

GLOBAL



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**THE SCHOLARLY JOURNAL FOR THE NEW HEALTH SECURITY PARADIGM
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GLOBAL HEALTH GOVERNANCE IS AN OPEN ACCESS, PEER-REVIEWED, ONLINE JOURNAL THAT PROVIDES A PLATFORM FOR ACADEMICS AND PRACTITIONERS TO EXPLORE GLOBAL HEALTH ISSUES AND THEIR IMPLICATIONS FOR GOVERNANCE AND SECURITY AT NATIONAL AND INTERNATIONAL LEVELS.

THE JOURNAL PROVIDES INTERDISCIPLINARY ANALYSES AND A VIGOROUS EXCHANGE OF PERSPECTIVES THAT ARE ESSENTIAL TO THE UNDERSTANDING OF THE NATURE OF GLOBAL HEALTH CHALLENGES AND THE STRATEGIES AIMED AT THEIR SOLUTION. THE JOURNAL IS PARTICULARLY INTERESTED IN ADDRESSING THE POLITICAL, ECONOMIC, SOCIAL, MILITARY AND STRATEGIC ASPECTS OF GLOBAL HEALTH ISSUES.

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HUMAN RIGHTS IN GLOBAL HEALTH GOVERNANCE

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Human Rights in Global Health Governance

Benjamin Mason Meier, Hanna Huffstetler and Lawrence O. Gostin

INTRODUCTION

Human rights frame global health governance. In codifying a normative foundation for global governance in the aftermath of World War II, states came together under the auspices of an emergent United Nations (UN) to develop human rights under international law.¹ Human rights law, establishing international norms to advance global justice, has thereby become a universally accepted framework for global health,² and the past seventy years have witnessed an evolution of international human rights law to define the highest attainable standard of health.³ Conceptualizing health disparities as rights violations, these health-related human rights offer universal standards to frame government responsibilities for the progressive realization of health and facilitate legal accountability for health policy.⁴ Where globalizing forces have created an imperative for global governance institutions to meet an expanding set of global health challenges, human rights have come to guide institutions of global health governance.⁵

As rights-based approaches have become fundamental to global health governance, the proliferation of global governance institutions has warranted a wider sharing of human rights responsibilities for health beyond the UN human rights system.⁶ Institutions of global governance are not only seen as instrumental to the development of international human rights law but also as essential to assuring the implementation of rights-based obligations in a rapidly globalizing world.⁷ Over the past twenty-five years, the UN has sought to formalize these human rights implementation responsibilities across the entire global governance system. Translating international law into organizational action, global governance institutions seek to “mainstream” human rights across their policies, programs, and practices.⁸ To understand the ways in which human rights are realized in global health, this Special Issue of *Global Health Governance* examines the role of global health governance institutions in structuring the implementation of human rights for public health.

THEMATIC CONTENT OF THE SPECIAL ISSUE

The diverse scholarship highlighted in this Special Issue identifies the rights-based actions of global health institutions and analyzes facilitating and inhibiting factors for human rights mainstreaming in global health governance. Rather than looking only to the language of human rights in institutional documents, these articles seek to assess how institutional policies, programs, and practices support or limit human rights advancement for public health promotion. Where institutions of global health governance face challenges in mainstreaming human rights through institutional actions, multi-sectoral approaches, coordination, and collaborations across institutions and stakeholders are discussed as ways to facilitate the implementation of health-related human rights. To explore these aspects of human rights mainstreaming, the articles in this Special Issue address critical questions across key themes that define global governance for health.

Operationalizing Human Rights in Global Health through the World Health Organization

First among these themes is the role of the World Health Organization (WHO) in operationalizing human rights for global health. Although WHO once had unrivaled

leadership over global health, the contributions to this Special Issue highlight the lack of a contemporary institutional leader to coordinate rights-based global initiatives to prevent disease and promote health. In this shifting global health landscape, contributing authors analyze WHO's contemporary efforts to reassert health-related human rights for vulnerable populations through its multilateral policy platform and international normative guidance.

In a commentary on WHO's role in advancing the right to healthcare in conflict, Leonard Rubenstein discusses WHO's failure to address attacks on healthcare workers and facilities. Rubenstein suggests that while WHO's "broad view of the scope of healthcare protection is consistent with the right to health," the organization does not frame its work in accordance with human rights criteria. Although the WHO Executive Board voted to pass a resolution on WHO's role in humanitarian emergencies, internal confusion and capacity limitations have restricted WHO's ability to realize its obligation to "develop methods for systematic data collection and dissemination" in complex humanitarian emergencies. Cooperation among WHO member states, who are often the perpetrators of violence against healthcare workers and facilities, remains an unresolved challenge in realizing rights to protect health systems through WHO governance.

Framed by these challenges to cooperation among member states, Po-Han Lee's commentary examines WHO's engagement to realize the right to health for lesbian, gay, bisexual, and transgender (LGBT) individuals. Where the WHO Executive Board is seen as "the gatekeeper of the global health agenda," Lee argues that the debate about LGBT health at WHO is "deadlocked" by a "lack of globalism." Despite evidence of health risks faced by LGBT individuals, many governments still maintain discriminatory practices against sexual and gender minorities in domestic policy and, in accordance with domestic practices, seek to block LGBT health on the global health agenda. As the Executive Board continues to be constrained by conflicts among national ideologies, these conflicts inhibit WHO's cosmopolitan vision of "health for all." To achieve more open dialogue, the author contends that a people-centered approach to global health governance, "accommodating the 'polyvocality' of civil societies," is imperative to the realization of health justice.

The achievement of a people-centered approach to health, however, requires meaningful WHO guidance to inform both national and international health policy. Mark Eccleston-Turner investigates the utility of the WHO Pandemic Influenza Preparedness (PIP) framework—developed through negotiations with industry, civil society, and other stakeholders—in facilitating the realization of the right to health in the context of an influenza pandemic. Although there exist core legal obligations to provide essential drugs and immunization against major infectious diseases under the right to health, Eccleston-Turner argues that such obligations presuppose "that the state is capable of adequately addressing the problem with the resources it has available to it." Where the state lacks the means to secure access to medicines on behalf of its population, the WHO PIP framework seeks to create a global "virtual Stockpile" of pandemic influenza vaccines for distribution to countries in need. Yet, while the PIP framework enables "equalized vaccination timing" between developing and developed states, Eccleston-Turner argues that it insufficiently addresses the needs of developing states to achieve minimum vaccination coverage to establish community immunity. This shortcoming suggests that the framework "is not able to ensure that developing states are able to make use of the Stockpile in order to discharge their right to health obligations." Moving forward, Eccleston-Turner suggests that the WHO put greater emphasis on transfer of technology in its Standard Material Transfer Agreements, empowering developing states to manufacture sufficient levels of vaccines domestically to discharge their right to health obligations.

Promoting Human Rights Across Multi-Sectoral Institutions that Govern Underlying Determinants of Health

Where WHO has faced shortcomings in implementing human rights for health, there is tremendous value in collaboration across multi-sectoral governance institutions to facilitate global solidarity and bolster efforts to mainstream human rights in addressing underlying determinants of health. As a second theme of this Special Issue, contributing authors review how institutions throughout the UN system have sought to mainstream human rights in a multi-sectoral approach to global health partnerships. These articles examine the achievements of, and challenges faced by, institutional collaborations for human rights advancement to meet global health goals.

The implementation of human rights law in global health governance can be seen as a measure of success for human rights governance; yet, as the articles in this Special Issue demonstrate, global health governance at times suffers from a paucity of institutional mechanisms to facilitate accountability for the realization of health-related human rights. Reflecting a lack of coordination between institutions, varied institutional approaches have arisen to monitor the realization of health-related human rights. This lack of standardized assessments is analyzed by Sara Davis, Doris Schopper, and Julia Epps, who compare sexual violence intervention monitoring and evaluation indicators across global health institutions. By examining a set of organizations particularly active in the area of sexual violence in humanitarian contexts—the WHO, International Red Cross, and UNFPA among them—the authors find that “there is as of yet not one core package of interventions for sexual violence survivors agreed among all institutions: some emphasize mainstreaming, while others emphasize specific types of programming.” Despite this fragmentation of indicators to assess medical care, mental health and psychosocial support, and legal aid in the context of sexual violence in conflict settings, the authors find that there are a “number of commonalities” between programmatic interventions, such as an emphasis on access to emergency care and the need for women’s participation in stakeholder consultation and governance mechanisms.

Given that overlapping institutions operate under independent normative frameworks and political motivations, inter-organizational partnerships can provide a means to harmonize shared norms through human rights. The Office of the UN High Commissioner for Human Rights (OHCHR) has sought to facilitate greater normative consensus in these partnerships through its participation “in inter-agency bodies and activities to advocate for a human rights-based approach in all UN activities.” Through the identification of key factors that have influenced the evolution of the right to health at the OHCHR, Gillian MacNaughton critically examines the ways in which the OHCHR has promoted human rights mainstreaming through its institutional leadership. However, low financial commitment, insufficient staff, and difficulty transitioning from to “conceptualization implementation” are highlighted as central challenges to human rights mainstreaming for health through OHCHR support. Despite these challenges, salient OHCHR leadership and engagement has supported institutions of global health governance across the UN system, building human rights capacity among institutions in translating their commitment to human rights into rights-based policies and programs. Acknowledging the significance of health-related human rights to the realization of other rights, MacNaughton concludes that a greater interdisciplinary approach to the practice of human rights “could substantially advance the mainstreaming of the right to health – at the OHCHR and globally.”

As such multi-sectoral collaborations can influence the substance and process of human rights mainstreaming, Samantha Plummer, Jackie Smith, and Melanie Hughes examine the inter-organizational networks formed by intergovernmental organizations (IGOs) for health and transnational social movement organizations (TSMOs) for women’s

and other human rights. By looking at longitudinal trends in the links between TSMOs and prominent health IGOs, the authors find that while the number of organizational partnerships between the two has grown over the past thirty years, recent trends suggest that “for human rights groups addressing the right to health, not all health-related IGOs are equally attractive partners.” Noting a lack of TSMOs reporting ties to the WHO, the world’s leading global health organization, the authors contend that this lack of partnerships is “largely a consequence of the WHO’s lack of formal infrastructure for non-state engagement and of its failure to challenge neoliberal approaches to health policy.” Through additional network analysis, the authors find that other agencies addressing issues underlying health, particularly the United Nations Children’s Fund (UNICEF) and the Food and Agriculture Organization of the United Nations (FAO), have become “more central” in global health governance networks.

Economic Governance for Global Health through Human Rights

These rights-based inter-organizational partnerships have become particularly relevant in an expanding global health landscape limited by scarce resources and increased competition among a growing number of stakeholders. In the final theme of this Special Issue, contributing authors explore how the structure of economic governance, through financial support for global health or economic impediments to health governance, can influence the realization of health-related human rights. Through rights-based approaches to public health financing and international trade law, these bilateral and multilateral partnerships for specific health priorities can either advance economic governance to achieve health goals or advance economic ends in ways that damage public health.

Focusing on the role of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), Sharifa Sekalala and Toni Haastrup examine the practices and mechanisms utilized by the GFATM to promote human rights among recipient countries. While the GFATM has sought to integrate human rights considerations into its institutional funding practices, thereby developing new rights-based rules of appropriate behavior at the domestic level, it has “created challenges in the transposition of human rights norms within domestic contexts.” The authors note that a challenging institutional context, contestation by domestic partners, lack of human rights indicators, and limited resources hinder the Fund’s ability to achieve a full realization of human rights on the ground level. Where the work of the GFATM is crucial to ensuring that human rights are realized through health policy and practice in recipient countries, Sekalala and Haastrup argue that GFATM must push for an increased intersectional approach, not only in its conceptualization of human rights, but also among its programs and methods of financing.

The effective translation of human rights under international law into human rights realization in public health practice is a metric of success for human rights mainstreaming, and the failure to meet this standard limits the credibility of an institution in global health governance. Through an institutional analysis of the World Bank, Yusra Shawar and Jennifer Prah Ruger identify factors that have either facilitated or challenged the advancement of rights-based approaches in the World Bank’s global health funding. Continuing barriers to human rights mainstreaming include not only resistance from some member states, as discussed in other articles of this Special Issue, but also the Bank’s strictly economic, non-political mandate and approach to funding. Sustained advocacy from NGOs and the work of the Nordic Trust Fund—which was created as “an internal ‘knowledge and learning initiative’ to assist in showing Bank staff how human rights relate to their work and goals”—are identified by the authors as factors that support the Bank’s future engagement in rights-based approaches to health initiatives. Reflecting on the challenges to human rights that lie ahead for the World Bank, the authors contend that “an ethical demand for health equity—rather than a legal demand for a ‘right to health’—will better enable the Bank

to deliver improved health development outcomes.”

Framed by this institutional analysis of the World Bank, Hiwote Fantahun’s commentary uses Ethiopia as a case study to examine the Bank’s responsibility to ensure respect for human rights in highly repressive countries that receive international health assistance. Although such international assistance has played a vital role in improving global health outcomes, it has also been used as a government financial tool to further discrimination and oppression. As a number of NGO reports have uncovered, the Ethiopian government has utilized Bank-backed programs, including the Promoting Basic Services and the Productive Safety Net Program, “to control the population, punish dissent, and undermine political opponents.” The author suggests that monitoring and evaluation mechanisms at the Bank focus mainly on administrative and financial assessments, neglecting human rights accountability in Bank funding. To remedy this gap in accountability, Fantahun argues that the Bank should thoroughly incorporate human rights into its social safeguard mechanisms, enabling the Bank to assess national laws and policies in a manner that is consistent with universal human rights obligations.

Summarizing this debate over why the Bank is reluctant to engage with human rights, Desmond McNeill’s commentary draws from authoritative critiques, reiterating the challenges of instrumentalism and the Bank’s economic mandate. In distinguishing the human rights responsibilities of the Bank from those of its member states, McNeill argues that the Bank, by virtue of its financial resources and expertise, takes on a “special moral responsibility” for human rights. To meet this responsibility, McNeill builds from a recent viewpoint in *The Lancet*, proposing that the Bank “set in motion a deliberative process” to “establish ‘principles for ensuring fair resource allocation for health’.” These principles, McNeill argues, should be derived from core human rights principles established in the Bank’s own report on *Integrating Human Rights into Development*.

Where institutions like the World Bank face challenges in mainstreaming human rights in international health financing, partnerships with other stakeholders can provide a shift in the policy forum to facilitate greater alignment with human rights norms and develop new ways of thinking about rights-based approaches to governance. Meri Koivusalo and Katrina Perehudoff explore the influence of this forum shifting, examining how new trade agreements have impeded global governance and health-related rights and finding that the mere adoption of human rights provisions is insufficient to support global governance in health. Acknowledging contemporary challenges to rights-based approaches in governance—particularly the legitimization in trade agreements of corporate actors, which are not bound by international human rights obligations—the authors further explore whether and how human rights law and principles can contribute to global governance for health. Koivusalo and Perehudoff argue that despite the current lack of consideration of human rights as part of global trade law, human rights may still be promoted through the improved utilization of human rights obligations in treaty texts; the strengthening of health and human rights considerations in trade and investment agreement negotiations; and the strengthening of current global public health law through the establishment of a new global governance reference such as the proposed Framework Convention on Global Health.

FROM GLOBAL HEALTH GOVERNANCE TO GLOBAL GOVERNANCE FOR HEALTH

Contemporary global governance has expanded beyond multilateral negotiations among nation-states.⁹ The inability of international health law to respond through states to globalized determinants of health has necessitated the construction of new normative frameworks through global health governance.¹⁰ In response to this challenge, a number of international, national, and non-governmental actors have turned to international human rights law to frame mechanisms for collective action and accountability systems for policy implementation.¹¹ Where these international, national, and non-governmental actors in

global health governance increasingly invoke a rights-based approach to health, this Special Issue examines the role played by global governance partnerships in operationalizing human rights for global health.

Human rights norms and principles increasingly provide legitimacy to institutions of global health governance, as this Special Issue demonstrates, yet there remains no consistent, universal definition of the rights-based approach to health. As a consequence, global health governance institutions have demonstrated varied approaches to human rights implementation through organizational actions. Decentralized institutions of global health governance have mainstreamed human rights in their institutional policies, programs, and practices; however, the fragmentation of these uncoordinated human rights initiatives raises a comparative research imperative to assess the institutional structures that are conducive to human rights implementation. This imperative for comparative analysis is taken up in the forthcoming Oxford University Press volume on *Human Rights in Global Health: Rights-Based Governance in a Globalizing World*, the first volume to systematically examine the role of global institutions in operationalizing human rights for global health.¹²

Such comparative institutional analyses are necessary to assure that human rights mainstreaming in global health governance can realize human rights in global health. Where this Special Issue does not present a comprehensive overview of the myriad of stakeholders that have a role in an expanding global health landscape—focusing on key global health themes, including WHO, partnerships among international organizations, and global economic governance—this initial survey highlights how each institution is engaging human rights in unique ways and through different structures. While there exist concerns that the proliferation of stakeholders in global health can undercut efforts to mainstream human rights, the contributions to this Special Issue emphasize the ways in which an expanding number of global institutions—despite challenges—are actively seeking to address interconnected health-related human rights in ways that reflect interrelated determinants of health. These institutions are only just beginning to develop organizational structures to mainstream human rights into their policies, programs, and practices. Through an improved understanding of the heterogeneous ways in which stakeholders operationalize human rights in global health, the identification of good practices for human rights implementation through global health governance can provide a basis to advance health as a means to a more just world.

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Human Rights in Global Health: Rights-Based Governance for a Globalizing World (2018) is now available from Oxford University Press.

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Transforming the WHO's Role in Advancing the Right to Health in Conflict

Leonard S. Rubenstein

A decade ago, when I was researching attacks on health workers and facilities over the preceding decades, I was struck by the fact that the World Health Organization (WHO) was silent on violence against hospitals, patients, and health workers, a human rights problem that has such a profound effect on health services in situations of conflict. The right to health requires the availability and accessibility of health services in conflict, and as international humanitarian law does, obligates states to refrain from interfering with health services or personnel and protecting them from violence, obstructions, and threats by third parties.¹ Moreover, the WHO is uniquely positioned to advance the right to health in conflict because of its lead role on health in humanitarian emergencies, its broad reach, and its constitutional mandate to lead on international health policy and provide statistical and epidemiological services.²

In particular, the WHO could provide the evidentiary base for advancing the right to health in conflict by collecting and disseminating data on attacks on health services. As in other realms of human rights and global health, that evidentiary base is essential – in this case, to increase understanding of the dynamics of attacks, identify trends, contribute to policies and strategies to prevent attacks, and promote political will toward global action.³ The WHO's inaction was also puzzling given that WHO already had an initiative, albeit not one grounded explicitly in human rights, to reduce risks to hospitals from natural disasters. But in conversations I had with WHO officials at the time, it was apparent that the WHO did not see data collection or policy development in this realm as part of its efforts toward the realization of the right to health.

The WHO's reticence was in part a product of the WHO's traditional concern about offending member states, which are often the perpetrators of violence against health care.⁴ Further, like many others, the WHO had a narrow view of the right to health that gave no attention to advancing the right in situations of conflict.

