs.[64]

Yet despite the rise of the Health & Human Rights Team within the Secretariat Headquarters in Geneva, the development of human rights focal points in select program clusters, and the creation of human rights officer positions in each regional secretariat and country office, human rights efforts faced reduction in budgetary allocations and isolation in the Secretariat. With human rights deemphasized in WHO governance in response to member state pressures, the Health & Human Rights Team came to be disconnected from the work of Headquarters clusters and national offices, as scholars and advocates criticized WHO programs for their increasing departure from the path of human rights.[65] In spite of strong evaluations in 2010 on the effectiveness of WHO's rights-based approach to health,[66] Director-General Margaret Chan began, as part of a larger 2011 budgetary reform process, to consider shifting WHO human rights staff within the Secretariat.[67] With the WHO Executive Board calling on the Secretariat to find more effective ways to mainstream its multiple cross-cutting priorities, WHO's 2012 strategy sought to restructure the Secretariat to be equally responsive to gender, equity, and human rights – reinforcing the conceptual interconnectedness of these priorities and creating efficiency gains in staff training.[68] Situating only a single human rights technical officer within WHO's new Gender, Equity and Human Rights (GER) Unit (located within the Family, Women's and Children's Health Cluster), the integration of human rights among normative frameworks for gender and equity has been viewed by critics within and outside WHO as diminishing the role of international human rights law as a basis for global health governance.

The current Gender, Equity and Human Rights mainstreaming process, launched at the 2012 World Health Assembly, seeks, as described by Director-General Chan, 'to achieve a WHO in which each staff member has the core value of gender, equity and human right in his/her DNA.'[69] Supported by a small central GER Unit, it is expected that program clusters will assume greater responsibility for mainstreaming human rights and employ GER focal points with dedicated time to pursue rights-based efforts.[70] Under this decentralized approach to meeting WHO's cross-cutting priorities, Director-General Chan seeks to assure mainstreaming across the Organization through the reporting agenda of senior leadership and the performance appraisals of Secretariat staff. With stable budgetary support for the GER Unit, the WHO Secretariat has pressed ahead in 2013 to synergize these three cross-cutting priorities: to develop a six-year 'roadmap and plan of action' to implement and monitor the mainstreaming of gender, equity and human rights;[71] to pursue high-profile initiatives to justify and strengthen the rights-based approach to health;[72] and to collaborate with regional secretariats and country offices to assure coordination in the mainstreaming process.[73] Given longstanding obstacles to a 'legalistic' approach to human rights within the WHO Secretariat, highlighting the limitations of international organizations as leaders in the fight for human rights under international law,[74] such a merger of human rights with gender and equity may prove uniquely conducive to overcoming political obstacles to rights advancement, to spotlighting the operationalization of the GER approach with select technical units, and to meeting WHO's disaggregated indicators for effectiveness in the mainstreaming process.[75] As WHO seeks anew to mainstream human rights efforts across the Secretariat—emphasizing enabling legal environments, marginalized populations, and accountability as rights-based pillars of the Organization's work—it remains unclear what role these efforts will play in advancing human rights in an expanding global health governance landscape.

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The future of human rights in global health governance

With the reform of WHO's traditional institutions for health and human rights and the creation of new institutions in an increasingly fragmented architecture for global health governance, human rights are increasingly framing a more expansive vision of justice in global health – within WHO's international legal authorities, in public-private partnerships for health, and through a proposed Framework Convention for Global Health.

WHO's international legal authorities

WHO's continuing mandate to promote human rights—implemented through WHO's legal authority to develop normative instruments—has remained a force for global health policy, as seen most prominently in the WHO Framework Convention on Tobacco Control (FCTC) and International Health Regulations (IHRs).[76] The FCTC preamble affirms the determination of states to give priority to public health, drawing on the right to health codified in the WHO Constitution and international human rights treaties.[77] Elucidated under the Punta del Este Declaration, the FCTC has evolved and been reinforced by guidelines for the implementation of Article 8's duty to protect from tobacco smoke and Article 12's duty to educate, communicate with, and train people to ensure a high level of public awareness of tobacco control, the harms of tobacco production, consumption, and exposure to tobacco smoke, and the strategies and practices of the tobacco industry to undermine tobacco control efforts.[78] Looking to the enjoyment of the right to health, the guidelines further encourage governments to adopt and implement effective legislative, executive, administrative, or other measures to protect individuals from threats to their fundamental rights and freedoms. Similarly, as human rights considerations partially underpin the public health security provisions of the revised IHRs, the IHRs now provide for full respect of human rights in aspects relating to their implementation.[79] Requiring the WHO Director-General 'to determine, on the basis of the information received whether an event constitutes a public health emergency of international concern,' the IHRs provide explicitly for the protection of the human rights of travellers, including respect for gender, socio-cultural, ethnic, or religious considerations, and must be implemented 'with full respect for the dignity, human rights and fundamental freedoms of persons.'[80] Taken together with World Health Assembly resolutions reinforcing WHO's human rights authorities, the FCTC and revised IHRs reflect WHO's continuing human rights mandate, provide a legal basis for human rights in WHO policy, and create implied powers essential to the performance of WHO's duties.[81]

