The Pan American Health Organization and the Mainstreaming of Human Rights in Regional Health Governance

Benjamin Mason Meier and Ana S. Ayala

In the development of a rights-based approach to global health governance, international organizations have looked to human rights under international law as a basis for public health. Operationalizing human rights law through global health policy, the World Health Organization (WHO) has faced obstacles in efforts to mainstream human rights across the WHO Secretariat. Without centralized human rights leadership in an increasingly fragmented global health policy landscape, regional health offices have sought to advance human rights in health governance and support states in realizing a rights-based approach to health. Examining the efforts of the Pan American Health Organization (PAHO), this article explores the evolution of human rights in PAHO policy, assesses the mainstreaming of human rights in the Pan American Sanitary Bureau (Bureau or PASB), and analyzes the future of the rights-based approach through regional health governance.

Through documentary analysis of PAHO policies and sixteen interviews with key PASB stakeholders, the authors look to the understandings and actions of policymakers in implementing human rights through PAHO governance. Employing snowball sampling and semi-structured interview methodologies, the authors spoke with the current Director, former Directors, legal counsel, human rights advisor, and technical officers from a range of program units. These interviews examined issues related to the development, implementation, and future application of human rights in PAHO policies and programs. Complemented by official documentary records, both from the PAHO archives and the files of PASB technical officers, the interviews were additionally informed and contextualized by an array of scholars, advocates, and practitioners who have worked regularly with PAHO in the realization of human rights for the public's health.

This article examines the role of human rights in PAHO policies and programs, assessing the influence of regional health governance in supporting a rights-based approach to health. From the birth of the Bureau, Part I reviews early international efforts to address public health in the Western Hemisphere, the birth of the post-war international health system

Benjamin Mason Meier, J.D., LL.M., Ph.D., *is an Assistant Professor of Global Health Policy at the University of North Carolina at Chapel Hill. Dr. Meier's interdisciplinary research – at the intersection of international law, public policy, and global health – examines human rights law as a basis for global health governance. Working across UNC's Department of Public Policy and School of Global Public Health, Dr. Meier studies the development, evolution, and application of human rights under national and international law. As a contributor to the development of global health policy, he serves additionally as a Scholar at Georgetown Law School's O'Neill Institute for National and Global Health Law and as a consultant to international organizations, national governments, and nongovernmental organizations. Dr. Meier received his Ph.D. in Sociomedical Sciences from Columbia University, his J.D. and LL.M. in International and Comparative Law from Cornell Law School, and his B.A. in Biochemistry from Cornell University.* **Ana S. Ayala, J.D., LL.M.,** *is an Institute Associate at the O'Neill Institute for National and Global Health Law at Georgetown University. Ayala has worked on a wide range of areas of global health law, including health and human rights, global tobacco control, sexual and reproductive health, patients' rights, and the World Health Organization's International Health Regulations. She has worked with an array of organizations, including the World Health Organization, Open Society Foundations, Campaign for Tobacco Free Kids, the Lawyers Collective, and Women's Link Worldwide. Ayala holds a Master of Laws in Global Health Law from Georgetown University; a law degree from American University, Washington College of Law; and a Bachelor of Arts degree in Anthropology and International Studies from the University of Chicago.*

under the United Nations (UN), and the political debates that led PAHO to become WHO's Regional Office for the Americas. Part II discusses the evolving role of human rights as a basis for PAHO's work, drawing on a robust history of social medicine and human rights in Latin America and the institutionalization of human rights in: resolutions of the PAHO Directing Council, responses to a burgeoning HIV/AIDS pandemic, and challenges to mental health practices. With the UN moving in the late 1990s to mainstream human rights throughout international organizations, Part III highlights the mainstreaming of rights in PAHO through: PASB technical units, national capacity building efforts, the Inter-American human rights system, and the PAHO Directing Council. Analyzing the expanding application of human rights, Part IV examines the structural factors that have supported PAHO's rights-based efforts, concluding that human rights have flourished through regional governance where the rights-based approach has found support from the Secretariat leadership, member states, legal staff, and technical offices.

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I. PAHO in Global Health Governance

PAHO serves as both the specialized health agency for the Organization of American States (OAS) and, following the Second World War, the WHO regional office for the Americas. In these roles, PAHO currently represents 35 member states (in addition to three participating states, four associate members, and two observer states), providing technical cooperation and coordinating international norms to structure health systems in the region and improve public health in the Americas. To achieve these ends, the PAHO Constitution established three governing bodies through which member states set PAHO policy: the Pan American Sanitary Conference, meeting every five years to set the general policies of the Organization; the Directing Council, meeting each year that the Sanitary Conference does not meet to set annual goals; and the Executive Committee, meeting twice each year (with nine elected member states) to review PAHO programs, budgets, and administration. These PAHO governing bodies allow member states to oversee the PASB, the PAHO Secretariat responsible for carrying out the decisions of the aforementioned organs through an elected Director and appointed staff.

A. Origins of the Pan American Sanitary Bureau

As the world's first permanent international health body, states of the Americas initially established the PASB to harmonize quarantine regulations throughout the Western Hemisphere. Founded in December 1902 and headquartered in Washington, D.C., the Bureau long sought to coordinate national regulations as a basis to control infectious diseases and thereby assure the free flow of goods across the Americas. Beginning out of a concern for communicable disease control at the Hemisphere's ports (focused on the control of yellow fever, malaria, yaws, tuberculosis, and smallpox), the development of the 1924 Pan American Sanitary Code became the basis for uniform regulations and international actions to protect public health.[1]

The Bureau's duties and functions derive from the Pan American Sanitary Code and the Pan American Sanitary Conference. Through these authorities, the PASB was intended to act as the "central coordinating sanitary agency" and the "distribution center" of sanitary information.[2] With its staff coming largely from the U.S. Public Health Service, the Bureau was also charged with advising national health authorities on public health matters and application of the Code.[3] Based upon the terms of the Code, the Bureau's focus would expand to include standards for the collection of mortality and morbidity data, measures for the prevention of communicable diseases, and methods to help member states cooperate in reducing the spread of disease.