In the past half decade, however, the WHO's posture on its role in addressing the problem, if not the human rights imperative to do so, has changed dramatically. At the policy level, the WHO has integrated the need to develop strategies to protect health care from attack into its Global Strategy for Human Resources for Health: Workforce 2030.⁵ It now devotes a page of its web site to a dashboard on attacks.⁶ And most importantly, it has initiated the systematic collection of data to track attacks on health care in conflicts that fills such an important gap in advancing the right to health.⁷ That leadership in systematic data collection, moreover, has been embraced and affirmed by the United Nations (UN) General Assembly⁸ and the UN Secretary-General.⁹

The turnabout was not a product of an increase in the intensity and number of attacks on health workers and facilities, although the global picture is indeed highly disturbing.¹⁰ Attacks on health care services are hardly a new phenomenon. During the 1980s, 1990s, and 2000s, conflicts in El Salvador, Sri Lanka, the Occupied Palestinian Territories, Bosnia, Chechnya, Kosovo, Mozambique and elsewhere were accompanied by the burning, shelling, and looting of health facilities, abduction, killings and arrests of health workers, or obstructions of the passage of ambulances, or combinations of them.¹¹ Rather, the change appears to have resulted from three factors: first, successful efforts by a civil society coalition and other groups, including the International Committee of the Red Cross, to raise the visibility of attacks on health care and demand that the WHO use its authorities and capacities to contribute to a solution; second, the willingness of key WHO member states to support those demands; and third, recognition by leaders of the WHO that the

organization should not ignore violence against health care and is positioned to contribute to ameliorating the problem.

TOWARD A WORLD HEALTH ASSEMBLY RESOLUTION

The work toward a new posture and role began in 2011. On the eve of the World Health Assembly, sixteen civil society organizations wrote a letter to Director-General Margaret Chan asking her to convene an expert group to address ways to collect evidence of attacks on health care and to offer a platform on prevention and accountability. The initiative was reinforced through a side event at the WHA as well as global attention to the incarceration and torture of doctors and nurses by Bahrain during Arab Spring protests. Although Dr. Chan did not create an expert group, she drew attention to assaults on health personnel and facilities in her opening address to the Assembly and asked officials at the WHO to meet with representatives of the civil society groups and consider how the WHO could address the problem.¹²

The need for action gained momentum as the International Committee of the Red Cross (ICRC) released a report later in 2011 showing the scope and severity of attacks on health care services in sixteen countries.¹³ At its international conference later that year, the ICRC launched its Health Care in Danger initiative, which focuses on strategies to prevent attacks on health services in conflict. Although the Health Care in Danger platform did not identify a role for the WHO in policy leadership or systematic data collection,¹⁴ the attention the ICRC brought to the problem contributed to WHO member state support for the civil society initiative.

At the WHO Executive Board meeting in January 2012, an opportunity arose to push for action through a pending resolution on the WHO's role in emergencies. Norway and the United States negotiated additional language in the resolution that mandated WHO leadership to develop methods of systematic data collection and dissemination of attacks on health facilities and personnel in complex emergencies. Bruce Aylward, then director of the WHO's emergency division, signaled the Secretariat's support for strong resolution language that included a requirement that the WHO collect and disseminate data on attacks on health care in emergencies. He viewed the data collection and dissemination as a foundation to advocate for respect for principles of impartial care and for the safety of health workers and infrastructure in conflict.¹⁵ Although the final resolution watered down the proposed language, the Executive Board voted to include a requirement that the WHO provide leadership in methods of systematic collection and dissemination of data on attacks on health care in emergencies. In May, 2012, the resolution was approved by the World Health Assembly. It asked the Director-General:

to provide leadership at the global level in developing methods for systematic collection and dissemination of data on attacks on health facilities, health workers, health transports, and patients in complex humanitarian emergencies, in coordination with other relevant United Nations bodies, other relevant actors, and intergovernmental and nongovernmental organizations, avoiding duplication of efforts.¹⁶

IMPLEMENTING THE RESOLUTION

Initiating data collection under the resolution, however, took more than five years. The complexity of the task of designing a workable and effective system, including the need for verification, was rendered even more difficult by resistance among some staff in the WHO bureaucracy to undertaking a task that seemed to come out of nowhere.¹⁷ An advisory group formed to discuss technical issues on such questions as sources of information, data

security, and report verification, among others, was abandoned after a few meetings. Further, the resolution placed a new responsibility on the understaffed emergencies division without additional resources to accomplish the task at a time when it also had to respond to a seemingly endless series of severe humanitarian crises. As a result, internal proposals for fulfilling the mandate of the resolution buffeted between minimalist and overly complex approaches. After a preliminary methodology was finally adopted and pilot-tested, an evaluation was so critical of the methodology that it was abandoned.

Throughout the period after passage of the resolution, however, civil society demands on the WHO for fulfilling the resolution's mandate continued, especially by the Safeguarding Health in Conflict Coalition,¹⁸ a group of humanitarian, health provider, human rights, and academic groups that came into existence shortly before the 2012 resolution was adopted. Member states as well urged the WHO, privately and publicly, to fulfill the mandate. Further, the WHO's leadership recognized the severe consequences of attacks on health facilities and personnel for global health. At a discussion of the problem of attacks on health care at the UN in New York in 2014, Dr. Chan spoke passionately about violence inflicted on health care in war: "The sense of outrage has been muted. The fact that these attacks have become so widespread must not be tolerated as the new normal."¹⁹ In December 2014, the UN General Assembly reinforced the WHO's role in data collection and dissemination regarding attacks on health care by referencing the Assembly resolution in a resolution led by Norway and other states in the Global Health and Foreign Policy Group on health care in conflict.²⁰

At the same time, systematic attacks on hospitals and health care providers by the Assad regime in Syria began to gain the attention of the international community,²¹ providing further reinforcement of the need for WHO action. As the WHO implementation process plodded along, Physicians for Human Rights as well as the Health Cluster for northern Syria began their own data collection, and by 2016 the Health Cluster began publicly reporting attacks on hospitals in Aleppo.²² Meanwhile, additional global reporting by the ICRC,²³ the Safeguarding Health in Conflict Coalition,²⁴ and Médecins Sans Frontières,²⁵ and increasing attention to the issue in journals and the major media, all served to reinforce the need for systematic data collection and dissemination and for the WHO's voice. These developments encouraged the WHO both to continue work on a system of comprehensive data collection and dissemination and to engage in advocacy to protect health care. One result was that even before completing its methodology for data collection, the WHO issued a 2016 report (based on secondary data) on attacks on health care.²⁶

MAKING DATA AVAILABLE ON ATTACKS

Systematic data collection and dissemination by the WHO on attacks on health care is just getting underway in 2018, with programs in eleven countries, but signs point to the creation of a global system, including 17 additional countries after the initial roll-out. It seems clear as of this writing that the WHO is committed to implementation of a system on a country-by-country basis. This represents a major step forward for human rights protection in conflict and the advancement of the right to health. It means seeking to collect data in cases where with the government of a country with whom the WHO cooperates is itself committing assaults on health workers, hospitals, and patients. For Syria, where the regime of President Bashar al-Assad has been shown to be targeting health facilities, data collection is taking place through the WHO country office in Turkey.

At the same time, the process reveals the limitations of the WHO's approach to protecting health care from violence and realizing the right to health. Although the organization takes a broad view of the scope of protection of health care that is consistent with the right to health, e.g., addressing obstruction and threats as well as physical attacks, it does not plan to follow all human rights principles in its reporting. Most notably, it does

not plan to publicly identify perpetrators of attacks, a key dimension of human rights practice to further accountability, although it may use the information it has about perpetrators diplomatically. In Syria, it has not called out either the Assad regime or its Russian ally for their responsibility in hospital attacks in Syria. Additionally, while the WHO is concerned about the prevention of attacks, it does not address concrete steps toward accountability. The WHO leadership views these limitations as a product of its governance structure, as a member-state-driven institution, and its operational role in emergencies, where access to populations in need depends on the cooperation of governments.²⁷ Further, the WHO is often not in a position to engage in investigations to determine who was responsible for an attack or whether a violation of the law was committed, for example, whether proper steps were taken to minimize harm to patients when a hospital misused for military purposes is attacked. It has neither the capacity nor mandate to do so. But it does not intend to identify perpetrators even where it has evidence of who committed an attack. Finally, the documentation of attacks on health care has not been incorporated into its broader human rights program. For example, the WHO's Roadmap for Action for integrating equity, gender, human rights, and social determinants of health across all programs, offices, and management processes in the period 2014- 2019 does not mention the problem of attacks on health care services.²⁸

WHO member states have not committed to play their part in advancing the WHO's role in data collection and dissemination on attacks on health care. On each occasion when resolutions at the World Health Assembly proposed language for state cooperation in collecting and disseminating data on attacks on health care, the language was deleted at the behest of a member state. The Security Council has also called on member states to cooperate in data collection,²⁹ but to date there has been little response.

These limitations require some modesty about the role of the WHO in the advancing the human rights of the wounded and sick and the professionals who care for them to be protected from violence and obstruction of access. However, the WHO's reluctance to take a fully developed human rights approach to address attacks on health care in conflict still permits it to contribute to the identification of acts that constitute violations of human rights and international humanitarian law, and provide a foundation for others to carry the work of accountability forward. In this realm at least, by potentially making data available on attacks in close to real time and by expanding the evidence base to identify trends and provide a basis for the prevention of attacks, the WHO can fill a critical need in advancing the right to health in ways that no other organization can.

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The Demagogies of 'Lack': The WHO's Ambivalence to the Right to Health of LGBT People

Po-Han Lee

In May 2013, the World Health Organization (WHO) Secretariat produced its first-ever report regarding health issues related to lesbian, gay, bisexual, and transgender (LGBT) persons in preparation for an agenda item of the 2013 WHO Executive Board (EB) meeting. The debate resulted in the removal of the item from the adopted agenda. Since then, LGBT health has never been brought up again. Drawing on the debate, there are three 'lacks' causing the deadlock in the WHO: (1) the lack of consensus between universalists and cultural relativists on implementing the right to health, (2) the lack of capacity of the WHO in addressing political controversies, and (3) the lack of evidence thwarting the claim for health justice for LGBT people. However, in this paper, I argue that it is the lack of globalism, in contrast to internationalism, that prevents the WHO from achieving the health-for-all goal. While the EB is authorized to determine the global health policy agenda by the WHO Constitution, its prioritization of national interests has made human rights protection rhetorical rather than obligatory. Combating such institutional obstacles to LGBT health, I conclude that it is urgent to promote the people-centered approach to global health governance by accommodating the 'polyvocality' of civil societies.

INTRODUCTION

With regard to the role of the World Health Organization (WHO) in the development and operationalization of the human rights-based approach to health equity, this paper aims to problematize a controversial debate that took place during the 133rd Executive Board (EB) in 2013. In preparation for that meeting, the Secretariat produced a report on *Improving the Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender Persons* (EB133/6). Other than the HIV epidemic, the WHO Secretariat considered social determinants concerning physical violence and emotional abuse against these people due to "widespread stigmatization and ignorance in mainstream society and within health systems." The main health challenges for lesbian, gay, bisexual, and transgender (LGBT) persons include their higher morbidity and mortality as well as the barriers they face concerning health care accessibility. The report made the LGBT rights movement prominent in terms of an agenda for liveable lives because it acknowledges the correlation between social health and minority stress, which can be detected even in samples of people who are socioeconomically advantaged.¹

Based on the report, the debate between national delegates uncovers, in particular, the limits of the state-centered framework in enforcing *health as a human right*, along with the trajectories of the debate before and after the 133rd EB at the regional offices. The introduction of the sociocultural dimensions of health is part of the legacy of social medicine in the WHO's approach to health justice,² which is nonetheless by the principle of evidence-based health. Yet, the focus on looking for 'evidence' may limit the development of an argument for LGBT people's right to health equity in places where the authorities are reluctant to collect data or where people fear offering information. Indeed, there is generally scant data to make a conclusive judgment, especially from low- and middle-income countries, and there is a shortage of adequate knowledge about LGBT health, especially in terms of transgender issues. Therefore, it is necessary to rethink the role of the WHO in

fulfilling its mandate of ensuring *health for all*, when the problems at issue are ineluctably political.

THE CRIPPLED SOCIAL-HEALTH FUNCTION OF THE WHO

The long debate at the 133rd EB resulted in the item being deleted from the agenda due to opposition from a number of WHO member states.³ The substantive contentions included that: (1) 'LGBT' are simply a choice of unhealthy lifestyle, which should not be encouraged; (2) prioritizing their health concerns would constitute discrimination against others; (3) it is inappropriate for the WHO to get involved in LGBT issues, as they are too political; (4) promoting LGBT issues is harmful to some countries' value systems; and (5) the allegation that LGBT people are excluded from health systems has not been conclusively proven. Based on these reasons, since then, except for procedural matters, this topic has been closed, or perhaps we might say, closeted.

As for the first contention, some states, for example Nigeria and Tanzania, argued that non-heteronormative "behaviors" are by themselves a risky choice of an unhealthy lifestyle that should be discouraged and altered. As asserted by the Zimbabwean delegate, the Secretariat could not define "who LGBT persons are," precisely "because a globally agreed definition did not exist and because there was no universally accepted scientific basis for the term." This reveals the absurdity of the obsession with scientific etiology regarding human sexuality, which is misappropriated to justify state-sponsored heterosexism/cisgenderism against LGBT persons.

Secondly, certain states, such as Libya and Senegal, argued that prioritizing LGBT health would amount to discrimination against other vulnerable groups of people who are in need of a more urgent attention. Indeed, people's enjoyment of the right to health is related to resource distribution when it comes to states' obligation to *fulfil* it. Nonetheless, the Committee on Economic, Social and Cultural Rights (CESCR) had already held in its General Comment No. 20 that, in terms of combating discrimination, "a failure to remove differential treatment on the basis of a lack of available resources is not an objective and reasonable justification."

With regard to the third contention, some states, for example Namibia, asserted that LGBT issues had been over-politicized, without "consensus on the legal standing of the issue under consideration at the international level." They hence urged the WHO to step away from issues that are beyond its mandate. The states that disagreed with this view—such as the US, Uruguay, and Canada—argued that those reasons are by themselves politicizing the issue. Interestingly, both blocs of supporters and opponents in regard of LGBT health acquiescently agreed on the essential *non-political vocation* of the WHO.

Fourthly, the Algerian, Lebanese, Pakistani and Iranian delegates argued that LGBT persons' expressions and behaviors are fundamentally harmful to the value systems of their states, which had never attempted to intervene in other states' domestic affairs and thus hoped for respect and reciprocity. Therefore, they admonished the EB as well as the WHO as a whole not to "impose certain views...on the global community." At this point, these states exposed themselves to *re-politicizing* their genuine concerns about cultural/national relativism, although simultaneously they denied the existence of sexual and gender diversity under their jurisdictions.

Finally, yet importantly, many states—including Japan, Azerbaijan, Lithuania, and Albania—would prefer to wait for coordinated studies on an international level, since there was not sufficient evidence on this matter yet. However, a lack of evidence does not necessarily prevent states from tackling homo- and transphobia, which contribute to health inequities. In law, the anti-discrimination principle applies to all situations that unreasonably disadvantage certain groups of people. As the Swiss delegate pointed out, the

commitment of the international community to data collection and analysis has always been important in the WHO's long history of dealing with various contentious issues.

PEOPLE-CENTERED HEALTH AS AN ALTERNATIVE PATHWAY?

Although the most recent discussion on health disparities among sexual and gender minorities came to a deadlock due to its cultural and political controversiality, it is noteworthy to identify the possible trajectory of where the topic came from and how it may move forward in the future. Regionally speaking, the most enthusiastic members supporting LGBT rights are from the American (PAHO) and European (EURO) regions, and the most reluctant ones are from the African (AFRO) and Eastern Mediterranean (EMRO) regions, while more disagreements occur in the Western Pacific (WPRO) and South-East Asian (SEARO) regions.

Following the adoption of a regional resolution on *Health and Human Rights* (CD50.R8) in 2010, the PAHO has paid much attention to LGBT health by first recognizing sexual orientation as one of the social determinants of health and then requiring a comprehensive understanding of gender diversity. After the 133rd EB debate, the PAHO adopted another resolution on *Addressing the Causes of Disparities in Health Service Access and Utilization for LGBT Persons* (CD52.R6). Having required member states to address socio-political and historic barriers to care for the marginalized, the PAHO, in 2015, highlighted the need for data compiling and professional training for the LGBT community.

Rather than adopting population-focused resolutions, the EURO has placed LGBT health in the context of its *Health 2020 Policy Framework* (EUR/RC62/R4) since 2012, from which a people-centered approach to health system reform considers that "health is a political choice," which challenges the idea that international health agencies should stay unpolitical. The people-centered approach highlights individuals' perspectives, as both "participants in, and beneficiaries of, trusted health systems." EURO's advocacy has gradually influenced the current development of the WHO, which, in 2016, adopted a related EB resolution (EB138.R.2) urging member states "to address the broader social determinants of health and to ensure a holistic approach to services."

In regions where LGBT issues are more divisive, topics around sexual orientation and gender identity have never been raised. Rather, the WPRO and SEARO, for example, considered LGBT persons as "high-risk populations" in the context of the HIV response. Yet, there have been positive developments regarding socially marginalized groups due to SEARO's commitment to universal health coverage. In its resolution (SEA/RC65/R6), the SEARO considers social protection for all in a broad sense, especially for the "unreached populations" in society. In this light, the SEARO adopted another two resolutions (SEA/RC68/R4 and SEA/RC68/R6) on promoting people-centered health in order to gain "trust by the population."

With regard to the other two regions, the behavior-based concept of men who have sex with men (MSM) – rather than any reference to sexual identity – has been employed, again, in light of the HIV pandemic. Additionally, transgender situations are simply omitted from both regional committees. The EMRO's discussions over social health are focused on intraregional/interstate disparities, and in fact, there is a lack of data at the national and subnational levels on inequity. As for the AFRO, its intriguing resolution on *Health and Human Rights* (AFR/RC62/R6) in 2012, which posits the non-discrimination principle "within the context of national legal frameworks," predetermines African states' position of national relativism in the 2013 EB debate.

CONCLUSION

Along these trajectories, we may observe how the discourse of people-centered health has been influencing global and national health policies. Perhaps, there is an alternative pathway to address health inequities among LGBT persons by developing a more nuanced strategy for universal health coverage. Meanwhile, many governments still regard sexual and gender minorities as “irresponsible” in terms of the global burden of both the HIV epidemic and mental disorders, and such a bias, without reasonable grounds, is one of the greatest impediments that prevents LGBT health from being considered on the global social health agenda. Nowadays, states in global health fora tend to withhold the idea of sovereign supremacy over their “domestic affairs,” which adversely affects the improvement of the international legal infrastructure. This kind of internationalism, which determines the capacity of an intergovernmental organization, has suppressed the representation of the affected communities regarding a people-centered approach to global, not just international, health justice.

Moreover, the utmost worry is that the pursuit of *health as a human right* perishes when it becomes a diplomatic rhetoric of governments in the name of their *own* peoples' right to health. These delegates, self-contradictorily, have asserted that the WHO should not be involved with *other* human rights concerns, as if right to health issues could be addressed in isolation. The contentions around LGBT health have exposed the WHO's ambivalence toward the development of human rights-based global health governance between its state-based constitution (internationalism/provincialism) and human rights ideals (globalism/cosmopolitanism). This can also be found in the ICJ's advisory opinion versus its dissenting opinions on the 1996 case concerning the *Legality of the Use by a State of Nuclear Weapons in Armed Conflict* with regard to the WHO's role and legal duties. Nonetheless, in its General Comments Nos. 14 and 22, the CESCR recognizes the WHO's particular importance in both the normative and functional dimensions, especially in the making of a social world that promotes global health equity.⁴

Such an interrogation about the demagogies of “lack” (of international consensus, institutional capacity, and epidemiologic evidence) has informed the *opinio necessitatis* for the WHO to “come out” to address the health disparities among LGBT persons in order to fulfill its human rights obligations. Here, *opinio necessitatis*, which is distinguishable from a belief in the existence of a legal duty (*opinio juris*), stems from “political necessity and reasonableness” in terms of the development of law.⁵ That the EB, as the gatekeeper of the global health agenda, is constrained by the conflicts of national ideologies is inconsistent with the cosmopolitan vision of *health for all*,⁶ especially when there is more evidence, albeit disproportionate between regions, uncovering the stress-related health risks against LGBT people. When national governments normally represent the dominant social views regarding sexualities and gender expressions, such a *lack* of a globalist perspective becomes the fundamental obstacle in respecting sexual and gender diversity in global health policymaking, and this has made the immediate obligation to eliminate discrimination almost empty words.