Global health public–private partnerships

Within and beyond WHO, global public–private partnerships (GPPPs) have provided transnational collaborative governance, incorporating states and a diverse range of non-state actors to achieve shared public health goals.[82] Over 100 GPPPs for health have been reported and typically include the public sector such as WHO, the for profit sector such as pharmaceuticals, and the not for profit sector such as NGOs and philanthropic organizations.[83] These GPPPs have attracted significant resources, knowledge, and expertise for global health programs,[84] enabling private, not for profit, and corporate actors to exercise policymaking authorities alongside state actors.[85] With WHO highlighting the recent public health benefits of such partnerships which include: widespread inoculation against epidemic meningitis; a less expensive diagnostic tool for tuberculosis; and declining costs for antiretroviral therapy. These GPPPs are presenting both challenges to global health governance and opportunities for human rights.[86] Facing programmatic, leadership, and administrative challenges related to WHO hosting and participating in partnerships, these partnerships can: (1) overlap with WHO's functions, causing duplication and fragmentation; (2) create conflicting mandates from WHO Member States, causing uncertainty; and (3) lead to administrative challenges, causing harm to WHO's institutional reputation. With these GPPPs untested in global health governance,[87] often unaccountable to international standards,[88] beholden to the interests of non-governmental funders,[89] and amenable to capture by commercial interests,[90] GPPPs could threaten global health policymaking and pervert global health priorities in the absence of a sound normative framework for their governance.[91] A human rights framework can overcome these challenges by enabling the design, implementation, and evaluation of health policies and providing a universal operational framework for all GPPP actors.[92] Although explicitly addressed to states, human rights also require action by both international organizations and non-state actors to promote health.[49] Facilitating rights-based accountability through WHO monitoring, a rights-based approach to GPPP governance could include mechanisms for periodic assessment of the realization of international cooperation and good governance, including rights-based concerns for transparency, responsibility, participation, and responsiveness to the needs of people.[93]

The proposed Framework Convention on Global Health

In responding to a lack of coordination in the realization of health-related rights, a civil society-led coalition, the Joint Learning Initiative for National and Global Responsibilities for Health (JALI), has sought to secure a Framework Convention on Global Health (FCGH). The proposed FCGH seeks to revitalize efforts to, among other things, mainstream human rights principles throughout WHO programming, build human rights capacity in WHO staff, and elevate human rights law in global health governance.[94] Beyond WHO, FCGH proponents see it as a means to formalize coordination between the WHO Secretariat and the Office of the High Commissioner for Human Rights, combining their rights-based leadership to coordinate the wide range of actors whose actions impact global health. In establishing an intersectoral consortium on global health (including the UN agencies and other global institutions that impact health), the FCGH looks to formalize WHO's influence outside the health sector by mainstreaming health-related rights across multiple sectors and institutions.[95] At the national level, the

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FCGH could entail WHO training a 'human rights point person' in each WHO country office, with the country officers working to mainstream health and human rights across health issues and government sectors.[96] Re-energizing advocacy networks at the intersection of global health and human rights, JALI is mobilizing civil society and other actors to develop the FCGH as a means to redefine health systems to address fundamental human needs, focussing health systems on public health services, well-functioning infrastructures, and socio-economic conditions.[97] Through initial consultations that resulted in a 2012 *Manifesto for Health Justice*, which 'highlights the historic opportunity for advancing the right to health [and] lays out key principles that a FCGH should incorporate,' JALI has finalized a process by which drafting committees can develop the FCGH's scope and content.[98] With the potential to elaborate additional rights-based frameworks for WHO, the FCGH could re-engage collaboration for health-related rights across the global community, creating a framework to develop and implement human rights as a basis for global health governance.[99]

Conclusion

Born of the WHO Constitution, health-related human rights provide paths by which WHO can remain relevant in a changing global health landscape. While WHO possesses invaluable technical expertise in medical matters, giving it preeminent legitimacy in creating public health standards and monitoring state health programs, the WHO Secretariat must be competent to engage human rights frameworks if it is to bind policy actors in a fragmented global health governance landscape to realize the highest attainable standard of health. As advocates are again looking to human rights to provide a universal normative framework for global health in the post-2015 agenda, the case for WHO to prioritize human rights in its mandate is more compelling than ever before; requiring WHO to justify the incorporation of human rights in global health governance, marshal resources to mainstream rights in the WHO Secretariat, and collaborate with member states and non-governmental partners to increase the visibility of the rights-based approach. Yet the WHO Secretariat remains structurally limited in efforts to advance health-related human rights, with an institutional structure beholden to state political priorities, distant from the international legal system, and governed by medico-technical approaches to health. Given an unsteady path for human rights within WHO, it remains to be seen whether these contemporary global health governance initiatives will revitalize WHO's human rights authorities or whether WHO, as has been done in the wake of previous initiatives, will revert to its institutional isolation and human rights abnegation.

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