The Bureau's composition and priorities continued to evolve in the years leading up to the Second World War. From a staff of seven members, the promulgation of the Code (ratified in all member states by 1936) facilitated to the development of a larger permanent PASB staff, with increased programmatic responsibilities and state support.[4] As support for the PASB grew, so too did its budget. This financial security increased the Bureau's efforts to prevent the spread of disease, with the Bureau partnering with the Rockefeller Foundation and other organizations to spur scientific discoveries and seek the eradication of prevalent diseases.[5] Creating a health information network with other international health institutions, the onset of the Second World War led the Bureau to intensify its exchange of technical information, laying the groundwork for the post-war development of the World Health Organization.[6]

B. Incorporation into the World Health Organization

With the end of the Second World War and establishment of the UN, state representatives developed WHO as the UN's first specialized agency, with state delegates at the 1946 International Health Conference[7] adopting the WHO Constitution and subsuming within the WHO Secretariat all of the international health responsibilities of the League of Nations, the *Office International d'Hygiene Publique*, and the UN Relief and Rehabilitation Administration.[8] Recognizing a pressing post-war imperative to facilitate international health governance,[9] WHO's principal constitutional function would be "to act as the directing and coordinating authority on international health work."[10] Whereas previous international health organizations had existed primarily to prevent infectious diseases from crossing national boundaries, the WHO Constitution would endow this new international health bureaucracy with expansive authority to take "necessary action" over all manner of disease prevention and health promotion.[11]

Yet this action would not be centralized within the WHO Secretariat in Geneva. Auguring WHO's decentralization to regional offices,[12] the WHO Constitution provided that:

> a. The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.
> b. The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.[13]

Although the WHO Secretariat opposed the establishment of autonomous regions before the WHO Headquarters had fully established its central authority, regionalization quickly came to pass.[14] Set into motion in 1951, the WHO Secretariat would come to relinquish its international authority to six WHO regional offices, with WHO representatives lamenting that the prematurity of this decision "ensured that centralization did not become too firmly established."[15]

The Americas would prove uniquely autonomous through this regionalization process, as the United States, which sought to maintain its longstanding health diplomacy in the Western Hemisphere, pressed WHO to allow the American Region to operate within the existing structure of the PASB.[16] As rationalized by the PASB Director, continuing Pan American regionalization was justified by the common bonds of its members:

> The six WHO Regions…vary widely in those climatic, ethnic, political, religious, cultural, economic, and epidemiological factors which influence the nature of regional health problems and the development of national health services, and determine the ease of international collaboration. The 22 nations and the almost equally numerous territories of the Americas have a common cultural heritage from a small section of Western Europe and have none of the deep-seated racial, religious, ideological, and territorial dissensions which make international collaboration so difficult in some of the Regions.[17]

Under an arrangement unique to the Americas, states would provide a double assessment to WHO, funding the reconstituted "Pan American Sanitary Organization" separately from their contribution to the WHO budget and thereby securing an independent budget to meet regional priorities.[18]

With the first Directing Council of the Pan American Sanitary Organization meeting in 1947, member states adopted a new constitution "to promote and coordinate efforts of the countries of the Western Hemisphere to combat disease, lengthen life, and promote the physical and mental health of the people."[19] Further reflecting this new focus on health issues well beyond the prevention of disease, the Pan American Sanitary Organization was renamed in 1958 as the "Pan American Health Organization."[20] Serving as WHO's Regional Office for the Americas while continuing to serve as OAS's specialized health agency, PAHO would employ its regional independence and public health mandate to develop and implement human rights for health.

II. Origins of Human Rights in PAHO Governance

The contemporary origins of PAHO's health and human rights authority stem from the preamble of the 1946 WHO Constitution, wherein states framed international human rights cooperation for health under the unprecedented post-war 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."[21] Adopted at the regional level, the 1947 Pan American Sanitary Conference (in the same conference that it voted to join with WHO) noted a new vision of health coverage as a human right, seeking:

> to make a reality of the right of citizens to the preservation of health, the treatment of illness, rehabilitation, and to other economic subsidies in time of major want or inability.[22]

From these auspicious origins for health and human rights, the regional development of human rights would evolve alongside international law, with the 1948 American Declaration of the Rights and Duties of Man proclaiming a right to health protection, and, in language similar to the WHO Constitution, looking to "sanitary and social measures" in realizing this right. These rights continued to develop through regional agreements, as the 1978 American Convention on Human Rights formally codified human rights for the Americas and the 1988 Protocol of San Salvador further strengthened economic, social, and cultural rights, including specific protections for "the right to health."[23] Drawing on these evolving legal imperatives for public health in the Americas, human rights have come to form a normative foundation of PAHO's health governance.

A. Health and Human Rights in the Americas

Influencing the development of human rights in PAHO governance, rights have become a central normative basis for health policy in the Americas. Although the states of the Americas present diverse cultures, backgrounds, and institutions, the region has largely prioritized health rights, exemplified by the protection of the right to health and other health-related human rights in over half of PAHO member state constitutions.[24] Building from a focus on social medicine in Latin America, the early half of the 20th Century saw nations – including Chile, Argentina, Ecuador, and Uruguay – employ social medicine to "study the social determinants of health/disease and health services."[25] These principles of social medicine would come to be codified under the human right to health.[26] With the expansion of social medicine supporting a rights-based focus on health, PAHO policy has reflected the normative priorities of its member states.[27]

From an understanding that illness originates from the economic, social, and political inequalities inherent in societal structures, social medicine arose in the early 20th Century to form a key normative basis for health policy in Latin America. Inspired by the failed 1848 revolutions across Europe, the implementation of social medicine theory sought to address social conditions as a means to alleviate morbidity and mortality.[28] This ideology came to influence both revolutionaries and policymakers in Latin America. Linking social structures to the causes of disease, the Chilean National Health Service sought economic reforms in the 1920s as a way to resolve the health harms of underdevelopment through income redistribution, regulation of food and clothing supplies, national housing programs, and industrial reforms.[29] Chile's efforts served as a model across Latin America, combining medical measures and economic policies to elevate standards of living and create a more egalitarian society.[30] By the 1960s, this "revolutionary medicine" framed an expanding number of national health systems as a means to primary care, salubrious environments, and social change,[31] with the 1961 Charter of Punta del Este urging all OAS member states to examine health as part of development.[32] These social medicine discourses would play a fundamental role in PAHO governance.[33] Organizing grants and fellowships for social medicine groups across Latin America, the PASB encouraged national policymakers to address social inequalities in health,[34] critique the public health harms of international economic policies,[35] and incorporate the human right to health in health policy.[36]

From this Latin American grounding in social medicine, the right to health has come to be seen as a programmatic right, with social medicine creating "new and distinctive methodological traditions" in applying the right to health.[37] Latin American states were among the first to proclaim a human right to health in their national constitutions,[38] and through this "social constitutionalism," the right to health has transformed in definition and incorporated programmatic aspects integral to policy implementation.[39] As seen in the experience of Argentina, it was only one year after the UN's Universal Declaration of Human Rights that the 1949 Argentine Constitution included a general social obligation for "[t]he care of the physical and moral health of individuals," with the Argentine National Congress amending this right in 1994 to include legal accountability for specific government obligations.[40] Converging in their respect for rights, states in the Americas have come to agree that "each person must be assured a certain minimum level of individual health care and public health protection."[41] Despite varied difficulties throughout the region in implementing these rights through national law and creating accountability for national governments,[42] the right to health is now formally enshrined in 19 of the 35 PAHO member state constitutions, an illustration of how social constitutionalism has permeated the legal foundations of Latin American and Caribbean states.[43] Given such momentum for human rights in public health policy, these member state efforts have influenced the development of human rights in PAHO governance.