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Operationalizing the Right to Health through the Pandemic Influenza Preparedness Framework

Mark Eccleston-Turner

Developing states lack access to pandemic influenza vaccines. The provision of 'essential' medicines is a core, non-derogable obligation of the right to health in the International Covenant on Economic, Social and Cultural Rights (ICESCR), which states must fulfill as a minimum criterion. The ICESCR does not provide an exhaustive list of which drugs constitute "essential medicines," although influenza vaccine was listed as an essential medicine during the most recent influenza pandemics. This paper presents three, interlocking arguments: First, it argues that ensuring access to a vaccine during an influenza pandemic is a right to health obligation for all states. Second, it argues that the access threshold a state must meet in order to discharge its right to health obligation in respect of access to pandemic influenza vaccine is different to the access threshold with oral solid drugs, and attempts to quantify the vaccine access threshold. Third, it examines the extent to which the World Health Organization (WHO) Pandemic Influenza Preparedness Framework can enable developing states to meet the vaccine access threshold during an influenza pandemic, and discharge their right to health obligations in this area, arguing that the Framework is unlikely to have a significant positive impact on access to vaccines by developing states during the next influenza pandemic.

INTRODUCTION

Vaccines are a key component in the response to an influenza pandemic; the timely administration of an influenza vaccine is the most effective public health intervention to halt the spread of infection and prevent mortality from influenza in adults,¹ the elderly,² and children.³ However, developing states have long complained that they are unable to access influenza vaccines during a pandemic, despite their best efforts,⁴ which may have implications for the ability of these states to meet their right to health obligations during an influenza pandemic.

In an attempt to remedy poor access to pandemic influenza vaccines in developing states the World Health Organization (WHO) enacted the Pandemic Influenza Preparedness (PIP) Framework in 2011. The Framework creates a virtual stockpile of "at least 150 million doses" of pandemic influenza vaccine, which developing states can procure from during a pandemic. The WHO has traditionally played a major role in the management of pandemic influenza outbreaks since its inception,⁵ even going as far as to procure vaccines and distribute them to developing states that lack access during a pandemic, although this has been done on a largely ad-hoc basis.⁶ The PIP Framework aims to improve the procurement of pandemic influenza vaccines by developing states⁷ by creating a more structured approach to collection and distribution of donated pandemic influenza vaccines than the traditional ad-hoc manner in which the WHO has collected and donated vaccines. This is intended to ensure that the Pandemic influenza vaccines donated from manufacturers is not just given on an ad-hoc basis after orders from fee-paying states have been fulfilled, or once self-procuring states have determined they have excess pandemic influenza vaccines to meet their needs, as was the case with donations during 2009-H1N1.⁸ Instead, donations of pandemic influenza vaccine may be included within the company obligations within Standard Material Transfer Agreements⁹ completed via the PIP Framework, which mandate that a proportion of the real-time pandemic influenza vaccines production are reserved for, and transferred to, the PIP stockpile. This is a 'virtual' stockpile

of pandemic influenza vaccines which have been donated by vaccine manufacturers that the WHO will manage.¹⁰

The utility of the Framework at improving access to pandemic influenza vaccines during a pandemic has been explored in the literature, with no consensus being reached on how well, if at all, the PIP Framework can improve access in developing states. In order to advance these debates, this paper examines the utility of the Framework within the context of the right to health. It does this by examining how the PIP Framework improves the extent to which developing states can use the Framework to ensure that their populations have access to pandemic influenza vaccines. Prior to this analysis, it is necessary to demonstrate that ensuring access to pandemic influenza vaccines is an obligation binding upon states stemming from the right to health, and what a state ought to do in order to have discharged this obligation.

THE RIGHT TO HEALTH

The right to health has been referenced in international agreements since the 1940s.¹¹ The clearest articulation of the right to health has come in the International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted by the United Nations (UN) General Assembly in 1966.¹² The ICESCR built upon the ideas put forward in the WHO Constitution and the Universal Declaration of Human Rights, and, in placing obligations upon states, outlined what sort of action a state could take in order to ensure that the highest attainable standard of health could be enjoyed by its citizens. Within the context of pandemic influenza vaccine access, clearly 2(c) is most directly relevant: action necessary for “[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases;” as noted above, pandemic influenza vaccines are the most effective method to prevent and control a pandemic outbreak within a population.

The rights-based discourse is largely focused on the extent to which citizens of states can use the right to health in order to compel the state to act in a certain way to improve individuals’ health, such as providing for access to specific medicines. This rights-based approach has been particularly successful in improving access to medicines in developing states, particularly HIV/AIDS medicines.¹³ Within the context of access to medicines, the state’s attempt to fulfill this positive obligation has typically manifested itself through legislative or policy changes intended to improve access, such as limiting the patentability of pharmaceutical products,¹⁴ the issuing of compulsory licenses,¹⁵ or using nationalized manufacturers to cheaply manufacture medicines.¹⁶ However, very little academic commentary has been generated regarding access to a vaccine as a component of the right to health.

To this end, access to medicines, as a component of the right to health, was elaborated upon in the Committee on Economic, Social and Cultural Rights’ General Comment No. 14: the Right to the Highest Attainable Standard of Health.¹⁷ General Comment 14 holds that states have a tripartite obligation to *respect, protect, and fulfill* the right to health.¹⁸ Within the context of access to pandemic influenza vaccines, two of the “core obligations” of states are relevant:

States must ensure provision of health care, including immunization programmes against the major infectious diseases.¹⁹

The creation of conditions which would assure to all medical service and medical attention in the event of sickness...includes the provision of equal and timely access to basic preventive, curative, rehabilitative health services and...the provision of essential drugs.²⁰

It is clear that providing full access to vaccines during an influenza pandemic would enable a state to discharge its obligation fully in this regard. However, it remains unclear to what extent states can fail to provide full access to pandemic influenza vaccines (for whatever reason) and still be considered to have discharged their obligation. Indeed, the right to health is progressive – generally, states party to the ICESCR undertake to

[t]ake steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.²¹

This Article of the Covenant is not particularly helpful when seeking to determine if, and when, a state party can be said to have discharged its right to health obligations. It is weakly worded and filled with uncertainty, particularly in relation to what “the maximum of its available resources,” “achieving progressively,” and “all appropriate means” relate to.²² Given that a sufficient benchmark for a state having discharged its obligations in relation to access to vaccines is not provided in the ICESCR, it is necessary to turn to General Comment 14 for further guidance. In the context of access to medicines, the provision of ‘essential’ medicines is a core, non-derogable obligation, which states must fulfill as a minimum criterion to meet their obligations under the Covenant.²³ The ICESCR does not provide an exhaustive list of which drugs constitute “essential medicines,” instead relying upon the WHO Model List of Essential Drugs.²⁴ While not listed on the current Essential Drugs list,²⁵ influenza vaccine was listed as an essential medicine on the 2009²⁶ and 2010 lists²⁷, when 2009-H1N1 was prevalent. It is likely that during a future influenza pandemic an influenza vaccine will again be listed on the WHO Model List of Essential Drugs, and therefore be considered an essential medicine for the purposes of the right to health.

The Right to Health, and Access to Pandemic Influenza Vaccines

During the most recent influenza pandemic (2009-H1N1), despite the clear obligation to provide pandemic influenza vaccines as an essential medicine, access to the vaccine was very poor in developing states. Most developing states either were not accessing the vaccine at all, or were accessing it significantly later than their developed neighbors.²⁸ If a rights-based approach to 2009-H1N1 were adopted, one could argue that developing states failed to meet their obligations regarding the right to health by failing to provide an “immunization programme against a major infectious disease”²⁹ and failing to “provide essential drugs”³⁰ for their population during 2009-H1N1. However, such an approach may be too simplistic; developing states have long complained that they are unable to access influenza vaccines during a pandemic, despite their best efforts.³¹ This serves to highlight one of the significant drawbacks with the rights-based narrative regarding access to medicines in developing states: it presupposes that the state is capable of adequately addressing the problem with the resources that it has available to it. What of the state that lacks the means to secure access to medicines on behalf of its population? It would of course be unfair to claim that such states have failed to meet their positive obligations in regards to the right to health, when they lack the means to discharge the obligation.

This is neatly highlighted by contrasting Article 2(1) of the ICESCR, which states that

[e]ach State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the *maximum of its available resources*, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures³² [emphasis added]

With paragraph 47 of General Comment no. 14, which states that

[i]f resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.³³

Both the provision of essential drugs³⁴ and the provision of immunization against major infectious diseases³⁵ are *core* obligations within General Comment 14. Therefore, it is clear that not providing vaccines during an influenza pandemic constitutes a failure on the part of a state to meet its ICESCR obligations regarding the right to health, and resource constraints are not an adequate justification for failing to provide pandemic influenza vaccines. In short, states, including developing ones, must provide pandemic influenza vaccines to their population, or they will not have fulfilled their obligations under the ICESCR.

DISCHARGING THE OBLIGATION

In order to evaluate the extent that the PIP Framework can enable a developing state to discharge its right to health obligations in respect of access to pandemic influenza vaccines, it is necessary to make a determination regarding the threshold of vaccine access that needs to be met by a state in order for it to be considered to have discharged its obligation. On this point, General Comment no. 14 states that “[f]unctioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party,”³⁶ but no further guidance is provided as to what “sufficient quantity” means in this context. Within this paper, the notion of “sufficient access” is used, which is based on two interlocking factors: vaccination levels and vaccination timings. If a state achieves sufficient access to vaccines during an influenza pandemic, it is considered to have satisfied the requirements to have discharged its obligations regarding the right to health – full vaccination is not required to have discharged right to health obligations in this context.

Vaccination Levels

When discussing access to oral solid dose drugs, it is fairly straightforward to determine when a state has discharged its right to health obligations in respect of access to that drug – the right can be said to be discharged when all patients that require access to that drug have access. For example, the antiretroviral drug zidovudine, which is used to treat HIV infections, appears on the WHO Essential Medicines list,³⁷ and therefore access to zidovudine constitutes a core obligation under General Comment no. 14, in much the same

way that access to pandemic influenza vaccines is likely to during a future pandemic. The right to health obligations in respect of zidovudine can be said to have been discharged when there is ready access to zidovudine for all patients who require it in order to treat their HIV infection. However, that is not the case when discussing vaccines – the beneficial effects of a vaccine are not just felt by the individual receiving the vaccine, but by those in the wider community too, due to community immunity.³⁸

Due to the mutations that occur with each strain of influenza virus, the vaccination coverage required in order to establish community immunity has fluctuated with each pandemic since 1900.³⁹ Aside from 2009-H1N1, which was noted for having a particularly low mortality and infection rate⁴⁰ when compared with more typical pandemics,⁴¹ a minimum vaccination coverage of at least 33% has been required in all pandemics in order to establish community immunity and slow down the rate of infection.⁴²

When discussing access to pandemic influenza vaccines as a right to health obligation, we are not just discussing access to pandemic influenza vaccines on an individual basis, but also the right to *benefit* from the herd immunity, which is established within a community when sufficient vaccine is administered. To that end, enough vaccine to immunize at least 33% of a state's population will be taken to be 'sufficient access'. This threshold is taken as it is sufficient to provide the beneficial effects of community immunity. Therefore, if sufficient vaccine has been procured in order for community immunity to be achieved within a population, it is possible to argue that the state's right to health obligations have been discharged in respect of pandemic influenza to the entire community that is benefiting from the immunisation campaign, not just the individuals that have received the vaccine directly.

Vaccinating Timings

Pandemic influenza strains predominantly emerge in, and spread rapidly through, developing states.⁴³ The states that are at a heightened risk from pandemic influenza are the most likely to be reliant upon donations from the WHO to gain access to pandemic influenza vaccines.⁴⁴ These donations from the WHO arrive in much smaller batches than in developed states, and much later than in self-procuring developed states.⁴⁵ This significantly hampers these states' abilities to combat pandemic influenza outbreaks, meet community immunity thresholds, and limit or prevent the spread of the disease beyond its borders. Therefore, it is not just the amount of pandemic influenza vaccines that a state can access that is of relevance to this research, but also when access is gained.

As the timing of vaccination administration is important for an effective domestic and international response to the pandemic, for the purpose of this research a state can be said to have discharged its right to health obligations in respect of pandemic influenza vaccines if its population has access to the vaccine within the same timeframe as developed states.

USING THE FRAMEWORK TO DISCHARGE THE OBLIGATION

The PIP Framework envisages that the WHO manage a stockpile of "around 150 million vaccines"; 50 million doses of the stockpile will be for use in "affected countries, according to public health risk and need, to assist in containing the first outbreak or outbreaks of an emerging pandemic" and "100 million for distribution...to developing countries that have no or inadequate access to...influenza vaccines, on a per capita basis that can be distributed to affected and at risk developing states during a pandemic."⁴⁶

Since the creation of the Framework in 2011, the major developments in this area have been focused on the Standard Material Transfer Agreements (SMTAs) that the WHO has negotiated. The success of the Framework hinges upon the uptake of SMTAs by

pandemic influenza vaccine manufacturers, and the terms and conditions to which they are willing to agree. In the most recent review of the pandemic influenza vaccines manufacturing capacity, Partridge & Kieny (on behalf of the WHO) identified twenty-four manufacturers that are active in manufacturing pandemic influenza vaccines.⁴⁷ In addition to this categorization of influenza manufacturers, the WHO, when calculating partnership contributions for the running costs of the Global Influenza Surveillance and Response System (GISRS), identifies those influenza vaccine manufacturers using the WHO GISRS, in order for them to contribute to the running costs.⁴⁸ Of those manufacturers identified by Partridge & Kieny, eighteen also make partnership contributions to the WHO, on the basis that they use the WHO-GISRS.⁴⁹ Use of GISRS is understood to include receipt of physical materials, or use of data and/or information, some of which may not be routinely provided to the general public.⁵⁰ Uptake of SMTAs by pandemic influenza vaccine manufacturers was initially slow, and despite the fact that eighteen active pandemic influenza vaccines manufacturers benefited from the work of GISRS, from 2011-late 2016 only three of these manufacturers had an SMTA2 in place, with only 46 million doses being committed to the Stockpile.

However, more recently, there has been a proliferation of Agreements being signed with pandemic influenza vaccine manufacturers, and to date the WHO has signed SMTAs with eleven pandemic influenza vaccine manufacturers. All of these manufacturers have committed to donating 7.5%-9% of their 'real-time' pandemic influenza manufacturing output to the WHO to supply the stockpile.⁵¹ The exact number of doses within the PIP Stockpile are not known, but the WHO has stated that it is "approximately three times the amount of pandemic vaccine available [to the WHO for distribution] during the H1N1 pandemic." Given that the stockpile the WHO managed during 2009-H1N1 distributed 78 million doses,⁵² it is reasonable to assume that the stockpile currently holds around 230 million doses. Such a drastic increase in the capacity of the Stockpile is clearly welcome, but it is necessary to determine to what extent this increase in commitments to the PIP Stockpile is likely to improve the extent to which developing states can use Framework to discharge their right to health obligations in respect of access to pandemic influenza vaccines.

In respect of the "vaccination timing" element of the criterion against which we are judging the utility of the PIP Framework, it is clear that the one major benefit of the PIP stockpile is the removal of the time delay of donated vaccine being committed to the WHO, which has been a barrier to discharging the obligation during previous influenza pandemics.⁵³ However, this benefit may not actually be realized in practice during the next pandemic. During 2009-H1N1, governments of developed states with domestic manufacturing capacity restricted exports to other territories, and to the WHO, until domestic demand had been fulfilled,⁵⁴ and concern has been expressed by pandemic influenza vaccine manufacturers that member states with domestic pandemic influenza vaccines production within their territory will place restrictions upon exports of vaccines that have been committed to the PIP stockpile, until domestic demand had been fulfilled.⁵⁵ Indeed, the Framework makes provision for such an event occurring, holding "no Party shall be liable for any delay in the performance of or failure to perform its obligations under this Agreement, where such a delay or failure is caused by Force Majeure,"⁵⁶ including "embargo or requisition" and "acts of government."⁵⁷ Member States with domestic pandemic influenza vaccine manufacturing capacity have given assurances to the WHO that they would enable domestic manufacturers to fulfill their SMTA2 commitments without government interference;⁵⁸ however, despite this, government requisition is a very real possibility, particularly during a severe pandemic. Such a requisition causing a delay to the real-time commitments to the Stockpile, and onward transfer to developing states would severely impact on the ability of a developing state to use the PIP stockpile in order to discharge its right to health obligation in respect of pandemic influenza vaccines.

The utility of the Stockpile to enable developing states to discharge their right to health obligation in respect of pandemic influenza vaccines appears less viable when vaccination levels are taken into consideration. The idea that the PIP Stockpile would be insufficient to rectify inequities in access to vaccines during a pandemic was addressed before the Stockpile went live, with scholars noting that even if the PIP Stockpile secured the 100 million doses to distribute to “developing states in need” as initially anticipated, this would provide for a vaccination level of approximately 1.8% of the population of developing states, even if a single dose regime was viable.⁵⁹ However, since this time, the capacity of the Stockpile has grown considerably, beyond that which was initially envisaged by the WHO. The current PIP stockpile has approximately 230 million doses committed to it. However, not all of this stockpile is reserved specifically for developing states that are unable to procure Pandemic influenza vaccines on the open market.

If the WHO maintains the proportions at which it intended to distribute the donated vaccine with

One-third ‘for use in affected countries, according to public health risk and need, to assist in containing the first outbreak or outbreaks of an emerging pandemic’, two-thirds to ‘developing countries that have no or inadequate access to H5N1 influenza vaccines, on a per capita basis, with use to be determined by those countries.’⁶⁰

Assuming that two-thirds of this Stockpile is reserved for “developing states in need,” the stockpile could ensure a vaccination level coverage of 4.14% in developing states on a one-dose strategy, and 2.07% on a two-dose strategy, which is much more typical of an immunization campaign against pandemic influenza. Both of these vaccination coverage levels are significantly below the target of 33% needed to establish herd immunity within a population. While the PIP Stockpile was not explicitly created with the 33% vaccination target in mind (nowhere in the drafting or the final text was a vaccination coverage target set), the herd immunity level of 33% is well established within the literature as the most desirable vaccination coverage target. In relation to this target, clearly, the commitments provided in the example SMTA2 do not make procurement from the PIP stockpile a particularly attractive procurement option for developing states, particularly if a developing state is seeking to procure sufficient vaccine in order to establish herd immunity levels within their territory in order to discharge their right to health obligations.