B. Bringing Human Rights into PAHO Governance

As states in the Americas came to see health as a human right, they began looking to PAHO to secure this vision of health throughout the region. In reflecting on the Bureau's expanded organizational mission in the late 1950s, PAHO's new Director argued that "[w]e do not accept any discrimination or any compassion in health, we regard it as a right."[44] Driven by the rapid pace of recognition for the human right to health, states began in 1968 to discuss the application of international human rights instruments to the Bureau's technical cooperation. In seeking to harmonize national public health laws as a means to make the right to health a reality, the PAHO Executive Committee requested that the Bureau provide advisory services to promote and coordinate efforts across the region to incorporate the right to health in medical education, health administration, and international cooperation.[45] Drawing attention to this new rights-based focus in the region, PAHO and OAS co-edited a 1973 Special Issue of *World Health* (then WHO's principal publication) on "The Right to Health," with PAHO's Director opening the issue by arguing:

> [T]oday we can see health as being at the root of life, and in the destiny that each human being molds for himself; we understand it to be the infrastructure of happiness and the stimulus and component of development. We regard it as a goal for each person and as a means to achieve collective well-being. This enormous conceptual evolution – a reflection of scientific achievements and of the work of men, women, institutions, and governments – gives due priority to our plans, whose ultimate aim is making health a right and duty of all, not the privilege of some.[46]

Yet despite invoking the right to health in a political effort to secure universal medical coverage across the Hemisphere, this focus on human rights in the rhetoric of the organization did not immediately translate into rights-based PASB programming. Where PAHO legal officers saw "no direct link" between the international human right to health and PAHO policies,[47] the Bureau did not seek regional standards to clarify or implement the human right to health. As WHO sputtered in its attempt to create an international rights-based health policy framework in the 1978 Declaration of Alma-Ata, with this universal rights-based vision falling prey to WHO's decentralized authority,[48] PAHO would take little action to concretize human rights in regional governance.

This neglect of a rights-based approach to health in PASB programming would shift dramatically in the 1980s with the advent of the global HIV/AIDS response. As governments responded to the emergent threat of AIDS through traditional public health policies — including compulsory testing, named reporting, travel restrictions, and coercive quarantines — human rights were seen to alleviate public health infringements on individual liberty and serve as a rallying cry for HIV-positive activists.

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human rights protections in the Bureau's response to HIV.[52] Even as the Bureau's HIV/AIDS cluster faced subsequent cutbacks in its budget and staff, these early rights-based efforts provided a foundation for PAHO's broader public health efforts.[53]

Extended to the Bureau's mental health programs, the practice of applying rights in PAHO programs highlighted the instrumental value of human rights law in reforming national health systems. With PASB's expanding focus in the 1980s on both the mental health harms of war and the human rights violations occurring within psychiatric institutions, human rights had long found strong support in the Bureau's mental health unit, which recognized that policy reform could be facilitated through rights-based advocacy.[54] Solidifying this pragmatic approach to human rights in influencing state mental health practice, the Bureau convened mental health practitioners, national legislators, and human rights lawyers in 1990 to develop a set of psychiatric principles based upon human rights standards, with the resulting Caracas Declaration serving as the first regional public health statement to be grounded explicitly in international human rights.[55] With the OAS human rights system providing additional avenues to combat harmful psychiatric practices, the Bureau's mental health unit (supported by the legal office) went shortly thereafter before the Inter-American Commission on Human Rights to request formal hearings on the conditions of mental health institutions.[56] As PASB technical officers worked programmatically with human rights lawyers to improve care for mental illness, address determinants of mental health, and reform legislation for health systems, the mental health unit became a principal champion for a "non-traditional approach to health" — a rights-based approach to health.[57]

These select human rights efforts through the Bureau's legal office — expanding in the 1990s to include indigenous rights, child health, violence against women, and access to medicines — would create a model for incorporating rights across the organization.[58] While the WHO Secretariat and other WHO regional offices had principally employed human rights rhetorically, with rights serving only as a catchphrase to describe all their public health efforts, PAHO was beginning to analyze health policies, plans, and laws under human rights standards and to employ PASB officers to mainstream human rights principles throughout PAHO policies and programs.

III. Mainstreaming the Rights-Based Approach in PAHO Policies and Programs

Mandating a cross-cutting approach to the application of human rights, UN Secretary-General Kofi Annan called on all UN specialized agencies in 1997 to "mainstream" human rights throughout their policies and programs.[59] The WHO Secretariat took up this effort, seeking to reintroduce human rights as a basis for global health governance and reestablish WHO as "the world's health conscience."[60] Building upon Jonathan Mann's work in the HIV/AIDS response, WHO sought to revitalize Mann's framework to analyze the "inextricable linkages" between health and human rights.[61] This human rights mainstreaming was quickly replicated in the regional health offices, where it flourished in PAHO governance and national programs.[62] In mainstreaming health-related rights in the Americas, the Bureau would (a) embark on a series of rights-based technical projects, (b) build state capacity through national-level trainings, (c) advise the Inter-American human rights system on public health issues, and (d) receive increasing support for human rights from PAHO's governing bodies.

A. Collaborations with Technical Units

With both WHO and PASB creating human rights teams in the late 1990s, there was great initial promise for the development of a rights-based approach to global health governance.[63] Under PAHO Director George Alleyne, human rights arose out of the PASB Legal Department, with a human rights advisor working under the legal counsel and with technical units to advance public health through international law.[64] Where previous human rights actions had been undertaken through ad hoc projects, outside consultants, and independent funding, the appointment of a permanent human rights advisor allowed the Bureau to rely on sustainable resources for organizational mainstreaming.[65] In this capacity, the health and human rights advisor would have a mandate to coordinate with the WHO Secretariat, but also to work independently throughout the Americas — under the right to health and a range of health-related human rights. From this initial foothold in human rights law, PAHO Director Mirta Roses Periago relied on the legal counsel and human rights advisor to coordinate the mainstreaming of rights throughout the Bureau. While these efforts initially maintained a low profile, with Bureau staff concerned that some governments might take objection to an explicit human rights focus in the PAHO governing bodies, the Bureau was able to look to a series of external grants to fund rights-based projects on specific health issues and sustain human rights on the PAHO agenda. Examining the application of human rights to health policy, drawing on Mann's WHO efforts to conceptualize health and human rights, the Bureau would seek to carry out Mann's vision in the Americas.[66]

Introducing human rights into the work of the Bureau's technical units, the human rights team has worked with technical units to conduct trainings for PASB staff (in Washington and in country offices) on the Bureau's role in facilitating the implementation of international human rights instruments. Assisted by PAHO's academic partners — under either an "agreement for technical cooperation" (the Washington College of Law at American University), a designation as a "WHO collaborating centre in health and human rights" (Centers for Law and the Public's Health at Georgetown and Johns Hopkins Universities), or a partnership for a specific project (University of Albany's Institute for Health and Human Rights) – these PAHO trainings have introduced the entire PASB staff to the role of human rights as a basis for PAHO governance and a tool for health promotion. With guest lectures by the UN Special Rapporteur on the right to health and a new online human rights training course for all PAHO personnel,[67] the Bureau has gained increasing competence to operationalize a rights-based approach in regional health governance.

With the human rights team focusing on the incorporation of rights-based obligations in a series of technical units, 13 PASB technical documents have addressed the intersection of health and human rights. From early efforts in mental health, one "building block" was selected each year to apply human rights to a specific technical unit report, with over 10 years of "human rights themes" leading to a series of corresponding human rights resolutions in the Directing Council on populations in situations of vulnerability — including the mentally ill,[68] older persons,[69] persons with disabilities,[70] maternal mortality and morbidity,[71] gender equality and violence against women,[72] HIV/AIDS,[73] indigenous people,[74] and adolescent and child health.[75] Through these focused initiatives, technical units came to see the practical value of human rights mainstreaming to their substantive focus, with concrete outcomes for PAHO governance, as seen in:

- Mental Health — With the Bureau hiring its human rights advisor from the mental health practice community, this new officer turned first to the development of rights-based mental health policy,[76] analyzing rights-based policies on primary prevention and mental health promotion.[77] In supporting an expanding right to live in the community, these social protections created a political basis for states to address human rights in mental health, culminating in a 2009 Directing Council resolution to "strengthen the legal frameworks of the countries with a view to protecting the human rights of people with mental disorders."[78]
- Sexual Health — Drawing on its work in HIV/AIDS, PAHO in 2000 developed *Promotion of Sexual Health*, the first PASB document to discuss barriers to sexual rights.[79] In diverging from other regions in recognizing sexual rights, the Bureau then worked alongside the World Association for Sexual Health: to analyze in 2008 the extent to which sexual health factored into the realization of the UN Millennium Development Goals,[80] to examine in 2011 the relevance of human rights to the health of transgender populations,[81] and to provide in 2013 a set of recommendations for member states to address the link between discrimination (based on sexual orientation and gender identity) and access to health care.
- Adolescent Health — Grounded in the human right to health, the PAHO report *Adolescent and Youth Regional Strategy and Plan of Action 2010-2018* is the product of a collaboration between the human rights team and two technical units (Adolescent Health and HIV), advancing 'intersectional' rights issues involving overlapping vulnerabilities.[82] The resulting strategy and plan of action — passed by the Directing Council in 2008 and 2009, respectively — guide member states in improving the health of young people through an integrated response, framed normatively by the UN Convention on the Rights of the Child.
- Aging — In an effort to incorporate human rights in the provision of health services and the design of health systems with respect to older persons, the healthy aging program has worked closely with the human rights team to develop rights-based materials geared toward health personnel.[83] Developing a 2002 manual for primary care physicians who work in senior care, this manual sought both to frame older persons' health-related needs as legal entitlements and to transform human rights from an abstract concept into a practical tool for governments to better protect aging populations.[84]
- Tobacco — The tobacco control unit and human rights team have engaged in a range of efforts to combat tobacco consumption using human rights law. With the unit's first publication in 2006 focused on the human rights implications of secondhand smoke, subsequent reports have presented rights-based legal strategies to address tobacco.[85] Producing a manual to guide governments in drafting legislation to

> establish smoke-free environments, this report examines the relationship between state obligations under the WHO Framework Convention on Tobacco Control and those required under international human rights law, highlighting the "key role" that human rights play in "supporting and strengthening tobacco control policies."[86]

With efforts to address human rights in a new technical unit each year, the office of the legal counsel applied human rights — in collaboration with other cross-cutting themes (gender, ethnicity, equity) — to steadily accumulate support from technical offices, employing this support to (a) apply human rights law to new topic areas, (b) commemorate those technical units that have succeeded in advancing rights, and (c) justify the continuing importance of human rights in the Directing Council. Documenting the implementation of human rights for the health of vulnerable populations, human rights would come to be employed as a framework to reform health systems through health policies, plans, and laws.[87]

B. Building Government Capacity for Human Rights

In this implementation effort, the PASB has taken responsibility for national government capacity building on human rights. As national health ministries are increasingly employing human rights law, the Bureau has faced a "growing demand for technical cooperation [and] specialized information on public health in the context of international human rights instruments."[88] This technical cooperation, working with WHO country offices, has disseminated information on international human rights instruments, conducted technical trainings for government officials, and advised on the integration of human rights standards in national health policies, plans, and laws. With the Bureau seeking to raise awareness of human rights instruments and to train health policymakers on implementing a rights-based approach to health, each PAHO workshop begins with a discussion of Mann's tripartite framework as a basis for understanding the linkages between health and human rights.[89] From early trainings in mental health and human rights,[90] these in-person workshops and online trainings have expanded to improve the application of human rights to issues of:

- Aging — Directed at government and civil society representatives, the healthy aging program and human rights team have held a number of capacity building workshops to introduce human rights obligations as a mechanism for achieving universal access to health and social services for older persons. These workshops seek to train stakeholders on the development, implementation, and evaluation of public policies and programs that promote healthy and active aging, facilitating the enjoyment of highest attainable standard of health for older persons.[91]
- Adolescents — Emphasizing human rights implementation, the adolescent health unit has worked with the human rights advisor — along with WHO, UNICEF, the University of Southern California, and Save the Children — to train a broad range of local stakeholders on the meaning and application of the right to health. Participants in these daylong exercises develop actions plans for implementing the right to health, with the Bureau thereafter monitoring national progress to ensure plan realization.[92] With follow-up trainings on the sexual and reproductive rights of the young, the Bureau has continued to hold workshops to develop multi-sectoral national approaches to health and human rights.[93]
- Mental Health — The Bureau has held country workshops to facilitate the reform of national mental health policies and action plans in conformity with both international human rights norms and PAHO/WHO technical guidelines. For example, following an Inter-American Commission on Human Rights (Inter-American Commission) settlement with Paraguay on the human rights of institutionalized patients, the PASB conducted human rights training workshops to provide a space for Paraguayan stakeholders to discuss the implementation of the Inter-American Commission's precautionary measures while offering human rights training for public health officials.[94] Expanded across the region, PAHO has begun to examine the application of human rights instruments to mental health policies in eighteen countries, analyzing policies that are reflective of the progressive realization of rights in mental health policies, plans, and laws.[95]
- Tobacco — Together with the human rights team, the tobacco control program has designed and carried out country workshops across the region to train health officials on approaches to using the human rights framework to reduce tobacco consumption.[96] Upon the request of member states, the tobacco program and the human rights team continue to provide follow-up advice and technical guidance to governments in drafting tobacco control legislation.