The low uptake of SMTAs amongst pandemic influenza vaccines manufacturers, combined with the reduced commitments being given by pandemic influenza vaccines manufacturers in those SMTAs that have been concluded, make the PIP stockpile an undesirable procurement method for developing states. Moreover, even when all of the vaccine that has been committed to the WHO via SMTAs has been delivered, it is likely that the WHO will need to seek donations from pandemic influenza vaccines manufacturers (outside of SMTA2 commitments) and developed states in order to be able to meet the procurement needs of developing states, in much the same way they did during 2009-H1N1. This is a particularly undesirable scenario because, when making appeals for donated vaccine, the WHO will again have “little leverage to influence developed countries [and Pandemic influenza vaccines manufacturers] other than rhetoric about equity, justice, and solidarity.”⁶¹ If the WHO must again make appeals to equity and justice in order to procure vaccine to donate to developing states, as appears likely, it will highlight the significant shortcomings in the PIP Framework, which was designed specifically to minimize such a scenario during a pandemic.

RECOMMENDATIONS

Moving forward it would be beneficial if the WHO placed greater emphasis on transfer of technology in the SMTA negotiations. The PIP Framework envisages that manufacturers concluding an SMTA with the WHO may have agreed to transfer technical knowhow regarding the manufacturing of pandemic influenza vaccines to the WHO, for onward transfer to developing states. However, none of the eleven manufactures that have SMTAs with the WHO has agreed to transfer technology as part of their Agreements. The onward transfer of technology from established pandemic influenza vaccine manufacturers to developing states could allow these developing states to establish pandemic influenza vaccine manufacturing capacity, which they could procure from when needed. If developing states were able to manufacture sufficient levels of pandemic influenza vaccines in order to achieve herd immunity, they could discharge their right to health obligations without being reliant upon procurement from established pandemic influenza vaccine manufacturers in developed states or receiving donations from the WHO, both of which are unviable procurement options for developing states. The importance of transfer of technology to the success of this model has been noted by the World Health Assembly and the Developing Countries' Vaccine Manufacturing Network.⁶²

Indeed, transfer of technology from an established vaccine manufacturer to Brazil has led to the state pharmaceutical manufacturer in Brazil, the Butantan Institute, to establish manufacturing capacity in the field of pandemic influenza vaccines. In 2011, the Butantan Institute delivered the first batch of vaccines against influenza entirely produced in Brazil. Currently, the Butantan Institute is able to manufacture both seasonal and pandemic influenza vaccines⁶³ and has manufacturing capacity for approximately 20 million doses.⁶⁴ While it is important to note that this is not sufficient manufacturing capacity to meet the target to immunize 33% of the Brazilian population,⁶⁵ and thereby discharge the right to health obligations, it is sufficient for approximately 10% coverage. This figure is significantly higher than the 4.4% vaccination coverage that is the best case scenario that could be achieved by developing states procuring from the PIP Framework.

CONCLUSION

This paper has argued that that direct procurement from the PIP Stockpile is not a viable option for developing states seeking to obtain sufficient access to pandemic influenza vaccines in order to discharge their right to health obligations. In the context of the right to health, the PIP Framework does provide one distinct benefit: if developing states were to procure vaccines from the PIP Stockpile, then these vaccine would be distributed within the same timeframe as developed states.⁶⁶ While this is a clear benefit over procurement during 2009-H1N1, procurement from the PIP Stockpile merely satisfies one element of the two-part test outlined earlier in this paper. The second element of the two-part test, procuring sufficient levels of vaccine to immunize at least 33% of their population, cannot be satisfied by procurement via the PIP Framework. Therefore, a developing state cannot fulfill and discharge its right to health obligations in respect of pandemic influenza vaccines by relying upon procurement from the PIP Framework. With this in mind, it is reasonable to argue that the PIP Framework is not able to ensure that developing states are able make use of the Stockpile in order to discharge their core right to health obligations in respect of pandemic influenza vaccines, as mandated by General Comment 14.

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⁴ The Lancet. "Global Solidarity Needed in Preparing for Pandemic Influenza." The Lancet 369, no. 9561 (2007): 532-532; Caplan, Arthur L. and David R. Curry. "Leveraging Genetic Resources Or Moral Blackmail? Indonesia and Avian Flu Virus Sample Sharing." The American Journal of Bioethics 7, no. 11 (2007): 1-2.

⁵ For an overview of the work WHO undertakes in relation to pandemic influenza see: Gostin, Lawrence. Global health law. Cambridge, MA: Harvard University Press, 2014, 367-378.

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⁷ World Health Assembly. Resolution WHA60.28: Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits. 2007.

http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf.

⁸ Eccleston-Turner, M.R. "Vaccine procurement during an influenza pandemic and the role of Advance Purchase Agreements: Lessons from 2009-H1N1," Global Public Health 11 no. 3 (2015): 322-335.

⁹ Standard Material Transfer Agreements is the method by which the WHO enters into agreements with entities outside the WHO GISRS, such as pharmaceutical companies that manufacture pandemic influenza related products such as vaccines or antivirals. SMTA2's have provisions related to benefit sharing included within them.

¹⁰ See for example the SMTA2 with GlaxoSmithKline available at: World Health Organization. Standard Material Transfer Agreement between GlaxoSmithKline and the World Health Organisation. 2013.

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¹² UN General Assembly. International Covenant on Economic, Social and Cultural Rights. Res. 2200A (XXI), December 16, 1966.

¹³ Matthews, Duncan. "Right To Health And Patents". In Research Handbook On Human Rights And Intellectual Property, edited by Christopher Geiger. Edward Elgar Publishing, 2015; Rosina, Monica Steffen Guise, Daniel Wei Liang Wang, and Thana Cristina de Campos. "Access to Medicines: Pharmaceutical Patents and the Right to Health" In Access to knowledge in Brazil: New research on intellectual property, innovation and development edited by Lea Shaver. Bloomsbury Academic 2010.

¹⁴ For example, see S.3(d) of The Patents (Amendment) Act 2005 in India, which excludes certain pharmaceutical substances from being patentable. See also Correa, Carlos. "Is Section 3(d) Compatible with the TRIPS Agreement?" *Economic and Political Weekly* 32 (2013).

¹⁵ A recent Commission on Intellectual Property Rights, Innovation and Public Health study found, "virtually all developing and least developed countries [who had implemented the Agreement] provided for the granting of compulsory licenses." See WHO Commission on Intellectual Property Rights. *Public health, innovation and intellectual property rights*. Geneva: World Health Organization, 2006.

<http://www.who.int/intellectualproperty/documents/thereport/ENPublicHealthReport.pdf>.

¹⁶ The Butantan Institute in Brazil is an example of a state-owned pharmaceutical manufacturers that has been particularly successful in addressing health needs in a developing state. See De Franco, Marcelo and Jorge Kalil. "The Butantan Institute: History and Future Perspectives." *PLoS Neglected Tropical Diseases* 8, no. 7 (2014): e2862.

¹⁷ CESCR (Committee on Economic, Social and Cultural Rights). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). UN Doc. E/C.12/2000/4, August 11, 2000.

¹⁸ *Ibid*, Para. 33.

¹⁹ *Ibid*, Para. 36.

²⁰ *Ibid*, Para. 17.

²¹ UN General Assembly. International Covenant on Economic, Social and Cultural Rights. Res. 2200A (XXI), December 16, 1966, Article 2(1).

²² This wording has been heavily criticized in: Alston, Philip and Gerard Quinn. "The Nature and Scope of States Parties Obligations Under the International Covenant on Economic, Social and Cultural Rights" *Human Rights Quarterly* 9 no. 2 (1987), 156; O'Connell, Rory. "A Human Rights Framework Part 1: Exploring Article 2(1) ICESCR Obligations" In *Applying an international human rights framework to state budget allocations: Rights and resources* edited by Rory O'Connell, Aoife Nolan, Colin Harvey, Mira Dutschke, Eoin Rooney. Routledge, 2013, 61.

²³ CESCR (Committee on Economic, Social and Cultural Rights). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). UN Doc. E/C.12/2000/4, August 11, 2000, Para. 43(d).

²⁴ *Ibid*.

²⁵ World Health Organization. WHO model list of essential medicines 19th list (April 2015). World Health Organization, 2015.http://www.who.int/selection_medicines/committees/expert/20/EML_2015_FINAL_amende_d_AUG2015.pdf?ua=1.

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Monitoring Interventions to Respond to Sexual Violence in Humanitarian Contexts

Sara Davis, Doris Schopper and Julia Epps

Sexual violence in conflict settings is recognized as a war crime, constituting a grave violation of human rights. This article compares and contrasts sexual violence intervention monitoring and evaluation (M&E) tools recommended by the Inter-Agency Standing Committee and indicators used by leading international humanitarian organizations to monitor and evaluate medical care, mental health care and psychosocial support, and legal aid services for survivors of sexual violence in humanitarian contexts. We find that few organizations have published their M&E tools. Among those that have, there is a wide diversity of definitions and indicators, creating knowledge gaps on what works, especially around less-studied populations such as male survivors. This study finds methodological and epistemological questions in the use of quantitative indicators in contexts of stigma, violence, and discrimination and challenges in mainstreaming sexual violence interventions in health.

Sexual violence is recognized by World Health Organization (WHO) as having serious impacts on physical, mental, sexual and reproductive health.^{1,2} Sexual violence can result in immediate and acute physical injuries, even in some cases fatalities. It can result in chronic health problems; gynecological disorders; sexually transmitted infections, including HIV; adverse mental health outcomes, including depression, suicide attempts, and anxiety disorders; and more.³ In conflict settings, sexual violence is recognized as a war crime, constituting a grave violation of human rights.⁴ Addressing these humanitarian contexts,⁵ international attention by global governance agencies to the problem of sexual violence in humanitarian settings has increased in recent years.⁶ This has included the recognition of sexual violence under the Rome Statute, resolutions by the United Nations (UN) Security Council, the 2009 establishment of a UN Special Representative of the Secretary-General on Sexual Violence in Conflict, and a 2014 Global Summit to End Sexual Violence in Conflict.⁷ In 2016, UN member states recognized the importance of addressing sexual violence in the Sustainable Development Goals (SDGs), with target 5.2, which aims to “eliminate all forms of violence against all women and girls,” presumably including in humanitarian settings.

Yet, recent reviews of interventions to prevent and respond to sexual violence in humanitarian settings have repeatedly pointed to the lack of evidence on which to base interventions. One of the most cited and thorough scientific reviews was published in 2013. It examined the impact of initiatives in low- and middle-income countries to reduce the incidence, risk, and harm from sexual violence in conflict, post-conflict, and other humanitarian crises. Only 40 studies were identified in a 20-year period from 1990 to September 2011.⁸ The authors noted that:

most interventions addressed opportunistic forms of sexual violence committed in post-conflict settings. Only one study specifically addressed the disaster setting. Actual implementation of initiatives appeared to be limited, as was the quality of outcome studies.⁹

A follow-up review, analyzing further evidence of good practices in prevention and response to gender-based violence in humanitarian contexts, found that only 15 of the approximately 100 guidelines, tools, papers, evaluations, studies, and other documents reviewed were

deemed robust enough to be included on the basis of their quality and relevance.¹⁰ The lack of evidence on the outcomes of interventions, and lack of evidence from regions other than Africa, were highlighted and echoed again in a special report in the *Lancet*.¹¹ Similarly, a consultation with experts organized by the Georgetown University Global Women's Institute in early 2017 noted gaps in evidence, including on service mapping and utilization, baseline data, monitoring reports and evaluation results, and qualitative data, including personal accounts.¹²

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) upholds the right to the highest attainable standard of health.¹³ General Comment No. 14 analyzes this right as including the elements of availability, accessibility, acceptability, and quality, with the "quality" element meaning that goods and facilities are "scientifically and medically approved."¹⁴ Article 15 of the ICESCR also upholds the right of everyone "to enjoy the benefits of scientific progress and its applications."¹⁵ Yet meeting, and in some cases even defining, these scientific standards in sexual violence programming poses methodological, ethical, and logistical challenges.¹⁶

Some of the challenges are inherent in the nature of sexual violence. While widespread, sexual violence is largely under-reported; survivors¹⁷ tend to avoid disclosing their attacks due to stigma and fear of retaliation, and humanitarian programs have been slow to incorporate the issue into their respective mandates. In some contexts, where survivors may be blamed, expelled from their communities, or even subject to honor killings, the very process of gathering data in order to build a sounder evidence base carries the real risk of causing further harm. In humanitarian settings, where resources are constrained, there are further challenges to data-gathering: urgent priorities often take precedence over routine tasks such as monitoring and evaluation (M&E), services are frequently interrupted, and medical facilities are sometimes vulnerable to attack.¹⁸ Even when sound M&E practices can be implemented, they may not be sustainable for the length of time needed to create robust evidence, as projects in humanitarian settings are sometimes only implemented for short time-periods.¹⁹

Currently, there is little internationally-recognized guidance on how to monitor and evaluate programs addressing the needs of survivors of sexual violence. Few organizations have chosen to publish their M&E indicators or tools externally. As a result, it appears that each organization designs its own set of indicators, data-gathering methods and impact measures without reference to (or often, access to) those used by peer organizations. In order to compare implementation and impact of programs across settings and across organizations in this newly-emerging area of global health governance, the evidence base for programs to meet the needs of survivors would be strengthened if there were a standard approach to M&E that could be complemented and enhanced to meet the needs of specific contexts.

In this article, we examine M&E guidance and indicators used by some leading UN agencies, intergovernmental organizations, and nongovernmental organizations (NGOs) to monitor and evaluate programs that provide medical care, mental health and psychosocial support (MHPSS), and legal aid services to survivors. Our aim is to assess whether the indicators currently published by different agencies show commonalities, where gaps exist, and where further thinking may be needed as research, monitoring, and evaluation develop in the field.

METHODOLOGY

We gathered information on guidance and tools to monitor and evaluate programs responding to sexual violence in conflict settings by writing to and/or visiting the websites of international organizations that are particularly active in this area. These included the International Committee of the Red Cross (ICRC), International Rescue Committee (IRC),

WHO, United Nations High Commissioner for Refugees (UNHCR), and the United Nations Population Fund (UNFPA).²⁰ Other organizations shared indicators for background use only. We also consulted guidelines developed in consultation with these and other agencies by the Inter-Agency Standing Committee (IASC) and the Reproductive Health Response in Conflict (RHRC) Consortium. While the IASC guidelines focus on prevention and mitigation of sexual violence, they include some response programs, and thus were included in this study.²¹ The International Federation of the Red Cross (IFRC) has a pilot set of standards for interventions that only address prevention and mitigation, and thus these were not included in the study.²²

Based on our review of these published and off-the-record materials, we identified 76 indicators that were classified by the organizations as used to monitor and evaluate medical care services (47 indicators), MHPSS (19 indicators), and legal aid services (10 indicators). We collected the indicators on Excel spreadsheets, following the categorization used by the organizations, although, as discussed below, these categorizations sometimes varied among organizations. While we focused on guidance that addressed M&E of programs responding to sexual violence specifically in humanitarian settings, we also consulted guidance designed for developmental and other contexts.

To compare and contrast the indicators, we begin by exploring the similarities and differences in institutional approaches and programmatic activities for sexual violence. Indicators should measure the outputs of programs and their impact, but to do so, there must be some agreement on what those programs are and how they are measured. Different programs and approaches will result in different indicators.

We then focus on analyzing indicators for three specific areas: medical care, mental health care/psychosocial support, and legal aid services. We focused on these three types of interventions as medical care and mental health care are commonly agreed to be essential services; given that sexual violence in conflict is both a violation of human rights standards and is recognized as a war crime, legal aid for survivors is also critical. We found little or no M&E guidance or indicators for some other areas commonly understood to be part of the response, such as protection.

DIFFERING INSTITUTIONAL MANDATES

Sally Merry's study of human rights indicators, in particular indicators used to measure violence against women, notes the differing institutional and cultural understandings that can shape the development of indicators used in global governance. At the global level, "conceptions of violence and of the relationships and social structures within which it occurs are highly variable. Moreover, what constitutes violence against women is highly contested."²³ Likewise, our review found that agencies position themselves differently in terms of the scope of the problem, nature of the problem, and prioritized responses for sexual violence. These differing positions in what is still an emerging field also shape interventions, language, and approaches to M&E.

For example, some organizations emphasize addressing sexual violence in conflict settings, as do the Sphere Project guidelines, which assert that humanitarian actors must respond to sexual violence as part of a minimum humanitarian standard for the emergency response.²⁴ Other organizations view sexual violence as one part of a larger spectrum of "sexual and gender-based violence."²⁵ IASC frames the issue even more broadly, defining gender-based violence as rooted in the socio-economic inequality between women and men.²⁶ Institutions also diverge in their understanding of whether the "gender" in "gender-based violence" (GBV) should include violence experienced by men.²⁷

Institutions take different approaches to programming and measurement that reflect these differences in focus and emphasis.

DEFINING PROGRAMMATIC INTERVENTIONS

In order to compare indicators, we aimed to first identify a set of core programs that could be monitored and evaluated comparably. However, in part because of the differing institutional mandates discussed above, we found significant diversity in terms of which institutions emphasized which types of programs. Institutions that define their mandate more broadly tend to recommend a broad array of types of interventions, and recommend ways to integrate them into other programs. Institutions with narrower mandates tended to emphasize the importance of the types of programs in which they have specific expertise.

The IASC guidelines are based on a broader analysis of gender-based violence as rooted in socio-economic inequalities. Thus, the IASC guidelines emphasize integration of GBV response services into cross-cutting humanitarian programming areas. The 2015 edition of the guidelines aim to integrate GBV interventions in 13 thematic areas: camp coordination and camp management; child protection; education; food security and agriculture; health; housing, land, and property; humanitarian mine action; livelihoods; nutrition; protection; shelter, settlement, and recovery; water, sanitation, and hygiene; and humanitarian operations support sectors. However, one result of this emphasis on mainstreaming is that such technically complex areas as mental health and psychosocial support or legal aid services, normally addressed with standalone programs, are discussed only briefly as sub-topics within other thematic areas, such as child protection and housing.²⁸

UNFPA's *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies*, which draws extensively on the IASC guidelines, has its own slightly different emphasis. The UNFPA *Minimum Standards* give significant emphasis to some areas neglected in the IASC guidelines, such as MHPSS and legal aid, but do not specifically address child protection.²⁹ UNHCR's approach differs slightly, in that it emphasizes integration of prevention and response interventions across other humanitarian programming for refugees. UNHCR has defined a list of 48 "essential actions" for addressing sexual and gender-based violence (SGBV), selected based on the institution's review of published guidance and on consultation with other agencies.³⁰ The 48 essential actions include, for example, establishing medical referral systems for survivors, promoting community-based watch groups, establishing separate latrines for men and women, providing training to staff, and others.³¹ UNHCR's monitoring and evaluation report on this project focuses on an initiative to place senior protection officers in diverse contexts in order to put these 48 essential actions into place, and evaluates the degree to which the 48 actions are completed. UNHCR has a broader approach to evaluating the outcomes and impact of the 48 actions, but it is not externally published.

ICRC's *Addressing the Needs of Women Affected by Armed Conflict* outlines recommended interventions within the areas of medical/health assistance, psychological support, economic assistance, social/community healing, and reporting violations. ICRC's approach to M&E differs from other organizations examined for this study in that it monitors and evaluates MHPSS and primary health care interventions for adult and child victims of violence in general, without distinguishing sexual violence.³²

In short, there is as yet no single core package of interventions for sexual violence survivors agreed among all institutions: some emphasize mainstreaming, while others emphasize specific types of programming. There are a number of commonalities: all of the agencies emphasize access to emergency medical care and the need for adequate training and technical support for field staff; all agencies also recommended meaningfully including women in stakeholder consultation and governance mechanisms.

Given that there are diverse views among institutions on what should constitute a core package of services for survivors, it is natural that our review of indicators also found that organizations take diverse approaches to M&E.