Looking to the impact of this rights-based capacity building, understanding trends across nations and creating models for future trainings, PAHO is seeing the effects of its workshops on national health systems, with several governments in the region having since established specific rights-based institutions within national health ministries (and other government agencies) as a basis for human rights accountability in public health policy.[97] In examining the process by which human rights are implemented across the region, the Bureau is currently working with its collaborating centers to develop indicators that can evaluate: the impact of human rights through public health trainings, the fulfillment of human rights through national health systems, and the realization of human rights in public health outcomes.

In expanding implementation across the region, OAS member states included human rights as a guiding principle in the *2008-2017 Health Agenda for the Americas*, referring explicitly to the obligations necessary to realize specific attributes of the right to health.[98] Framing national health plans, health-related law reforms, and PASB technical cooperation, this *Health Agenda* has moved the Bureau beyond working only with health ministries, with such an intersectoral approach to health mirroring the interconnected nature of human rights. This OAS effort was then translated into the *2008-2012 PAHO Strategic Plan*, with the Pan American Sanitary Conference detailing how human rights could frame all of PAHO's intersectoral action on determinants of health:

> Human rights law, as enshrined in international and regional human rights conventions and standards, offers a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify the accountability and responsibilities of the different stakeholders involved.[99]

Reframed in the *2014-2019 PAHO Strategic Plan*, the Bureau is seeking to address determinants of health throughout the life course in accordance with a more expansive set of cross-cutting themes — including a holistic approach to gender equity, equity in health, ethnicity, and human rights.[100] Given this cross-cutting framing of the rights-based approach to health and detailed clarification of accountability of national stakeholders, the Bureau is continuing to expand its work with national governments to reform health-related laws and develop plans of action to incorporate human rights in health policy as a means to achieve universal health coverage.[101]

C. Relationship with the Inter-American Human Rights System

In expanding health and human rights policy-setting throughout the Americas, the Inter-American Commission has come to look to the Bureau for technical collaboration on public health issues and has supported PAHO in human rights efforts to realize public health. The Bureau's interactions with the Inter-American Commission – through informal conversations, formal testimony, and written opinions – have proven influential in advancing health issues across member states. With the PASB legal office serving as a bridge between the OAS's public health and human rights mechanisms, this relationship has served both to advance PAHO's health agenda through human rights law and to advance regional human rights agreements on public health issues.

The Inter-American Commission began work with PAHO on issues of mental health. Co-sponsoring the 1990 Regional Conference on Restructuring Psychiatric Care in Latin America, the resulting Declaration of Caracas (considered a "milestone" in mental health reform, in the region and beyond[102]) proclaimed human rights standards necessary to combat harmful psychiatric practices.[103] From this initial collaboration, the Bureau first came before the Inter-American Commission in 1994 to provide technical testimony on mental health practices and request human rights hearings on the conditions of psychiatric institutions.[104] Supported thereafter by the PASB Office of the Legal Counsel, the Bureau returned to the Inter-American Commission in 2001 to testify on the rights of persons with mental disabilities, contributing to an initial Recommendation on the Rights of Persons with Disabilities.[105] This PAHO collaboration on mental health has continued with the Inter-American Commission, facilitating a series of formal visits to mental health institutions, individual human rights claims on psychiatric practices, and human rights workshops for mental health officials.[106] To ensure enduring collaborations, the Bureau has recommended that its technical opinions on mental disabilities be "incorporated in final reports" of the Inter-American Commission, thereby raising government awareness on the right to mental health and developing concrete actions for the promotion and protection of persons with mental disabilities.[107]

The Inter-American Commission has now solidified a process for requesting PASB guidance and looks to PAHO's technical opinions in developing human rights obligations on a wide range of public health issues. While PAHO does not offer an opinion on the human rights merits of an issue, the PASB legal office works with technical units to develop OAS presenta-

tions and advisory sessions based upon PAHO technical guidelines.[108] In this advisory role, the Inter-American Commission has requested that PAHO provide technical opinions on, among other topics, infant malnutrition, disability, mental health, in vitro fertilization, Chagas disease, health technologies (including medications), health services, and HIV/AIDS.[109] As seen in the case of HIV/AIDS, where civil society organizations pressed the Inter-American Commission in 2004 for precautionary measures to guarantee access to antiretrovirals (ARVs), the Commission first sought PAHO testimony on technical issues related to the severity of the HIV/AIDS pandemic, the impact of HIV treatment, and the need to ensure availability of combination treatment.[110] Through the cooperative efforts of the HIV technical unit and human rights team, this PASB testimony on HIV/AIDS paved the way for states to develop policies guaranteeing ARV access.[111] Building from this initial HIV/AIDS guidance, the Inter-American Commission called on the Bureau again when discussing HIV in the Caribbean region, with PAHO's 2012 testimony noting that human rights violations are a barrier to overcoming HIV/AIDS and recommending an expansion of right to health indicators in assessing HIV/AIDS efforts.[112]

In facilitating accountability for human rights implementation, the Bureau's technical support to the Inter-American Commission has facilitated jurisprudence related to the right to health and indicators to assess realization of human rights. While PAHO does not bring human rights cases or provide human rights testimony in jurisprudence before the Inter-American Court of Human Rights, PAHO may indirectly influence the Inter-American Court's jurisprudence by recommending outside human rights experts to provide testimony on health and human rights issues.[113] Pressing for accountability through indicators beyond the Millennium Development Goals (MDGs), the Bureau has argued before the Inter-American Commission that:

> in addition to the MDGs as a measurement instrument, it was also necessary to include all the resolutions that concern the right to health, in particular on primary health care and protection of vulnerable groups, discussed and adopted by the OAS member states in the Directing Council and/or the Pan American Sanitary Conference of the PAHO in the context of the Constitution of the WHO.[114]

Such concerted cooperation on human rights accountability between the Inter-American Commission and PAHO has supported the formalization of rights-based indicators on the measurement of economic, social, and cultural rights, and through the OAS, PAHO has now assumed responsibility for the implementation of these indicators pursuant to the right to health.[115]