ANALYSIS OF INDICATORS

We grouped indicators according to area of intervention (medical care, mental health and psychosocial support, and legal aid) and identified whether each was an input, output, process, or outcome indicator. Input indicators measure the resources invested in a program: availability of supplies, personnel, or facilities. Output indicators measure the quantity of services or persons served (e.g., number of completed training courses). Process indicators measure how goods and services are provided. Outcomes are the broader results of the services, whether on the program, the agency, or the community at large.

Generally, medical care M&E approaches appear most clearly defined, although they tended to focus on inputs and outputs rather than on medical outcomes. We found that there is much less definition of services and indicators for MHPSS and legal aid, although somewhat more inclusion of output indicators. In some cases, we found indicators that were irrelevant to the area being evaluated.

Medical Care

Significant evidence exists for the medical care services to be provided to sexual violence survivors.³³ Here, we found clearer alignment on interventions than in the other two areas studied. There were also more areas of overlap in terms of indicators recommended than in the areas of mental health and legal aid. However, we found an overall emphasis on input and output indicators, and little guidance on measuring health outcomes. Some indicators also appeared to rely on unclear denominators, as further explored below.

WHO's *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* provides a checklist of recommended interventions, which includes gathering forensic evidence; prevention of sexually transmitted infections (STIs) and HIV (providing care is sought within 72 hours of the incident); emergency contraception; wound care; prevention of tetanus and hepatitis B; counseling; and referrals to mental health care.³⁴ This set of services appears to be consistently offered by others: for instance, MSF's *Medical Protocol for Sexual Violence Care* outlines a similar list of services.³⁵ MSF was one of the first providers of medical care to sexual violence survivors in conflict settings, and it offers an evidence-based package of clinical services to survivors in diverse settings.³⁶ Since 2004, the Sphere Project's *Humanitarian Charter and Minimum Standards in Disaster Response* has also included the *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health*, including many of the same services as those recommended by WHO.³⁷

While overall this is commendably consistent, it was concerning that none of the medical guidelines we reviewed either addressed the medical needs of either male or transgender survivors of sexual violence or had recommendations for monitoring or evaluating services for those populations. Moreover, despite evidence of links between unsafe abortion and high rates of maternal mortality, MSF is one of the few organizations with an explicit policy on the provision of abortions.³⁸ WHO's guidelines only recommend that women who are pregnant as a result of rape "be offered abortion, *in accordance with national law*" (emphasis added).³⁹

We collected 49 indicators that measure health services from ICRC, RHRC, IASC, and other organizations that requested their materials be used only for background reference. Many of these indicators focused on input or output of services. ICRC, IASC, and RHRC each had indicators that looked solely at the number of sexual violence or GBV reports received at health centers, as well as indicators that aimed to measure access to medical care by survivors. Consistent with the MISP, ICRC and RHRC monitor the number of rape victims to access services within 72 hours, a critical window for HIV pre-exposure prophylaxis. IASC recommends a number of indicators that measure availability of services,

coverage of supplies, and training of staff on GBV. We found relatively few process or output indicators for medical care.

We also found some areas of concern. IASC's recommended indicators for health do not monitor and evaluate medical care itself, but emphasize planning and administration: for example, the "number of non-health sectors consulted with to address GBV risk-reduction activities as a percentage of number of existing non-health sectors in a given humanitarian response" or the "number of affected persons consulted before designing a programme who are female, as a percentage of number of affected persons consulted before designing a programme."⁴⁰

The Problem of Denominators in Medical Service Coverage

In some cases, it is necessary to have some indication of the number of survivors in order to judge whether access to medical and mental health care is assured. The UN has supported tools to facilitate this data-gathering, such as the Gender-Based Violence Information Management System (GBV IMS), an online platform for tracking GBV data by service providers.⁴¹ However, it is methodologically challenging to establish a denominator for service coverage.

Many survivors will not report an incident to health facilities, resulting in implausibly small denominators. The ongoing displacement of populations also creates difficulties for analyzing the scope of sexual violence.⁴² Davis and colleagues find that when attempting to reach stigmatized and hidden populations with health services, small denominators can result in high service coverage reports that "paint a false picture of success."⁴³ Additionally, Dolan cautions that male survivors are unlikely to disclose their status in many contexts, including in countries where only female rape is recognized, or where same-sex sexual behavior is criminalized.⁴⁴ Thus, unless a health facility is taking special measures to screen and find male survivors, the overall number of cases reported to a health facility may fail to include the full denominator of survivors.

Moreover, individual survivors may experience repeat incidents of sexual violence and/or multiple forms of sexual violence. This poses a methodological challenge: Should agencies strictly report only the number of individuals affected or the total number of incidents of sexual violence? If the former, then the reported victims may underrepresent the scale of violence in settings of high re-victimization.⁴⁵ This is recognized as a problem by the UN,⁴⁶ WHO, and UNFPA⁴⁷ guidelines.

In the absence of normative guidance on the question of what a change in the number of reported cases means, the meaning of changing data is also treated differently by institutions.⁴⁸ Without data on broader prevalence, indicators that monitor service coverage could mistakenly be taken to imply success. A reduction in the number of cases reported to a health facility could be a sign that sexual violence is reducing; yet, it could, on the other hand, be a sign that a health facility has failed to provide high-quality services or has violated confidentiality, and has lost the trust of survivors in the community. Thus, we found different approaches to interpreting changes in number of reported cases: while IASC recommends viewing the reduction of reported cases as a sign of a successful prevention program, RHRC views an increased number of reports as an indication of a successful access to justice program.

WHO has developed robust ethical guidance on data-gathering about sexual violence, and notes that genuine informed consent is a challenge in conflict and emergency settings.⁴⁹ Most of the guidance reviewed for this study adopts or references the WHO ethical guidance in some form.⁵⁰ However, the guidance documents we reviewed also provide a range of tools for data-gathering, including incident report forms, statistical report forms, and client feedback forms, which could jeopardize confidentiality without strict data protection policies and training for staff.

Mental Health Care and Psychosocial Support

Sexual violence in conflicts and emergencies can have profound and long-term effects on the mental health and well-being of survivors, their families, and the community at large. Survivors of sexual violence may experience diminished ability to function, post-traumatic stress disorder, depression, and suicidal thoughts, as well as numerous other impacts.⁵¹ While these problems are well-documented, the types of interventions recommended vary among agencies, reflecting diverse institutional areas of expertise and theoretical orientations – as well as, perhaps, diverse needs of survivors.

To address the complex forms of harm to survivors, Tol and colleagues recommend a “multi-layered approach,” building on the IASC pyramid, which identifies “different levels of psychosocial and mental health interventions,” including specialized services for individuals, non-specialized support (such as psychological first aid), strengthening community and family supports, and addressing social considerations in basic services and security.⁵² Tol and colleagues note the challenges in isolating specific effects of interventions.

Thus, apart from IRC’s guidance for treating child sexual abuse survivors, we were unable to identify published technical guidance outlining one package of mental health and psychosocial support interventions specifically for sexual violence survivors in humanitarian settings.⁵³ Schopper notes a lack of scientific evidence for some psychosocial support interventions offered to sexual violence survivors, including “psychological first aid, community-based support and structured social activities.”⁵⁴

Among the guidance and indicators reviewed for this study, we identified 19 indicators for use in M&E of MHPSS interventions, almost all either input, output, or process indicators. These included output indicators aimed at measuring the numbers of survivors to access psychological services in a given setting (here, we encountered the same problem with lack of clear definition of denominators, as discussed above); process indicators that measure referrals to MHPSS, and output indicators measuring community ability to provide psychosocial support services; as well as number of health staff trained to provide MHPSS (an input indicator). All these indicators are measured for all victims of violence, and for children separately from adults.

ICRC had one of the few outcome indicators we found in our study: it measured numbers of patients to show reduced distress, improved functioning, and improved coping. However, from the materials provided, it was not clear how these indicators are assessed or what the time frame is for assessment.

The IASC guidelines do not provide M&E guidance for mental health and psychosocial support interventions, which, as mentioned above, are mainstreamed into other programmatic areas. RHRC’s “Psychosocial: individual and community” indicators seem to be mistakenly categorized under mental health and psychosocial support when they actually focus on gender balance in community mobilization among refugees, gender equity in refugee decision-making, level of community awareness, and “survivors/women at risk engaged in reintegration and/or empowerment activities.”

Legal Aid

Although almost all of the guidance on sexual violence we examined referenced the fact that sexual violence is a violation of human rights and humanitarian law, none of the institutions examined in this study offers legal aid services for sexual violence survivors. Thus we were unable to locate normative guidance on this important technical area. Rather, legal aid is sometimes referenced as being necessary, but there is little M&E guidance.

For example, UNHCR’s above-mentioned 48 essential actions include the establishment of a referral mechanism for legal aid; however, UNHCR has not published an

M&E approach to assess the quality or outcome of legal aid services. Similarly, both the IASC and RHRC guidelines recommend monitoring whether free legal aid services exist and are accessible, for instance within other cross-cutting thematic areas (such as legal aid to enable women to recover housing, land, and property rights) but not whether the services are effective.⁵⁵

Thus, indicators for legal aid offered to sexual violence survivors tend to emphasize input (availability of services), or, in some cases, process/output (RHRC has one outcome indicator to monitor the number of GBV cases with acquittal or conviction within six months).⁵⁶

Access to justice is a long and complex process, and input or output indicators do not capture the many stages at which cases may drop out of the system after referral. The judicial process can include, depending on the legal system, processes of registering cases, investigating them, interviewing witnesses, the trial process itself, sentencing, and appeal.

A more robust approach would also consider how to evaluate the complex support that survivors need in order to be able to access services and see a case through to completion, such as know-your-rights training, counseling, and more.⁵⁷ More robust indicators could also include assessment of the legal framework's approach to sexual violence; effective enforcement of the law; knowledge and performance of police; capacity and competence of service providers (including judges); ability of relevant actors to gather and preserve forensic evidence; quality of judgments; eligibility of migrants and refugees to file a case at all in a given context; and more. Other indicators could include measurement of "successful sensitization of lawyers, judicial staff and magistrates."⁵⁸

Measurement of the outcome of legal aid services could also be integrated into evaluations of the outcome of other services. Work on monitoring and evaluation of legal aid services for sexual violence survivors could usefully draw from the significant body of research and guidance on the impact of law on health that is published or under development in relation to human rights, gender equality, and HIV.⁵⁹

CONCLUSION

Overall, our review found that while the leading international humanitarian agencies show commonalities on the importance of addressing sexual violence in humanitarian settings, there is work to be done to align and elaborate approaches, normative guidance, and indicators. This diversity of approaches exists because some guidelines have tended to emphasize mainstreaming sexual violence programming into other humanitarian activities while others are focused solely on the technical areas they know best, creating challenges in commensurability and in accumulating a body of evidence.

First, we found lack of clear agreement on what constitutes core interventions for survivors, especially in the areas of MHPSS and legal aid services. No UN or humanitarian agency appears mandated to provide legal aid services, leaving the provision and evaluation of these services largely in the hands of domestic NGOs that may or may not be sufficiently resourced to meet the need.

Second, there is a lack of consensus on what should be measured in order to robustly assess all three areas we examined. Some indicators rely on weakly-defined denominators; the methodological (even, epistemological) problems posed by a denominator of "cases reported to health facilities" as a basis for service coverage requires a more forthright and in-depth examination. Too few of the indicators examined attempt to evaluate the wider outcomes of the interventions, and none aimed to evaluate long-term impacts.

Third, while agencies naturally have diverse mandates and emphases, the guidance and indicators we reviewed showed that programs to respond to male and transgender

survivors still appear invisible within existing approaches to M&E, suggesting that these hidden populations may remain largely unserved.⁶⁰

In a 2014 discussion of the evidence base for various sexual violence interventions, Schopper cautioned that “we have many gaps in our knowledge;” this study finds a continuing need to create a stronger evidence base. The development of more consistent thinking and approaches may require more inter-agency cooperation and active governance to incorporate lessons learned about which indicators work in context, ensuring that survivors of sexual violence have access to the highest attainable standard of health services.

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Doris Schopper is professor of the medical faculty of the University of Geneva and director of CERAH. She obtained a medical degree at the University of Geneva (1978), trained as a specialist in Internal Medicine (1986), and completed a Doctor in Public Health at the Harvard School of Public Health (1992). Between 1982 and 1990 Doris Schopper spent several years with Médecins Sans Frontières (MSF) in the field. She was president of the Swiss branch of MSF (1991–1998) and twice president of the MSF International Council during this period. In 2001 Doris Schopper was asked to constitute an Ethics Review Board for MSF International. Since then she has chaired the Board coordinating the ethical review of MSF research proposals and providing advice on ethical matters to the organization. Doris Schopper also worked as health policy adviser in the Global Programme on AIDS at WHO headquarters in Geneva (1992-95). Further international work includes two years as senior health policy adviser at the Swiss Tropical Institute and developing several policies and strategies for WHO (e.g. guideline for policy makers on national policies for violence and injury prevention; strategy for mother-to-child transmission of HIV in Europe; WHO-wide strategy on child and adolescent health). Professor Schopper has also been responsible for the development of health policies and strategies at the national and regional level in Switzerland (e.g. Swiss National Cancer Control Programme 2005-2010; framework to prevent obesity at the national level; comprehensive health policy for the canton of Geneva). In November 2012, Doris Schopper was appointed member of the International Committee of the Red Cross (ICRC).

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¹ This study addresses conflict, disaster, and post-conflict settings. For consistency, these settings are collectively referred to as “humanitarian settings” in this article.

² World Health Organization. *Understanding and addressing violence against women*. Geneva: World Health Organization, 2012.

³ Ibid.

⁴ Foreign and Commonwealth Office. *International Protocol on the Documentation and Investigation of Sexual Violence in Conflict*. 2nd edition. London: Foreign and Commonwealth Office, 2017.

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Promotion and Protection of the Right to Health by the Office of the UN High Commissioner for Human Rights

Gillian MacNaughton

Since 1994, the Office of the High Commissioner for Human Rights (OHCHR) has taken a lead role in promoting human rights around the globe. This article examines the work of the OHCHR on the right to health. Based on the annual reports of the High Commissioners for Human Rights on the activities of the OHCHR and the archival records of OHCHR initiatives related to health, the article first outlines the evolution of the right to health at the OHCHR. Then, drawing on interviews with OHCHR staff and external experts on the right to health, the article adds to this portrait by identifying key factors that have facilitated and inhibited the evolution of the right to health at the OHCHR.

INTRODUCTION

Since the mid 1980s, there has been growing recognition of the right to health, and other economic and social rights.¹ Milestones in this evolution include: the creation of the United Nations Committee on Economic, Social and Cultural Rights (CESCR) in 1985, which monitors the progress of states parties in implementing the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Committee's General Comment 14 issued in 2000, elaborating on the content of the right to health; and the adoption of the Optional Protocol to the ICESCR in 2008, which authorizes the CESCR to consider complaints alleging violation of these human rights.² Another milestone was the establishment of the mandate of the UN Special Rapporteur on the right to health in 2002; the reports of the three mandate-holders over the past fifteen years have addressed a multitude of features of the right to health generally as well as in specific country contexts.³ Domestic case law, non-governmental organization (NGO) campaigns, and academic literature have also contributed substantially to the increasing global acceptance of health as a human right.⁴ Today, over two-thirds of countries recognize the right to health in their constitutions, and every country in the world has ratified at least one treaty that includes the right to health.⁵

The Office of the United Nations High Commissioner for Human Rights (OHCHR) is also an important global actor in the promotion and protection of the right to health, as it supports the United Nations (UN) human rights mechanisms, advises on mainstreaming human rights throughout the UN, develops human rights guidelines and tools, and provides training on human rights in country contexts. This article examines the role that the OHCHR has played in the promotion and protection of the right to health over the past twenty-four years.

BACKGROUND ON THE OFFICE OF THE HIGH COMMISSIONER FOR HUMAN RIGHTS

The OHCHR was established in December 1993 by the UN General Assembly when it created the post of the UN High Commissioner for Human Rights. The UN Commission on Human Rights and the Economic and Social Council had both recommended the establishment of the post of High Commissioner for Human Rights in the mid-1960s; however, the General Assembly was unable to reach a consensus until the end of the Cold War.⁶ The idea was then revived at the World Conference on Human Rights in 1993, which produced the Vienna Declaration and Programme of Action, recommending that the General Assembly "begin, as a matter of priority, consideration of the question of the

establishment of a High Commissioner for Human Rights for the promotion and protection of all human rights.”⁷

Later that year, the General Assembly adopted a resolution creating the post of High Commissioner for Human Rights, to be appointed by the Secretary-General and approved by the General Assembly.⁸ The High Commissioner is an Under-Secretary General who reports annually to Human Rights Council and to the General Assembly.⁹ Central to the High Commissioner’s mandate is that the official:

Be guided by the recognition that all human rights – civil, cultural, economic, political and social – are universal, indivisible, interdependent and interrelated and that, while the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.¹⁰

Therefore, first among the responsibilities of the High Commissioner is “[t]o promote and protect the effective enjoyment by all of all civil, cultural, economic, political and social rights.”¹¹ Among these rights is the right to the highest attainable standard of physical and mental health (the right to health).¹²

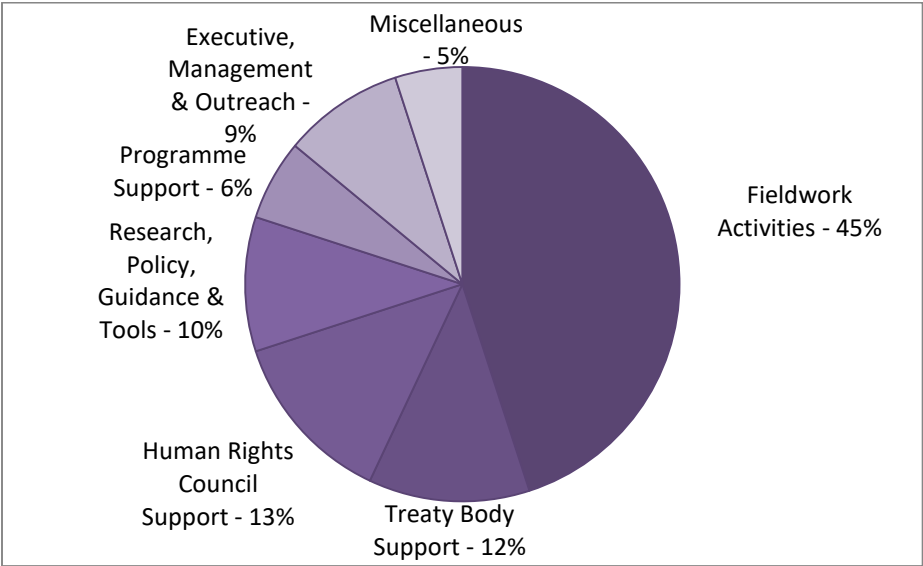
The 1993 UN General Assembly resolution that created the High Commissioner post also created the OHCHR to be located in Geneva with a liaison office in New York.¹³ Since 1994, the OHCHR has taken a leading role in promoting human rights around the world. Its mission is “to work for the protection of all human rights for all people; to help empower people to realize their rights; and to assist those responsible for upholding such rights in ensuring that they are implemented.”¹⁴ The OHCHR works in four broad areas.¹⁵

First, the OHCHR provides support for the human rights mechanisms, including the Human Rights Council, the fifty-seven Special Procedures mandate holders appointed by the Human Rights Council, and the ten UN treaty bodies. This includes both substantive and technical support. Second, the OHCHR produces policy, guidelines and tools that translate international human rights law into practice. In this realm, it also provides training, advice, and support to UN member states, civil society, and national human rights institutions.¹⁶ Third, the Office works to ensure that human rights are mainstreamed into all UN programs in development, peace and security, governance and the rule of law. It therefore participates in inter-agency bodies and activities to advocate for a human rights-based approach in all UN work. Finally, the OHCHR operates or supports sixty field presences, which collaborate with governments and other UN entities to respond to human rights challenges in context. This fieldwork involves, among other activities, trainings for police and judges, drafting legislation to implement international human rights laws, and aiding states in implementing the recommendations of the treaty bodies and other human rights mechanisms.¹⁷

At the time the OHCHR was created in 1993, its predecessor, the Center for Human Rights, employed 55 staff; six new positions were created to support the High Commissioner.¹⁸ Today, the OHCHR employs 1,179 staff.¹⁹ Similarly, the budget has grown from \$25 million (received by the Center for Human Rights) in 1993, amounting to 0.7 percent of the UN Secretariat budget, to \$190.5 million in 2016, amounting to 3.5 percent of the UN Secretariat budget.²⁰ Thus, the budget has increased fivefold as a portion of the Secretariat budget since the OHCHR was created. Nonetheless, the OHCHR remains deeply underfunded compared to global human rights concerns. To subsidize the allocations from the UN Secretariat, the High Commissioners have sought voluntary contributions (largely from member states), which in 2016 reached \$129.6 million.²¹ Still the OHCHR staffing and funding remain extremely limited in view of its global human rights mission. The 2016

budget was apportioned: 45 percent on fieldwork activities; 12 percent supporting the human rights treaty bodies; 13 percent supporting the Human Rights Council; 10 percent on research, human rights mainstreaming, developing policy, and providing guidance and tools; 6 percent on program support; 9 percent on the executive, management, resource mobilization and outreach, and 5 percent on miscellaneous. This budget breakdown is shown in figure 1.