This mutually beneficial PASB relationship with the Inter-American human rights system has culminated in the development of public health obligations in regional human rights agreements. As seen in the ongoing development of the Inter-American Convention on the Rights of Older Persons, the Pan American Sanitary Conference first urged member states in 2002 to advocate for the promotion and protection of the human rights of older persons.[116] By 2009, human rights were at the core of the Directing Council's *Plan of Action on the Health of Older Persons including Active and Healthy Aging*.[117] Taking up this health and human rights consensus, the OAS Permanent Council called in 2011 for a special meeting of stakeholders to share best practices and examine the feasibility of preparing an Inter-American Convention on the Human Rights of Older Persons.[118] As the OAS develops this Inter-American Convention, the Bureau has remained closely involved in framing public health obligations for this regional human rights treaty.[119]

D. Solidifying Human Rights in the Americas

Following from the PASB's efforts to mainstream human rights in the Bureau's technical units, provide technical assistance to states in developing rights-based health policy, and cooperate with OAS human rights institutions to consider health issues, PAHO member states have sought to create a legislative basis for these synergistic efforts at the intersection of health and human rights. With evolving state support for the Bureau's human rights work, reflected in a series of rights-based resolutions on a range of health issues,[120] the PAHO Directing Council adopted a 2010 Resolution on Health and Human Rights to solidify human rights in national health ministries and PASB technical programs. This Directing Council Resolution has created a specific PAHO mandate for human rights law, with states emphasizing "the need to raise awareness of the health-related provisions of binding international human rights instruments" and seeking to guide the Bureau's response to the region's increasing demand for technical cooperation on human rights matters.[121] Focused on Bureau support for the implementation of international human rights instruments in national policy, the Directing Council examined a series of proposals put forward in a PASB Concept Note.

The Bureau's Concept Note, developed at the request of member states, compiled the region's national practices in realizing health-related human rights and chronicled the PASB's 10-year effort to

With limited coordination or support across institutions of global health governance, these independent PAHO efforts have served the UN's goal of mainstreaming a rights-based approach to health in the Americas — working through the Bureau's technical units, national health ministries, the OAS human rights system, and the PAHO Directing Council. This Part analyzes the structural determinants that facilitated this rights-based approach to health in PAHO and considers generalizable themes for the implementation of human rights through regional health governance.

mainstream human rights in its policies and programs.[122] Framed by Mann's framework on the "inextricable linkages" between health and human rights, the Concept Note highlighted the necessity of international legal standards to respect, protect, and fulfill the health of vulnerable populations. By reviewing the Bureau's growing support for human rights in the Americas, this summary and analysis examined trends in PAHO's rights-based work with national governments, international institutions, and non-governmental organizations.

Emphasizing the increasing extent to which the Pan American Sanitary Conference and Directing Council have urged PAHO member states to formulate policies in accordance with human rights norms, the Concept Note offered recommendations to the Directing Council in solidifying the Bureau's authority to:

1. cooperate with international human rights institutions,
2. incorporate human rights in PAHO technical areas, and
3. support member states to: monitor human rights compliance, develop rights-based health policy, strengthen human rights competencies of health personnel, implement international rights through national governments, and train civil society organizations.[123]

As an annex to the Concept Note, the Bureau included a proposed Directing Council resolution that would provide "a unifying conceptual and legal framework for strategies to promote and protect the health of groups in situations of vulnerability."[124]

Recognizing the evolution of human rights in national health systems and PASB technical cooperation, the proposed Resolution on Health and Human Rights drew upon previous Directing Council statements to urge that:

- Member States — strengthen the technical capacity of health authorities to implement international human rights instruments, support law and policy reforms to incorporate human rights, and promote the right to health with policymakers and civil society organizations.
- The PASB — cooperate with the UN and OAS human rights systems, train the Bureau's technical staff on rights-based issues, collaborate with non-governmental actors to protect human rights, and promote rights-based practices among PAHO member states.

With this proposed Resolution introduced by Argentina — with support from Mexico, Canada, and the United States — no substantive edits were made by member states,[125] and the Directing Council unanimously adopted the Resolution as a roadmap for the Bureau's human rights efforts.[126]

The PAHO human rights advisor would describe this Directing Council vote as "the beginning of a new era in health and human rights" in PAHO policies and programs.[127] At the conclusion of voting, the human rights advisor addressed state representatives directly, recognizing Jonathan Mann's seminal role in linking health and human rights and outlining the ways in which these evolving rights could continue to prevent disease and reduce inequities in the region. Concluding that human rights approaches could be as important as public health approaches, he encouraged states to examine PAHO's initiatives to develop indicators that would highlight where states have successfully adopted policies to implement human rights obligations.[128] Following from a decade of PAHO efforts to implement human rights in the Americas, this state support has provided a new foundation to advance the rights-based approach to health through regional health governance.

IV. Promoting Human Rights through Regional Health Governance

Given this unique human rights trajectory within PAHO, there arises a research imperative to analyze the structural factors leading to the Bureau's application of human rights. Although the PASB began its mainstreaming efforts at approximately the same time as the WHO Secretariat and other regional offices, with similar aims and strategies governing their respective activities, PAHO has achieved greater incorporation of human rights in health policy and programming than other institutions.[129] With limited coordination or support across institutions of global health governance, these independent PAHO efforts have served the UN's goal of mainstreaming a rights-based approach to health in the Americas — working through the Bureau's technical units, national health ministries, the OAS human rights system, and the PAHO Directing Council. This Part analyzes the structural determinants that facilitated this rights-based approach to health in PAHO and considers generalizable themes for the implementation of human rights through regional health governance.

A. Human Rights Leadership

Within PAHO governance, human rights has had far-reaching support from the Director's Office, without which a human rights advisor would not exist to support rights-based programs and PASB technical officers would not have authority to engage with the rights-based approach to health. Secretariat leadership has long been seen as a pivotal driver of organizational promotion of human rights, exemplified in both UN efforts to mainstream rights[130] and WHO efforts to advance rights-based health reforms.[131] Where powerful states have often been cautious of the development and implementation of human rights in international organizations,[132] secretariat leaders have the political authority to overcome resistance in international relations[133] and implement human rights to realize their organizational mission.[134] Expending political capital to assure human rights promotion, the rights-based approach was seen to have the sustained support of every recent PAHO Director, each committed to the independence of the Bureau in pursuing human rights in PAHO policies, programs, and strategic plans.