Figure 1. OHCHR 2016 Budget



There is considerable literature on the OHCHR, as well as on the High Commissioners for Human Rights. Notably, in 2004, for the tenth anniversary of the OHCHR, the *Columbia Human Rights Law Review* produced a special issue of the papers presented at the 2003 *Symposium on the United Nations High Commissioner for Human Rights: The First Ten Years of the Office, and the Next*. Similarly, in 2013, for the twentieth anniversary of the OHCHR, Felice Gaer and Christen Broecker produced an edited volume, *United Nations for Human Rights: Conscience for the World*. There have also been several other articles and chapters discussing the evolution of the OHCHR and the records of the six High Commissioners.²² None of the literature, however, focuses specifically on the OHCHR's role in advancing economic and social rights generally, or the right to health specifically.

This article explores the contribution of the OHCHR to the realization of the right to health. It first outlines the evolution of the right to health at the OHCHR during the tenure of each High Commissioner since 1994. This section draws primarily on the annual reports of the High Commissioners on the activities of the OHCHR, as well as the archival records of OHCHR publications and initiatives. Second, the article considers the factors that have facilitated or inhibited advancing the right to health in the work of the OHCHR. This section draws on 20 semi-structured interviews, carried out during April and May 2017 with key informants.²³ Participants included ten current and former OHCHR staff and ten experts on the right to health or economic and social rights more generally, who have engaged with OHCHR, including three current and former Special Rapporteurs.²⁴ It finds

that the OHCHR has done much to promote and protect the right to health over the past twenty-four years; however, there remain substantial obstacles to fully supporting and integrating the right to health at the OHCHR.

THE ERAS OF THE SIX HIGH COMMISSIONERS FOR HUMAN RIGHTS

The responsibilities of the High Commissioner for Human Rights are set forth in the 1993 UN General Assembly resolution establishing the post. The High Commissioner is to:

1. Promote and protect civil, cultural, economic, political and social rights for all
2. Make recommendations to UN bodies, and carry out tasks assigned by these bodies, to improve the promotion and protection of human rights
3. Promote and protect the right to development
4. Provide technical and financial assistance to States to support action on human rights
5. Coordinate UN education and public information programs on human rights
6. Play an active role in removing obstacles to the full realization of all human rights
7. Engage in dialogue with all governments to secure respect for all human rights
8. Enhance international cooperation for the promotion and protection of all human rights
9. Coordinate human rights activities throughout the UN system
10. Strengthen the UN human rights machinery to improve efficiency and effectiveness
11. Supervise the Center for Human Rights (later merged with the OHCHR)²⁵

This mandate is extremely challenging. The UN High Commissioner for Human Rights is a human rights defender, diplomat, advisor, administrator, manager, coordinator, and human rights educator.²⁶ These responsibilities are both vast and often inconsistent. The central function of the High Commissioner, envisioned by human rights activists who advocated for the post for decades, is to call attention to gross human rights violations. This is the High Commissioner's public role: to stand on the side of victims of human rights abuses.²⁷ Harold Koh has described the High Commissioner as a secular moral leader for global human rights – often considered “the conscience of the world.”²⁸ Simultaneously, the High Commissioner has a vital “diplomatic role as an international executive dealing directly with leaders of 193 UN Member States.”²⁹ The High Commissioner must therefore condemn governments for human rights abuses while working with governments to establish field offices and advise on implementing human rights in country contexts. The dual role makes it difficult to fulfill the mandate.³⁰

To date, there have been six High Commissioners, as well as one Acting High Commissioner. Each of the High Commissioners has taken a different approach to fulfilling the responsibilities of the position, as well as toward economic and social rights – including the right to health. Beyond their individual influence, the discussion of the OHCHR through the eras of each High Commissioner paints a picture of the expanding work of the OHCHR on the right to health, which has evolved from a narrow focus on HIV/AIDS to diverse health topics, which are progressively integrated across programs today. Table 1 shows the dates of their terms.

Table 1: High Commissioners for Human Rights

	Term	Length of Service
José Ayala Lasso	1994-1997	3 years
Mary Robinson	1997-2002	5 years
Sergio Vieira de Mello	2002-2003	8 months
Bertrand Ramcharan (Acting High Commissioner)	2003-2004	13 months
Louise Arbor	2004-2008	4 years
Navanethem Pillay	2008-2014	6 years
Zeid Ra'ad Al Hussein	2014-2018	4 years

José Ayala Lasso (1994-1997)

José Ayala Lasso, a diplomat from Ecuador, was the first High Commissioner for Human Rights and served from April 1994 until March 1997.³¹ Human rights advocates in the Global North were disappointed by Ayala-Lasso's performance because he failed to publicly criticize governments on their human rights records.³² Governments and activists in the Global South, however, praised him for offering them technical support.³³ Not surprisingly for a diplomat, Ayala-Lasso emphasized his diplomatic role while High Commissioner. Thus, he emphasized building capacity in the Center for Human Rights, integrating human rights into the work of other UN entities, and establishing field presences. In his annual reports, Ayala-Lasso frequently expressed support for the right to development and economic, social, and cultural rights; however, he did not report OHCHR achievements specifically on the right to health. For example, in his 1995 report, he noted that “too often basic rights such as those to health, food, shelter and education receive insufficient protection” in the context of structural adjustment programs and that governments should consider the impacts of the policies they implement on the economic, social, and cultural rights of vulnerable groups.³⁴ In sum, Ayala-Lasso asserted their importance but recorded few OHCHR activities related to economic and social rights generally or to the right to health specifically during his years as High Commissioner.

Mary Robinson (1997-2002)

Mary Robinson, the former President of Ireland, was the second High Commissioner for Human Rights and served from September 1997 until September 11, 2002.³⁵ At the beginning of her term, the Secretary-General merged the Center for Human Rights into the OHCHR, greatly increasing the capacity of the OHCHR. In contrast to Ayala-Lasso, Robinson emphasized speaking out on behalf of victims of human rights abuses, and she was therefore praised by human rights activists in the Global North.³⁶ Robinson is also known for insisting on the indivisibility of all human rights, and was therefore a strong advocate for economic and social rights.³⁷ During Robinson's tenure, OHCHR work on economic and social rights expanded significantly. For example, the OHCHR worked with the Food and Agriculture Organization of the UN to define the content of the right to food,³⁸ engaged with the Commission on the Status of Women and the Commission on Human Rights regarding obstacles to women's full enjoyment of economic and social rights,³⁹ and collaborated with UN-Habitat on the right to adequate housing.⁴⁰ In 1999, Robinson issued a report documenting developments on the implementation of economic, social, and cultural rights at the international level,⁴¹ and in 2001, the OHCHR organized a workshop on the justiciability of these rights.⁴² Admittedly, much of this work was at the request of

the Commission on Human Rights. Nonetheless, Robinson's reports evidence an immense increase in OHCHR work on economic and social rights.

The OHCHR health-related work, particularly in the area of HIV/AIDS also greatly expanded during the Robinson era. In 1998, the OHCHR and the Joint United Nations Programme on HIV/AIDS (UNAIDS) jointly published the first edition of the *International Guidelines on HIV/AIDS and Human Rights*.⁴³ In 2001, Robinson created the first post at the OHCHR specifically focused on health, the Advisor on HIV/AIDS and Human Rights. Later that year, the OHCHR co-hosted a panel event with the World Health Organization (WHO) and UNAIDS on the multiple forms of racism and discrimination as determinants of and responses to the HIV/AIDS epidemic.⁴⁴ The OHCHR also collaborated on the development of the conceptual framework of the World AIDS Campaign for 2002-2003, which focused on stigma, discrimination and human rights.⁴⁵ In 2002, in cooperation with UNAIDS, the OHCHR developed a new strategy on HIV/AIDS to strengthen the capacity of the UN human rights system to address the human rights aspects of HIV/AIDS.⁴⁶ Finally, in 2002, the OHCHR co-hosted (with the WHO and UNAIDS) a meeting that brought together governments, NGOs, and UN agencies to discuss the human rights implications of recent developments on access to medicines and the right to health.⁴⁷ During the Robinson era, the OHCHR greatly increased its work on economic and social rights, including the right to health, and also developed a specific focus on HIV/AIDS and human rights.

Sergio Vieira de Mello (2002-2003)

Sergio Vieira de Mello, a Brazilian and a UN employee for over 30 years, was the third High Commissioner for Human Rights and served from September 2002 to May 2003. In May 2003, he took a temporary leave from the position to serve as UN Special Representative in Iraq.⁴⁸ On August 19, 2003, he was killed in a suicide bomb attack on the UN Headquarters in Iraq. Initially, Vieira de Mello had indicated that his focus as High Commissioner would be on strengthening the rule of law. In his only report to the Economic and Social Council, he declared his intention to build on the strong leadership of the OHCHR in crafting a human rights-based response to HIV/AIDS.⁴⁹ Due to his short term as High Commissioner, however, Vieira de Mello was unable to document OHCHR contributions to promoting and protecting the right to health during his tenure.

Bertrand Ramcharan (2003-2004)

When High Commissioner Vieira de Mello took the position in Iraq in late May 2003, Deputy High Commissioner Bertrand Ramcharan began serving as Acting High Commissioner. After Vieira de Mello was killed in August 2003, Ramcharan continued to serve as Acting High Commissioner until July 2004.⁵⁰ In his 2004 report, Ramcharan noted that the OHCHR was collaborating with WHO to identify indicators for monitoring the right to health.⁵¹ Along with WHO and UNICEF, the OHCHR also contributed to the elaboration of two health-related general comments adopted by the Committee on the Rights of the Child in 2003.⁵² During Ramcharan's tenure, the OHCHR continued much of the health-related work that was in progress under his predecessors.

Louise Arbour (2004-2008)

Louise Arbour, previously a justice on the Supreme Court of Canada, was the fourth High Commissioner, and served from June 2004 until July 2008.⁵³ Human rights advocates have generally praised her performance.⁵⁴ At the beginning of her term, she emphasized that extreme poverty was the most widespread denial of human rights and also the cause of many conflicts and human rights abuses,⁵⁵ and throughout her term, she supported

economic and social rights. During Arbour's tenure, the OHCHR embarked on a strategy to strengthen its expert capacity in the area of economic, social, and cultural rights, with a particular focus on legal protection and advocacy.⁵⁶ Arbour also advocated for the UN General Assembly to adopt the First Optional Protocol to the ICESCR to establish a complaints mechanism, and she encouraged member states to "consider how international and national jurisprudence had demonstrated that social, economic and cultural rights were not ideals, but legally enforceable entitlements."⁵⁷

During the Arbour era, the OHCHR continued its collaborations with WHO. For example, the OHCHR engaged with WHO in developing indicators for the right to health.⁵⁸ Additionally, the OHCHR and WHO jointly authored *Health, Human Rights and Poverty Reduction Strategies* in 2008,⁵⁹ and a fact sheet on the right to health in 2008.⁶⁰ The OHCHR also worked closely with UNAIDS, and in 2007, they jointly authored a *Handbook on HIV/AIDS and Human Rights for National Human Rights Institutions*.⁶¹ Arbour also established the second staff position in health; the single position on health—serving as the Advisor on HIV/AIDS and Human Rights and assisting the Special Rapporteur on the right to health—was transformed into two distinct positions. Additionally, Arbour created the women's rights and gender unit at the OHCHR to guide the mainstreaming of women's rights and gender in all OHCHR activities.⁶² The unit has since played an important role in developing the OHCHR's health-related work, particularly on sexual and reproductive rights. In sum, during the Arbour era, the OHCHR contributed substantially to advancing economic and social rights, continued the work on HIV/AIDS and human rights, and expanded the breadth of work on the right to health to encompass new areas, including poverty and right to health indicators.

Navanthem Pillay (2008-2014)

Navanthem Pillay, a South African human rights lawyer who had served both as a judge in South Africa and on the International Criminal Tribunal for Rwanda and the International Criminal Court, was the fifth High Commissioner.⁶³ She served in the position from September 2008 to August 2014.⁶⁴ Pillay's appointment was welcomed by human rights activists.⁶⁵ Initially, Pillay indicated that her focus would be on those held illegally in detention, including children, political prisoners, and those in Guantanamo Bay.⁶⁶ During Pillay's tenure, the OHCHR continued to engage substantively on economic and social rights. For example, Pillay held an office-wide consultation in 2009, which identified "pursuing economic, social and cultural rights and combating inequalities and poverty" as one of six thematic priorities for 2010-2011, recognizing also "that these rights make an integral part of all six priorities."⁶⁷ In her 2013 report to the Human Rights Council, Pillay noted that economic and social rights were still often neglected but that they were particularly important given that many countries had imposed austerity measures in response to the recent financial and economic crises.⁶⁸

During the Pillay era, the OHCHR broadened the areas of health to which it contributed. In 2010, for example, at the request of the Human Rights Council, Pillay issued a report on *Preventable Maternal Mortality and Morbidity and Human Rights*.⁶⁹ In 2011, the OHCHR and WHO finalized a policy assessment tool, *Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence*.⁷⁰ The OHCHR and WHO also promoted the implementation of technical guidance on maternal mortality and morbidity at the country level.⁷¹ Further, the OHCHR continued to operationalize the joint OHCHR/UNAIDS *Handbook on HIV/AIDS and Human Rights*, including holding regional workshops for national human rights institutions.⁷² The OHCHR also conducted an expert consultation in 2013 on the right to health in armed conflict.⁷³ During the Pillay era, the OHCHR continued the health-related initiatives begun by the previous High

Commissioners and also developed projects on health in prisons and on maternal mortality, among other projects.

Zeid Ra'ad Al Hussein (2014-2018)

Zeid Ra'ad Al Hussein, previously Jordan's Permanent Representative to the United Nations in New York and Jordan's Ambassador to the United States of America, is the sixth and current High Commissioner for Human Rights. He has served since September 1, 2014, and has announced that he will step down in September 2018 at the end of his first term.⁷⁴ During Zeid's tenure, activities on economic, social and cultural rights have included developing an online platform on social protection floors and human rights to provide tools on implementing a right to social security, as well as expert consultations and workshops on the links between armed conflict and violations of economic, social, and cultural rights.⁷⁵ The OHCHR is also developing an analytical framework for early warnings concerning infringements on economic, social, and cultural rights in order to build capacity to respond quickly.⁷⁶ Further, in 2016, the OHCHR, UNICEF, and other UN agencies jointly published a report on the impact of armed conflict on access to health care and education in Afghanistan.⁷⁷ The OHCHR has also been involved in system-wide dialogue on human rights and the Sustainable Development Goals (SDGs) for several years. In particular, the OHCHR has participated in consultations to prepare human rights-based indicators for the SDGs, with a focus on disaggregation of data and inclusive data collection systems.⁷⁸

Much recent health-related work at the OHCHR has focused on sexual and reproductive health and rights. For example, in 2015 the OHCHR launched *The Information Series on Sexual and Reproductive Health and Rights* to provide guidance to policymakers, judiciaries, health service providers, and civil society on laws, policies, and programs to promote women's sexual and reproductive rights.⁷⁹ To date, *The Information Series* has published briefings on HIV/AIDS, abortion, harmful practices, contraception and family planning, adolescents, women human rights defenders, violence against women, maternal mortality and morbidity, and lesbian, gay, transgender, and intersex people.⁸⁰ The OHCHR has also collaborated with WHO and the United Nations Population Fund (UNFPA) to produce a detailed technical guidance for health policymakers and national human rights institutions on applying a human rights-based approach to sexual, reproductive, maternal, newborn, and under-5 child health.⁸¹ Further, the OHCHR has provided support to develop training materials for the Council of Europe on sexual and reproductive health and rights and held multiple regional workshops on the topic.⁸²

In 2016, the OHCHR and WHO established the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents to secure political support for implementing the UN Secretary-General's *Global Strategy for Women's, Children's and Adolescents' Health 2016-2030*.⁸³ The Working Group launched its seminal report *Leading the Realization of Human Rights to Health and Through Health* in May 2017 at WHO and in June 2017 at the Human Rights Council, recommending that WHO and OHCHR collaborate closely on health and human rights.⁸⁴ To this end, in November 2017, WHO Director-General Tedros Adhanom Ghebreyesus and High Commissioner Zeid signed the *WHO-OHCHR Framework of Cooperation*, spelling out several ways in which the two agencies would strengthen their collaboration over the next four years.⁸⁵

Beyond the three key areas—sexual and reproductive health; women's, children's, and adolescents' health; and the SDGs—the OHCHR is working on several other aspects of the right to health, many in response to requests of the UN General Assembly or the Human Rights Council. For example, in 2016 and 2017, the OHCHR prepared reports on (1) the links between violations of economic, social, and cultural rights and social unrest and conflict,⁸⁶ (2) the relationship between climate change and the right to health,⁸⁷ (3) universal birth registration,⁸⁸ (4) mental health and human rights,⁸⁹ (5) girls' right to

education, including universal sexuality education,⁹⁰ and (6) the obligation to use “maximum available resources” to progressively realize economic, social, and cultural rights.⁹¹ Additionally, some OHCHR units—including those on child rights, women’s rights and gender; water and sanitation; and climate change—are making substantial progress in mainstreaming the right to health into their work. It is evident that in the Zeid era, the OHCHR continues to expand its work on the right to health into new areas.

FACTORS THAT FACILITATE OR INHIBIT PRIORITIZATION OF THE RIGHT TO HEALTH

The international right to health has evolved considerably since 1994, and the OHCHR has played an important role in this evolution. Key informants identified several factors that they believe have facilitated or inhibited the evolution of the promotion and protection of the right to health at the OHCHR.

Facilitating Factors

A key factor that facilitates the mainstreaming of the right to health at the OHCHR is the presence of champions in the OHCHR leadership. Although the High Commissioners have all expressed commitments to economic and social rights, they have not equally prioritized this area. Mary Robinson, however, stands out as a champion of economic and social rights generally, and the right to health specifically. Indeed, she is well known for her insistence on the equality of all human rights.⁹² Kevin Boyle, editor of *A Voice for Human Rights: Mary Robinson*, wrote, “A defining characteristic of Mary Robinson’s term as High Commissioner was her commitment to change the status of economic, social and cultural rights as the neglected clauses of the Universal Declaration of Human Rights.”⁹³ In an interview with BBC News, Robinson explained: “Extreme poverty to me is the greatest denial of the exercise of human rights. . . . It’s a denial of the dignity and worth of each individual, which is what the Universal Declaration proclaims.”⁹⁴ Robinson also made a substantial contribution to the right to health specifically, by establishing the first position at the OHCHR with a specific focus on health, the Advisor on Human Rights and HIV/AIDS. After leaving office, Robinson’s deep commitment to the right to health was evident as the NGO she founded, Realizing Rights – The Ethical Globalization Initiative, aimed to strengthen efforts to realize the human right to health among its five priorities.⁹⁵ While strong member state interest in the right to health is extremely important, deep commitment of OHCHR leadership is key to advancing the right to health at the OHCHR and globally.

A second factor that has facilitated the evolution of the right to health at the OHCHR is the rising profile of the right to health in the agendas of the human rights mechanisms. The CESCR’s General Comment 14, detailing the normative content of the right to health, greatly contributed to understanding of the right to health and its diffusion within the UN and in countries. The creation of the post of UN Special Rapporteur on the right to health—and the passionate advocacy of the three people who have held the post—has also impacted deeply on the extent to which health is regarded by human rights advocates, including those at the OHCHR, as a “real” human right. These Special Rapporteurs have also been involved in numerous initiatives, such as developing the OHCHR *Principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies*, and have advised WHO on several projects, deepening the relationship between the two organizations.⁹⁶ Further, the Human Rights Council has impacted on OHCHR health-related work, requesting that the OHCHR conduct numerous studies, hold expert meetings, and organize special events related to health. At times, these requests have coincided with initiatives at the OHCHR, such as maternal mortality, and given these initiatives greater attention. Unfortunately, in some cases, such requests have resulted in

short bursts of effort on a health-related topic with no follow up due to insufficient resources.

A third facilitating factor is the growing understanding that health is integral to realizing other rights. In the early years, the OHCHR focus was on HIV/AIDS and then on maternal mortality. The OHCHR now looks more holistically at health, including the underlying determinants of health. Due to the more expansive view of health that has emerged in recent years, staff at the OHCHR recognize that health is connected to and strengthens many other rights. Health is now integrated into work on women's rights and gender, child rights, and climate change and human rights, among other areas of the research at the OHCHR. This emerging understanding of health as an expansive right contributes to mainstreaming the right to health at the OHCHR. In recent years, Dainius Pūras, the current UN Special Rapporteur on the right to health, has played an important role in promoting this expansive understanding of health, and participation in the consultations on the 2030 Agenda has also helped to instill this holistic concept of health among OHCHR staff.

Inhibiting Factors

While the role of the OHCHR in promoting and protecting the right to health has grown continuously since 1994, there remain factors that inhibit this development. First among the inhibiting factors is the legacy of economic and social rights as second-class rights – or not really rights at all. The marginalization and even outright hostility toward economic and social rights continues among some UN member states, human rights NGOs, and human rights academics.⁹⁷ Against this background, the OHCHR has not consistently played a leading role in educating member states and human rights advocates on the interdependency and indivisibility of all human rights. Additionally, while all the High Commissioners have expressed commitment to economic and social rights, few have prioritized these rights in their own work. This legacy of marginalization is also evident among OHCHR staff, as some continue to view economic and social rights as a specialization, rather than crosscutting issues for all of the OHCHR's work.

Second, the low financial commitment of the UN Secretariat and member states means that resources are extremely limited in comparison to the OHCHR's global human rights mandate. The OHCHR is essentially a servicing organization. Seventy percent of its budget is allocated to field activities and to serving the Human Rights Council and the treaty bodies. However, there is simply insufficient staff to respond to the increasing demands from UN member states and the ever-growing number of special procedures mandate-holders.⁹⁸ As High Commissioner Zeid recently reported, “[w]hile there is increased demand for Human Rights Advisors, funds are insufficient, challenging both existing deployments and the ability to respond to new requests.”⁹⁹ In 2016, several Human Rights Advisor posts had to be discontinued.¹⁰⁰ Although many human rights activists would like the OHCHR to cultivate more of an independent voice, it lacks the capacity to fulfill its current servicing responsibilities, and therefore, cannot develop a substantial independent agenda. In the area of health, the picture is particularly bleak. Among the current 1,179 OHCHR staff, only one staff member is assigned to the health desk and one staff member is assigned to support the Special Rapporteur on the right to health. A third health position was eliminated in 2013. Although staff in other areas, such as women's rights and gender, are also working on the right to health, it is clear that two OHCHR staff members are an inadequate allocation of resources to address global right to health concerns.

Finally, an inhibiting factor for the mainstreaming of the right to health at the OHCHR is the difficulty in transitioning from conceptualization to operationalization. Experts agree that there is a need to move beyond narrow legalistic understandings of the right to health to implementation in the field.¹⁰¹ For the OHCHR to play a central role in

implementation, diversification of disciplines at the OHCHR may be necessary. In particular, to advance the right to health, the OHCHR must involve health professionals who are the best advocates to convince health professionals that adopting a right to health lens will advance their work. Among the key informants in this study, all but one of the current and former OHCHR staff were educated in law. Three participants were health professionals, but they were all experts from outside the OHCHR. It may be a significant challenge for the OHCHR to strengthen the interdisciplinary practice of human rights, but this could substantially advance the mainstreaming of the right to health – at the OHCHR and globally.

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¹ Human Rights Council, 32nd Session. *Report of the Special Rapporteur on Extreme Poverty and Human Rights*, UN Doc. A/HRC/32/31, April 28, 2016, 4-5.

² CESCR (Committee on Economic, Social and Cultural Rights). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*. UN Doc. E/C.12/2000/4, August 11, 2000.

³ OHCHR (Office of the High Commissioner for Human Rights). "Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health."

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⁴ Hunt, Paul. "Interpreting the International Right to Health in a Human Rights-based Approach to Health," *Health and Human Rights Journal* 18 no. 2 (2016): 109-130.

⁵ Kinney, Eleanor D. and Brian Alexander Clark. "Provisions for Health and Health Care in the Constitutions of the Countries of the World," *Cornell International Law Journal* 37 (2004): 285-355, 287 ("67.5% of the constitutions of all nations have provisions regarding health and health care"); OHCHR and World Health Organization. *The Right to Health: Fact Sheet No. 31*. Geneva: OHCHR, 2008, 1.

⁶ Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009, 10.

⁷ World Conference on Human Rights. *Vienna Declaration and Programme of Action*, UN Doc. A/CONF.157/23, June 25, 1993.

⁸ UN General Assembly. *High Commissioner For the Promotion and Protection of Human Rights*, UN Doc. A/RES/48/141, December 20, 1993, 3.

⁹ *Ibid.*, 3-4.

¹⁰ *Ibid.*, 3.

¹¹ *Ibid.*

¹² For example, see UN General Assembly. *International Covenant on Economic, Social and Cultural Rights*, Res. 220A (XXI), December 16, 1966, Article 12.

¹³ In 1993, the UN Center for Human for Human Rights was already located in Geneva. In 1997, Secretary-General Kofi Annan merged the OHCHR with the Center and put them both under the direction of the High Commissioner for Human Rights. See United Nations Department of Public Information. *Yearbook of the United Nations 1997*, Volume 51, 1997, 589.

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¹⁵ OHCHR. *OHCHR Report 2016*. Geneva: OHCHR, 2016, 58-59.

http://www2.ohchr.org/english/OHCHRreport2016/allegati/Downloads/1_The_whole_Report_2016.pdf.

¹⁶ Ibid, 59.

¹⁷ Ibid.

¹⁸ UN Secretary-General. *Staffing and Functions of the Office of the United Nations High Commissioner for Human Rights and of the Centre for Human Rights, Report of the Secretary-General*, UN Doc. A/C.5/48/77, May 31, 1994, 2-3.

¹⁹ OHCHR. *OHCHR Report 2016*. Geneva: OHCHR, 2016, 60.

²⁰ OHCHR. "Funding and Budget." Accessed June 12, 2017, <http://www.ohchr.org/EN/AboutUs/Pages/FundingBudget.aspx>.

²¹ Ibid.

²² See for example Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009; Boyle, Kevin, (ed.) *A Voice for Human Rights: Mary Robinson*. Philadelphia: University of Pennsylvania Press, 2010; Ramcharan, Bertrand. "The Office of UN High Commissioner for Human Rights," in *International Monitoring Mechanisms: Essays in Honor of Jacob Th. Möller*, Gudmundur Alfredsson ed., Leiden: Brill Publishing House, 2009, 199-204.

²³ The Institutional Review Board of the University of Massachusetts Boston approved this study proposal on March 14, 2017 (#2017062). For purposes of this project, the author obtained an introduction to the OHCHR staff member assigned to the health desk and also drew up a list of 12 experts, including OHCHR staff members, academics and special rapporteurs who had worked with her on the right to health over the past twelve years. The author and her research assistant, Mariah McGill, contacted those on this initial list, obtained the names and contact information from them of additional experts on the right to health and the OHCHR, and interviewed those willing to participate in the study. In total, they emailed 46 potential participants and were able to interview 20 key informants during April and May 2017. The author wishes to thank Mariah McGill for her excellent research assistance on this project.

²⁴ The author wishes to thank the key informants for their invaluable insights into the evolution of the right to health at the OHCHR. This study would not have been possible without their participation.

²⁵ UN General Assembly. *High Commissioner For the Promotion and Protection of Human Rights*, UN Doc. A/RES/48/141, December 20, 1993, 3-4.

²⁶ Ramcharan, Bertrand. "The Office of UN High Commissioner for Human Rights," in *International Monitoring Mechanisms: Essays in Honor of Jacob Th. Möller*, edited by Gudmundur Alfredsson, Leiden: Brill Publishing House, 2009; UN General Assembly. *High Commissioner For the Promotion and Protection of Human Rights*, UN Doc. A/RES/48/141, December 20, 1993, 201-203.

²⁷ Gaer, Felice and Christen Broecker, "Introduction" In *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 2.

²⁸ Koh, Harold Hongju. "A Job Description for the U.N. High Commissioner for Human Rights." *Columbia Human Rights Law Review* 35 (2004): 493-502, 495.

²⁹ Gaer, Felice and Christen Broecker, "Introduction" In *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 2.

³⁰ Ibid.

³¹ OHCHR. "José Ayala Lasso." Accessed June 13, 2017, <http://www.ohchr.org/EN/AboutUs/Pages/Ayala.aspx>.

³² Gaer, Felice and Christen Broecker, "Introduction" In *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 8; Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009, 32.

³³ Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009, 32.

³⁴ UN Economic and Social Council, 51st Session. *Report of the United Nations High Commissioner for Human Rights*. UN Doc. E/CN.4/1995/98, February 15, 1995, para. 57.

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³⁶ Gaer, Felice and Christen Broecker, "Introduction" In *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 9.

³⁷ Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009, 32; Pillay, Navanthem. "Address by the High Commissioner at the Jacob Blaustein

Institute for the Advancement of Human Rights,” in *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 2013, 63-63.

³⁸ UN Economic and Social Council, 56th Session. *The Right to Food: Report of the High Commissioner for Human Rights submitted in accordance with Commission Resolution 1999/24*, UN Doc. E/CN.4/2000/48, January 13, 2000, paras. 1-4.

³⁹ UN Economic and Social Council, 54th Session. *Report of the United Nations High Commissioner for Human Rights*, UN Doc. E/CN.4/1998/122, February 23, 1998, para. 48.

⁴⁰ UN Economic and Social Council, 55th Session. *The Right to Food: Report of the High Commissioner for Human Rights*, UN Doc. E/CN.4/1999/45, January 20th 1999, para. 41.

⁴¹ *Ibid.*

⁴² UN Economic and Social Council, 57th Session. *Justiciability of Economic, Social and Cultural Rights - Report on the Workshop*, UN Doc. E/CN.4/2001/62/Add.2, March 22, 2001, paras. 1-2.

⁴³ OHCHR and UNAIDS. *International Guidelines on HIV/AIDS and Human Rights*. Geneva; New York, NY: United Nations, 1998. http://data.unaids.org/publications/irc-pub02/jc520-humanrights_en.pdf.

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⁴⁵ *Ibid.*, para. 25.

⁴⁶ *Ibid.*, para. 19.

⁴⁷ *Ibid.*, para 30.

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⁴⁹ UN Economic and Social Council. *Report of the High Commissioner for Human Rights and Follow-Up to the World Conference on Human Rights*, UN Doc. E/CN.4/2003/14, February 26, 2003, para. 34.

⁵⁰ OHCHR. “Bertrand Ramcharan.” Accessed June 13, 2017

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⁵¹ UN Economic and Social Council, 60th Session. *The Right to Development: Report of the High Commissioner for Human Rights*, UN Doc. E/CN.4/2004/22, January 8, 2004, para. 46.

⁵² *Ibid.*, para. 44.

⁵³ OHCHR. “Louise Arbour.” Accessed June 13, 2017

<http://www.ohchr.org/EN/AboutUs/Pages/LouiseArbour.aspx>.

⁵⁴ Gaer, Felice and Christen Broecker, “Introduction” In *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 13-14.

⁵⁵ Mertus, Julie. *The United Nations and Human Rights: A Guide for a New Era*. Abingdon: Routledge, 2009, 34.

⁵⁶ UN General Assembly, 61st Session. *Report of the United Nations High Commissioner for Human Rights to the General Assembly*, UN Doc. A/61/36, 2006, para. 40.

⁵⁷ *Ibid.*, para. 36.

⁵⁸ UN Economic and Social Council, 62nd Session. *The Right to Development: Report of the High Commissioner for Human Rights*, UN Doc. E/CN.4/2006/24, December 16, 2005, para 52.

⁵⁹ OHCHR and World Health Organization. *Human Rights, Health and Poverty Reduction Strategies*. Geneva: World Health Organization, 2008.

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⁶¹ OHCHR and UNAIDS. *Handbook on HIV/AIDS and Human Rights for National Human Rights Institutions*. Geneva: OHCHR, 2007,

http://www.ohchr.org/Documents/Publications/HandbookHIV_NHRIsAug2007.pdf.

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- ⁷⁵ UN Human Rights Council, 31st Session. *Annual Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/31/3, December 23, 2015, paras. 71-72.
- ⁷⁶ UN Human Rights Council, 34th Session. *Annual Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/34/3, January 13, 2017, para. 63.
- ⁷⁷ *Ibid*, para. 65.
- ⁷⁸ UN Human Rights Council, 31st Session. *Annual Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/31/3, December 23, 2015, para. 65.
- ⁷⁹ OHCHR "Sexual and Reproductive Health Rights." <http://www.ohchr.org/EN/Issues/Women/WRGS/Pages/HealthRights.aspx>.
- ⁸⁰ *Ibid*.
- ⁸¹ UN Human Rights Council, 31st Session. *Annual Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/31/3, December 23, 2015, para 75.
- ⁸² UN Human Rights Council, 34th Session. *Annual Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/34/3, January 13, 2017, paras. 37, 39.
- ⁸³ *Ibid*, para. 64.
- ⁸⁴ High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, *Leading the Realization of Human Rights to Health and Through Health*. Geneva: World Health Organization 2017, 55.
- ⁸⁵ "Agreement Signed Between WHO and UN Human Rights Agency to Advance Work on Health and Human Rights," WHO, Life-course, News, November 21, 2017, <http://www.who.int/life-course/news/who-unhcr-agreement-on-health-and-human-rights/en/>.
- ⁸⁶ OHCHR. Early Warning and Economic, Social and Cultural Rights. Geneva: OHCHR, 2016. http://www.ohchr.org/Documents/Issues/ESCR/EarlyWarning_ESCR_2016_en.pdf.
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http://apps.who.int/iris/bitstream/10665/84203/1/9789241505420_eng.pdf.

⁹⁷ For example, see Ignatieff, Michael "Rights Inflation and Role Conflict in the Office of the High Commissioner for Human Rights," in *United Nations for Human Rights: Conscience for the World*, edited by Felice Gaer and Christen Broecker. Leiden: Brill Publishing House, 2013, 42 ("in the past twenty years, the low points [in the High Commissioners' work] were the failure to control rights inflation, the tendency to codify aspirations in the economic, social and cultural field into rights language").

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Transnational Human Rights Organizing and Global Health Governance, 1963-2013

Samantha Plummer, Jackie Smith and Melanie Hughes

Transnational social movement organizations (TSMOs) played a critical role in integrating human rights into the policies and programs of the United Nations, including in health governance. In this article, we examine the inter-organizational networks formed by women's and other human rights TSMOs and four health intergovernmental organizations (HIGOs) over the past 50 years. We find: (i) connections between human rights TSMOs and HIGOs increased dramatically in the late 1980s and 1990s; (ii) connections have leveled-off in recent years, as recently founded TSMOs—especially women's rights organizations—are less likely to report ties to HIGOs; and (iii) UNICEF is a prominent partner for human rights TSMOs, whereas the WHO is less central in human rights networks than expected.

INTRODUCTION

Transnational advocacy organizations have played an important role in facilitating the integration of human rights into the norms and structures of global health governance.¹ Researchers have demonstrated that international nongovernmental organizations (INGOs) have advanced human rights in global health governance by providing health care services, publicizing human rights violations, and engaging in advocacy and negotiations related to health policies, frameworks, and conventions.² Much of this research, however, analyzes a single time period, focuses on a small number of INGOs, or examines non-state actors as separate from, rather than in relation to, the leading institutions of global health governance. In contrast, we explore longitudinal developments and changes in the relationships between nongovernmental and governmental actors working to prioritize human rights in the global health field and shape health-related interventions worldwide.

In this article, we examine networks of transnational human rights and health organizations in the context of key developments in global health governance over the past 50 years. We focus, in particular, on the past 20 years, when the United Nations (UN) mainstreamed human rights and when international financial and trade organizations expanded their roles in global health governance.³ We explore how women's and other human rights organizations connect to four intergovernmental organizations (IGOs) that are central to global health governance: the World Health Organization (WHO), the Food and Agriculture Organization (FAO), the United Nations Population Fund (UNFPA), and the United Nations Children's Fund (UNICEF). We begin with a brief overview of the global politics of health and human rights since the 1950s. We then describe our data and methods before turning to substantive analysis of the relationships between transnational social movement organizations (TSMOs) and the intergovernmental health sector. We find that TSMOs dramatically increased their connections to health IGOs (HIGOs) in the late 1980s and 1990s, before connections stabilized in the 2000s. These patterns are influenced by TSMO founding year and issue focus, and there are notable differences in how TSMOs engage each of the four HIGOs.