This PASB leadership for human rights has afforded legitimacy to efforts to mainstream rights — across the Bureau and in work with member states. Supporting human rights in PAHO programming, PAHO Director Carlyle Guerra de Macedo (1983-1995) provided necessary financial support to hold the Caracas Conference on mental health, bringing together public health and human rights practitioners[135] and thereafter co-authoring an article that promoted the rights-based approach to mental health.[136] With the election of Director George Alleyne (1995-2003), the Bureau expanded this rights-based focus, looking specifically to equity in determinants of health and engaging human rights consultants to coordinate PASB efforts on the human rights of persons with mental disorders and those living with HIV.[137] Director Mirta Roses Periago (2003-2013) would bring renewed support to the Bureau's efforts to mainstream human rights norms and standards through all PASB departments and technical units, as seen where she (a) blunted state criticism of the Bureau's approach to sexual and reproductive rights, (b) endorsed the implementation of human rights as a tool for adolescent health,[138] and (c) recognized that human rights constitute a "powerful mechanism" for addressing the "high human and public health costs" of tobacco.[139] The Director's efforts, pressing for the 2010 Directing Council Resolution on Health and Human Rights, gave priority to human rights work across country offices (arguing that human rights is "not an optional tool" in health programming[140]), mandated human rights training for all Bureau staff (inviting the UN Special Rapporteurs on the right to health to speak with PAHO technical officers[141]), and highlighted support for the rights-based approach to health (representing the Bureau herself before the Inter-American Commission on Human Rights[142]). Since Director Carissa Etienne's January 2013 inauguration, she has set out early in her administration to provide direction on the rights-based approach, sending a clear message on her leadership for human rights, technical priorities for the Bureau, and support for health-related law and policy reform based on international and regional human rights instruments.

The support provided by the organization's leadership, both within the Bureau and in relations with member states, allows human rights to flourish within a technical organization. Through the PAHO Directors, PASB staff have been given: authority to incorporate human rights across the Bureau, space to work independently on rights-based grants, and guidance to coordinate technical collaboration with national governments to justify human rights in PAHO programming. At times when PAHO Directors have not actively supported the rights-based approach to specific health issues, they have nevertheless facilitated rights-based efforts by technical units. With PAHO's strategic plan 2014-2019 prioritizing human rights protection, universal health care, and health-related legislation, there continues to be a cross-cutting man-

date from the top of the organization to apply human rights law to PASB programming and to develop a rights-based approach to health.

B. State Support

The politics of health and human rights in the Americas structures the ability of the Bureau to implement human rights in regional health governance. From a basis in social medicine in Latin America, human rights have found a central role in framing health policy in American states. Beyond health issues, political support for human rights has steadily grown, as states experienced a shift from dictatorial regimes to electoral regimes and human rights advocacy networks emerged across the region.[143] This normative shift toward rights-based governance — focused initially on civil and political rights but evolving to encompass economic, social, and cultural rights — is seen as a hallmark of the democratization process, with specific focus on the right to health among newly-established electoral regimes.[144] As the rights-based approach took shape within PAHO, many member states were embracing health and human rights in the push toward democracy (seen in the constitutional codification of a right to health), working within OAS to advance rights-based governance (seen in the Inter-American Commission), and financing national human rights institutions (seen in human rights ombudspersons).[145] With American states increasingly receptive to the rights-based approach to health — beginning in Central and South America, expanding to the Caribbean and Canada, and now including the United States — the Bureau has been afforded far greater support from states than is seen in the WHO Secretariat or other regional offices.

States in the Americas have come to express strong support for human rights, both under the right to health and rights to interconnected determinants of health. In the early years of the HIV/AIDS response, rights-based rhetoric was quickly accepted by many states in the Americas (with notable exceptions in the United States and some Caribbean states, which restricted individual rights in seeking to control the epidemic[146]) and was widely embraced as the universal language of civil society advocacy.[147] Given this state and civil society support, it became politically practicable for PAHO to analyze the role of human rights for populations vulnerable to HIV and to encourage states to request the Bureau's technical cooperation in rights-based policy reforms.[148] From the HIV/AIDS experience, states in the region have looked to health-related human rights as a normative basis for their health policies, advancing these norms through PAHO governance, Inter-American Commission jurisprudence, and the UN human rights system.[149] Where the invocation of human rights at the PAHO Directing Council is not always matched by the implementation of rights in national policy, health ministers and NGOs have employed PAHO's rights-based resolutions in advocating for national reforms, as seen where NGOs employed PAHO Directing Council resolutions to garner state support for mental health protections in the 1990 Caracas Declaration and 2005 Brasilia Principles.[150] This national advocacy has, in turn, pushed states in the Americas to adopt increasingly progressive statements at the World Health Assembly in Geneva and PAHO Directing Council in Washington, leading to robust regional debates on human rights and culminating in the 2010 PAHO Resolution on Health and Human Rights.[151] Continuing to be felt in the Directing Council's 2013 debate on reducing health discrimination against LGBT populations, where every Latin American nation had already removed anti-sodomy laws and the United States introduced the resolution in the Directing Council, human rights are providing a means to develop regional health standards.[152]

States in the Americas have come to express human rights norms in national policy debates and to advance those norms in regional health governance. Despite a public silence on human rights issues in the early 2000s, with the United States then objecting to any mention of human rights beyond the WHO Constitution, human rights continued to be operationalized *sub rosa* through the support of Canada and Latin American states.[153] With the Directing Council now publicly celebrating human rights, the past six years have seen explicit discussion of rights-based causes in PAHO statements, resolving to support human rights in all PASB efforts and grounding PAHO strategic plans in the right to health.[154] Buttressed by the OAS human rights system, the Bureau has found regional support to advance state implementation of health-related rights. While states in other regions continue to place limits on human rights in global health governance, the states of the Americas have reached contemporary consensus in supporting PAHO's rights-based work through regional policies and PASB programs.

C. Legal Expertise

The interpretation and application of international human rights law in PAHO policies and programs has required a robust legal team to support human rights implementation and health-related laws. Legal expertise provides a path to advance human rights through health-related laws, translating public health standards into public policy and institutionalizing rights-based legislation in the Americas. Where organizations with limited legal capacity have been seen

as less effective in implementing human rights law,[155] legal expertise is thought to play a formative role in ensuring institutional capacity to mainstream human rights,[156] with lawyers translating international legal norms into rights-based programmatic actions.[157]

Drawing on legal expertise inside and outside of the PASB, the Office of the Legal Counsel could assure that PAHO efforts accorded with human rights law. This legal expertise has proven effective in PAHO consultations with national policymakers, the Inter-American Commission, and UN human rights institutions:

- National Policymakers — Legal expertise has proven beneficial for human rights advancement at the national level, allowing the Bureau to be involved in rights-based reforms of health systems and challenges in national courts. At the national level, the PASB Office of the Legal Counsel has consulted with national governments (in conjunction with technical units) to facilitate rights-based health legislation and has supported civil society organizations (in national judicial challenges) to uphold health-related rights.[158] With the PASB holding country workshops to advise states on the rights-based approach, these workshops have required comparative legal expertise to assure that PAHO's rights-based proposals are appropriate to the national context, incorporate best practices in public health, and assure realization of human rights.[159]
- Inter-American Commission — Support from the PASB Office of the Legal Counsel has provided a basis for legal collaborations with the OAS human rights system, facilitating legal accountability for human rights violations.[160] Beginning with legal support for the Bureau's mental health unit (in bringing PAHO's first request for hearings to the Inter-American Commission), the Commission has come to request PAHO technical advice in making human rights decisions on a range of public health issues, including mental health, HIV/AIDS, neglected diseases, access to health technologies, and aging. Yet where regional health offices are providing this technical testimony on public health issues, legal officers become necessary to translate the data of technical units into briefs that can support international legal decisions in a manner consistent with international treaties and standards.
- UN Human Rights Institutions — The PASB has served as a crucial link between the region and the UN human rights system, sharing legal expertise at the global level to benefit health in the Americas. In enlisting UN human rights resources for the Americas — in both rights-based programs in the regional office and rights-based policies among national governments — the Bureau has undertaken legal collaborations with WHO, UNICEF, UNDP, UNFPA, the Office of the UN High Commissioner for Human Rights, UN treaty bodies, and the UN Human Rights Council to develop best practices for policy implementation of health-related rights.[161] Facilitating accountability for human rights realization, PAHO has cultivated influential relations with several health-related UN Special Rapporteurs — with the Bureau supporting country missions, providing comments on legal reports, and linking rapporteurs to the Inter-American Commission, academic researchers, and civil society organizations.[162]

Through these legal collaborations, the Bureau has developed regional policy to protect health-related human rights, in PAHO and throughout the Americas. As seen in the PASB manual on senior care, developed by the aging unit and the human rights team, legal expertise provided a path to apply the Bureau's technical documents to international law and set an evidence-based foundation for the Draft Inter-American Convention on the Human Rights of Older Persons.[163] Such codifications of public health standards are not possible without legal expertise.

Even as the WHO Secretariat and other regional offices are reorganizing to combine human rights with other normative frameworks — developing a larger gender, equity and human rights (GER) mainstreaming unit[164] — PAHO has reintegrated human rights under the Office of the Legal Counsel, moving human rights out of the Gender, Diversity and Human Rights (GDR) Office.[165] Recognizing that human rights is fundamentally a legal institution, the Office of the Legal Counsel has assumed responsibility for human rights within PAHA and examined all legislative issues from a human rights perspective.[166] Where PAHO has lacked sufficient legal resources on rights-based issues, the Bureau has found support through "collaborating centers" at U.S. law schools, providing necessary legal expertise on discrete projects.[167] This gathering of legal expertise allows the human rights team to take ownership over human rights law, working from an office explicitly focused on the legal development and implementation of the rights-based approach to health.

D. Technical Unit Commitment

Catalyzing widespread organizational commitment to human rights, a number of PASB technical units see the programmatic advantages of human rights law to their technical programs, and in turn, have supported the human rights team in Bureau reorganizations. Technical team support for human rights is seen as essential to human rights mainstreaming, where "true believers" support organizational reforms and overcome internal obstacles to human rights;[168] conversely, human rights mainstreaming can be blunted where technical staff decline to participate in programs that do not align with their technical training and are not seen to impact their technical mission.[169] Yet institutional reform to mainstream rights is often a lengthy process, with incremental changes necessary to highlight the application of human rights to technical programs[170] and create buy-in from technical officers.[171] As seen in PAHO, the human rights team built PASB support from technical units one-by-one, working in collaboration with each unit to demonstrate the pragmatic benefits of human rights to the unit's technical agenda rather than seeking to mainstream rights across the entire organization. Through these intentionally incremental steps, the human rights advisor experimented with approaches to mainstreaming and created a record of successful rights-based consultations, relationships, and outputs across the Bureau. This 15-year approach to PASB mainstreaming (through piecemeal approaches rather than a universal mandate) has defined the Bureau's human rights work and led to steadily increasing technical unit support for human rights.

Technical units have come to see the potential of human rights norms as a powerful advocacy tool that could complement their biomedical efforts and press governments to adopt particular reforms. Through work with the human rights team, technical units discovered new avenues to both framing health measures as human rights entitelements law and institutionalizing accountability mechanisms for human rights realization, as seen in:

- Sexual Rights — where PASB technical units could alternate among public health, human rights, or sexual rights rationales (depending on the audience) and could clarify how each attribute of sexual health was linked to an international human rights obligation;[172]
- Aging — where framing the vulnerability of older persons around human rights led governments to assume greater responsibility for the health needs of aging populations and to secure health obligations in the draft Inter-American Convention on the Human Rights of Older People;[173]
- Mental Health — where human rights advocacy restructured psychiatric care throughout the Americas, supporting international declarations on the norm of deinstitutionalization and a right to live in the community;[174]
- HIV/AIDS — where technical officers looked to the human rights team to develop rights-based obligations in the 2008 Ministerial Declaration on Education to Prevent HIV;[175]
- Adolescents — where incorporating a rights-based approach allowed the technical unit to influence government investment in adolescent health and frame evaluations of for the progressive realization of health-related rights;[176] and
- Tobacco — where human rights have framed legal efforts to press for smoke-free environments under the Framework Convention on Tobacco Control.[177]

Complementing this normative development with rights-based legal accountability — with legal enforcement through litigation, indicators, and monitoring — human rights law has proven instrumental to advancing the health goals of technical units. As a result of these collaborative efforts, human rights are not seen as restricted to legal officers but useful across health issues, with technical officers employing human rights discourses and pushing human rights reforms.

The positive impact that human rights law could have on public health outcomes, reinforced in PASB human rights capacity building efforts, became an assumption that drove technical units to work with the human rights team. Through these collaborative efforts, the human rights team mobilized technical units to understand the value of human rights to their programming and rewarded those technical units that pursued rights-based programs, awarding large rainbow kites to those units that employed human rights in their reports and hanging these kites in technical unit offices to denote where human rights "soar" within the Bureau.[178] This expanding collaboration between the technical units and the human rights team — now encompassing well over half of the technical units, with kites hanging throughout the Bureau headquarters — reflects the success of a results-based approach to mainstreaming human rights.

VI. Conclusion

Human rights have framed PAHO efforts to address disease prevention and health promotion, with the Bureau increasingly framing public health threats as human rights violations. Through analysis of the

structural bases for these PASB efforts, it becomes possible to understand the institutional determinants of the rights-based approach to health, providing lessons to other WHO regions in efforts to mainstream human rights. Looking beyond regional governance, future national-level research can begin to understand the causal forces linking regional human rights work with national implementation, including in health-related laws, government programs, and health systems. Through an understanding of human rights implementation, from international institutions to individual lives, it will be possible to study the causal processes that shape the impact of human rights efforts on public health outcomes.

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