THE GLOBAL POLITICS OF HEALTH AND HUMAN RIGHTS

In 1948, the WHO Constitution entered into force, declaring “the enjoyment of the highest attainable standard of health” a fundamental human right. In its early years, the WHO advocated a comprehensive focus on the social determinants of human health and sought

to expand human rights for global health through partnerships with UN agencies, like UNICEF and FAO, and with nongovernmental actors. In the late 1950s, under pressure from the United States (on whose funding it increasingly depended), the WHO deemphasized the right to health and focused instead on vertically-organized medical intervention and disease eradication programs.⁴

The 1970s saw the emergence and growth of new transnational human rights organizations, which exerted increasing pressure on the intergovernmental system to prioritize and better enforce human rights principles.⁵ At the same time, developing countries—now the majority in the UN system—began calling for a New International Economic Order (NIEO) that would decrease inequality among states and protect states' economic sovereignty. The WHO adapted and incorporated the human rights claims of NIEO to redefine its objectives as "health for all" through a primary health care approach. The goals of primary health care and a rights-based vision of health were set forth in the Declaration of Alma-Ata at the 1978 International Conference on Primary Health Care, co-organized by the WHO and UNICEF. Though signed by delegates from 134 member countries, the Declaration placed no obligations on states, and the WHO's previous abandonment of health rights meant there were no institutional frameworks through which to achieve Alma-Ata's vision of universal and primary health care.⁶

Alma-Ata was the last accomplishment for NIEO, as worsening stagflation and growing indebtedness to the International Monetary Fund (IMF) in the 1980s caused developing countries to lose leverage. NIEO was replaced by neoliberal economic policies, most prominently structural adjustment programs (SAPs), which mandated economic liberalization, deregulation of industry, and privatization of the public sector in exchange for economic relief from the World Bank and IMF.⁷ In most economically developing countries, particularly in Africa, SAPs destroyed jobs and local markets and devastated health services, increasing the disease burden on the poor. Agreements regulating trade in intellectual property and agricultural commodities, administered under the World Trade Organization (WTO), had deleterious effects on health by limiting poor people's access to necessities such as land, clean water, health care, and essential drugs.⁸

Human rights activists in the global justice movement have mobilized against market-led globalization, and in numerous case studies, researchers have detailed how activists resisted the neoliberal emphasis on economic growth and trade.⁹ Scholars have paid less attention, however, to how struggles over the nature of globalization played out in the arena of global health governance. By the late 1980s, the WTO, IMF, and World Bank were expanding their roles in global health governance and reinforcing the market-led approach to healthcare.¹⁰ At the same time, transnational advocacy organizations were increasing in strength and number and bringing focused attention to the need for a gendered human rights approach to health.

In this article, we explore how these tensions are reflected in the relationships between TSMOs and HIGOs, and what these network patterns suggest about the integration of human rights into institutions of global health governance.

Social Movements and Global Health Institutions

Non-governmental organizations have long worked both inside and outside formal political institutions to challenge the agendas of states and later of intergovernmental trade and finance organizations. The end of the Cold War generated opportunities for even further transnational activism around a variety of issues of central importance to global health governance. TSMOs built on past organizing and networking to shape the agendas and platforms for action that emerged from the UN Global Conferences of the 1990s and to integrate women's and other human rights into the larger UN system.¹¹

At the 1993 World Conference on Human Rights in Vienna, over 3,000 NGO participants gathered to lobby governments and UN bodies at official conference proceedings and network at parallel NGO forums. Key outcomes of this Conference were ideas about ways to strengthen the global institutionalization of human rights practices through proposals like the establishment of a UN High Commissioner for Human Rights. Women's rights advocates in Vienna and other UN Conferences—often led by feminists from the Global South—similarly worked to incorporate gendered analyses and demands into Conference agendas and outcomes.¹² Mobilization around women's reproductive health helped engage an array of groups in transnational efforts to frame health as an essential component of human rights.¹³ The UN system responded to these efforts. In 1997, Secretary General Kofi Annan directed the UN to integrate human rights into all areas of the UN system, and UN agencies began defining health issues in terms of human rights.¹⁴

While successful, human rights and gender mainstreaming was hardly uncontested. In the 1990s, advocates made a strategic effort to develop shared frames that would resonate with already legitimate ideas in global governance, which often meant excluding claims made by groups with more radical agendas and/or with concerns about a UN-focused strategy.¹⁵ More critical analyses of global power arrangements and their effects on human health were also rejected by governments when those critiques challenged neoliberal policies. At Vienna and other UN Conferences, the United States, European Union, and other powerful states successfully prevented from appearing in final documents NGO statements holding states responsible for “environmental damage caused by weapons of mass destruction” and questioning the “compatibility” of human rights and SAPs.¹⁶ Governments also often excluded NGOs from formal negotiations and limited their influence on official agendas.¹⁷ Transnational women's activism for reproductive justice also faced considerable opposition from conservative countermovements and governments.¹⁸

For these reasons, many activists saw mainstreaming as a double-edged sword that risked co-opting more critical elements of movements and undermining efforts to draw attention to systemic problems. After decades of transnational organizing, many progressive and radical activists reached a consensus that fundamental power inequities in the interstate system—especially between and within global financial institutions and the UN—limited the ability of the UN to address pressing problems in global health governance, e.g., access to food, water, medical care, and essential drugs.¹⁹ As a result, more activist groups began organizing in spaces outside of the intergovernmental arena.²⁰

In December 2000, the People's Health Movement, a coalition of public health, feminist, and other human rights activists, organized the First People's Health Assembly, a response to countries' and global health institutions' failure to meet their commitments to achieve “health for all by the year 2000” in the Declaration of Alma-Ata. The Assembly generated the *People's Charter for Health*, a framework for action that affirms a human rights approach to health and demands “radical transformations” of the WHO to make it responsive to poor people rather than corporations.²¹

This worldwide popular mobilization challenging the primacy of neoliberal ideology and demanding recognition of human rights helped spur the WHO to pay more attention to the global economy's health impacts. In 2005, the WHO launched the Commission on Social Determinants of Health, which subsequently generated a standing WHO Unit on the Social Dimensions of Health in 2008. As in other areas of the UN, social movement groups have found themselves challenging the international financial institutions while also seeking allies within various UN agencies and bodies like the WHO to help advance human rights governance and address the contradictions between neoliberalism and international laws and norms around human rights and environmental protections.²² These changes in the global political landscape lead us to ask how patterns of relationships between social movements and international organizations have changed over

time and across issue groupings. Our analysis here begins to map and explain some of these patterns.

DATA AND METHODS

TSMOs are a subset of INGOs defined by their explicit efforts to alter the status quo. Members of TSMOs can be individuals or organizations, and they may include professionals and public officials. Compared to IGOs and less-contentious INGOs, TSMOs have little access to material and social/political resources. Nevertheless, TSMOs can draw on democratic principles that legitimize global authority to pressure states and transnational actors to uphold universal norms and standards like human rights, gender equality, and “health for all.”²³

To understand relationships between TSMOs and the intergovernmental health sector, we draw on biennial 1963–2013 data on the population of TSMOs from the *Yearbook of International Organizations*. We use data on each organization’s major issue focus, founding year, and connections to international agencies.²⁴ We use organizational descriptions to categorize TSMOs as women’s rights, other human rights, or something else (e.g., democracy).²⁵

Recognizing that organizations tend to be shaped in fundamental ways by their environments, we categorize the TSMOs by founding year.²⁶ The founding years of the TSMOs are evenly distributed across three periods: before 1978, between 1979 and 1991, and after 1991. These time periods are theoretically significant; they delineate the pre-Alma Ata, neoliberal, and post-Cold War periods, respectively.

We selected four of the most prominent IGOs in global health governance: WHO, UNFPA, UNICEF, and FAO.²⁷ The WHO is the premier health organization within the UN system, and, although its preeminence has been challenged in recent years, “the global health community continues to look to it as the leading global health governor.”²⁸ UNFPA focuses specifically on improving reproductive health and decreasing violence against women, both of which are public health concerns that have received notable attention from women’s rights groups. UNICEF allocated 70 percent of its 2014–2017 program budget to health-related services for children and mothers. FAO’s mission to achieve food security for all by eradicating hunger, eliminating poverty, and realizing sustainable management of natural resources is intrinsically linked to health security. We refer to these four organizations collectively as HIGOs.²⁹

Our empirical analysis is in two parts. First, we investigate longitudinal trends in connections between human rights TSMOs and HIGOs. We look at broad trends in inter-organizational ties between 1963 and 2013, and at subsets of human rights organizations, both by type and by founding year cohort. Second, we use social network analysis—a combination of descriptive analysis and network visualization—to examine changes in TSMO-HIGO networks from 1993 to 2013.

Social network analysis is a relational approach, allowing us to better understand patterns of relations between human rights TSMOs and HIGOs. Our network matrices rely on TSMOs’ self-reported ties to HIGOs. Our data are binary because they indicate simply whether a TSMO did (1) or did not (0) form a tie to each IGO, rather than the quality or strength of the tie.³⁰ The matrices capture how TSMOs connect to HIGOs, rather than TSMO-TSMO or HIGO-HIGO ties.

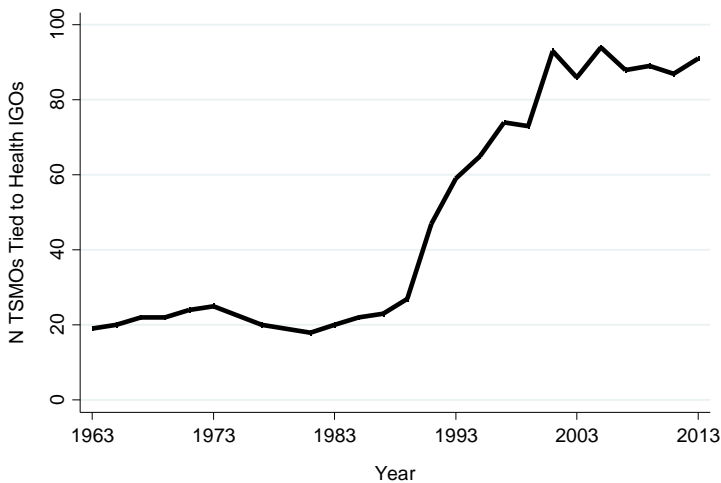
We evaluate the position of TSMOs and HIGOs in our inter-organizational networks by calculating network centrality. In network analysis, power is often operationalized in terms of centrality, which places a value on the structural (dis)advantage of network actors. Degree centrality describes the location of actors (in our case, organizations) by how many ties they have to other actors – a measure of popularity.

One advantage of network methodology is the ability to construct visual representations of relational data. Network pictures can help to show how organizations are positioned relative to one another, how dense or fragmented the network is, and how overall patterns of connections shift over time. We use the network analysis software UCINET to calculate centrality and the visualization software Cytoscape to generate images of the networks.³¹

LONGITUDINAL TRENDS IN RELATIONSHIPS BETWEEN HUMAN RIGHTS TSMOS AND HIGOS

Figure 1 presents the growth of human rights TSMOs reporting ties to HIGOs across 50 years, from 1963 to 2013. During the first 25 years, the number of TSMO connections to HIGOs remains stable, ranging between 19 and 25 ties. In the late 1980s, following the Declaration of Alma-Ata, the number of human rights TSMOs connecting to HIGOs increases dramatically and continues to grow until the early 2000s. Around 2001, however, the number of ties levels-off, with around 90 human rights TSMOs reporting ties to one or more HIGOs. This leveling-off took place at a time when corporate actors were becoming more influential, TSMOs' access to official policy arenas was becoming more limited, and some TSMOs were beginning to focus on building movement power outside of the inter-state system.³²

Figure 1. Growth of Human Rights TSMOs Connected to Health IGOs, 1963-2013



*Including Women's Rights and Other Human Rights TSMOs

Notably, human rights TSMOs that are connected to HIGOs are better connected to the intergovernmental arena more broadly than TSMOs that do not report a tie to HIGOs. In 2013, human rights groups that did not report ties to HIGOs reported a mean of two (2) ties to other IGOs, whereas human rights groups that *did* report ties to HIGOs reported a mean of five (5) ties to other, non-health IGOs (a statistically significant difference, $t=10.39$ $p<0.05$). This suggests that TSMOs that are not connected to HIGOs are not connecting to other IGOs instead.

Different cohorts and groups of human rights TSMOs engage HIGOs in varying ways. In Figure 2, we disaggregate human rights TSMOs by founding year cohort (before 1978, between 1979 and 1991, and after 1991) and by issue focus (women's rights versus other human rights organizations). Figure 2A displays women's rights TSMOs. Established women's rights TSMOs show spurts of growth in ties to HIGOs around the 1985 UN World Conference on Women in Nairobi, and then again around the 1995 World Conference on Women in Beijing. Connections between HIGOs and all cohorts of women's rights TSMOs level-off during the last decade.

Figure 2. Growth in Human Rights TSMO and Health IGO Connections by Cohort and Issue Area, 1963-2013

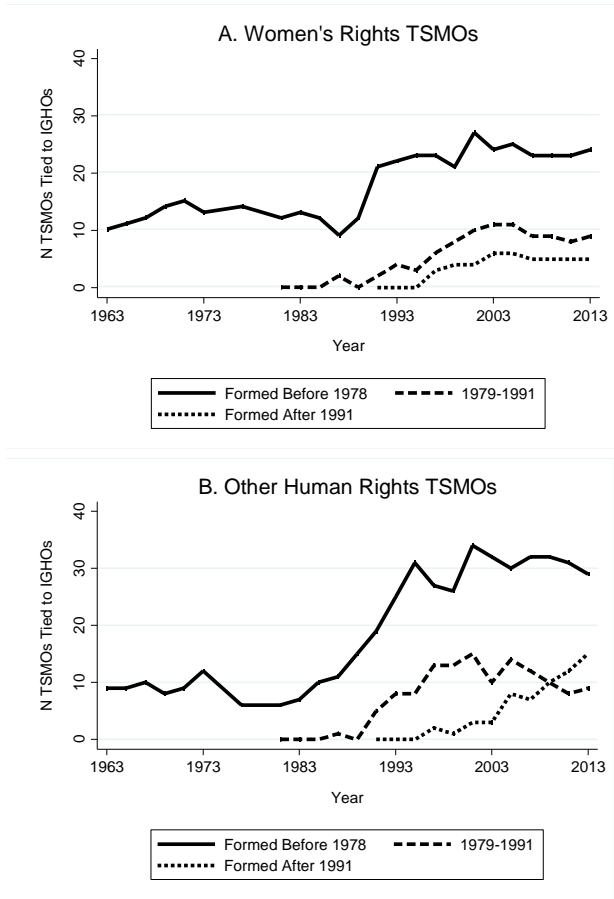


Figure 2B shows connections between other human rights TSMOs and HIGOs. Groups established before 1991 experienced steady growth throughout the late 1980s and 1990s. However, human rights groups formed after 1991 increasingly connect to HIGOs during the last decade of our study, a pattern distinct from both women's rights TSMOs and older cohorts of other human rights TSMOs.

Overall, Figure 2 reveals broad differences in the linking behavior of the three cohorts. Despite tremendous growth in the number of TSMOs and INGOs during the late-twentieth century, fewer organizations from the two younger cohorts of TSMOs report ties to HIGOs than from the older cohorts. Of the women's rights and other human rights TSMOs formed before 1978, 24 percent report at least one tie to a HIGO over our study period, compared to just eight percent of the TSMOs formed after 1978. Established organizations have the resources, wherewithal, and perhaps greater desire to formally associate with UN health agencies.

Still, a puzzle remains. Why are the youngest women's rights groups not linking to HIGOs, but other human rights groups founded in the same period are increasingly connected? On the one hand, it is useful to consider why women's rights groups are not connecting to HIGOs. The post-Beijing phase of feminist activism was a period of "high level sensitization regarding gender hierarchies worldwide" and simultaneous deterioration of many women's living conditions.³³ Many women's rights activists found the UN incapable of addressing the latter "vis-a-vis the neoliberal development framework proposed by international financial institutions."³⁴ It is possible their retreat from UN-related activism signaled to newer women's rights organizations that they should orient their work to different arenas.³⁵

On the other hand, we can consider why the youngest cohort of other human rights groups is increasingly linking to HIGOs. Compared to earlier generations of TSMOs, the youngest human rights organizations with ties to HIGOs are more likely to mobilize around multiple issues, particularly human rights and the environment. In 2013, of the 15 other human rights groups formed after 1991 with ties to HIGOs, nine (60 percent) take a human rights approach to environmental activism. The Global Forest Coalition, for example, frames deforestation as an indigenous rights issue.

TRANSNATIONAL NETWORKS AND GLOBAL HEALTH GOVERNANCE IN AN ERA OF HUMAN RIGHTS MAINSTREAMING

To understand how mainstreaming affected relationships between human rights TSMOs and HIGOs, we examine their networks in 1993 and 2013.³⁶ We begin by considering the popularity of each of our four HIGOs using degree centrality in 1993 and 2013 (Table 1). Then, in figures 3 and 4 below, we visualize the human rights TSMO-HIGO networks in these two periods. HIGOs are represented by black squares, women's rights groups are represented by grey circles, and other human rights groups are represented by black triangles. We size the HIGOs and TSMOs according to their degree centrality.

Table 1 shows UNICEF to be the most central HIGO in 1993 and 2013. UNICEF has the highest degree centrality of the four HIGOs (0.64 in 1993 and 0.78 in 2013), meaning it has ties to more women's and other human rights TSMOs than any other HIGOs. In contrast to the WHO and FAO, UNICEF receives funding on a purely voluntary basis; there is no statutory requirement for any government to pledge or provide funding to it. Yet, in the years for which data are available, UNICEF almost always outranks the other HIGOs in revenue, expenditures, and purchase orders—the overall procurement volume of goods and services from implementation partners.³⁷ UNICEF's fundraising and purchasing/operational capacity likely provides more opportunities for TSMOs to seek and maintain ties with it.

The WHO is the leading health agency of the UN and gave significant institutional support to the Declaration of Alma-Ata in 1978, which makes its low centrality in both networks somewhat surprising. The degree centrality of the WHO (0.29 in 1993 and 0.26 in 2013) is less than half that of UNICEF. Women's rights groups are particularly unlikely to form connections to the WHO, as seen in Figures 3 and 4. In both 1993 and 2013, only one women's rights organization is tied *solely* to the WHO; in fact, in both years, most women's

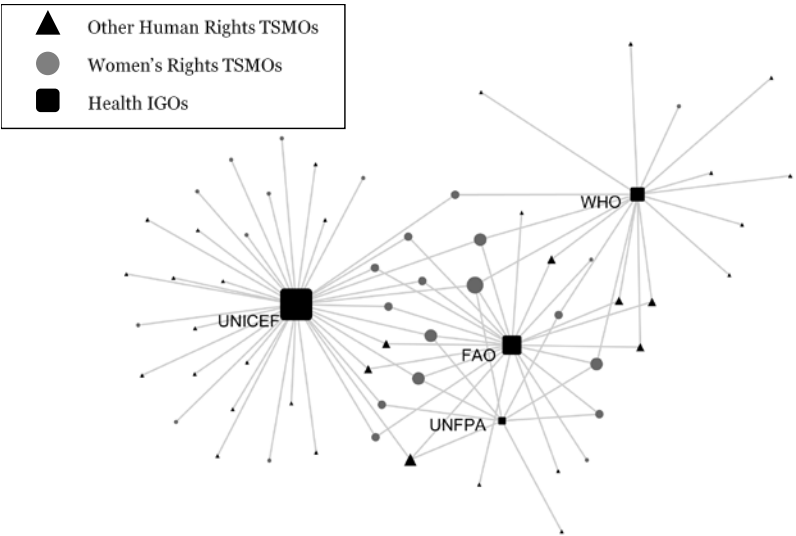
rights groups that report ties to the WHO are tied to at least two other HIGOs. Keep in mind, however, that in comparison to the other HIGOs, the WHO spends relatively little on development or humanitarian assistance and more on normative, treaty-related, and knowledge-creation activities, which may make it a less attractive partner for TSMOs.³⁸ Also, as we discuss above, WHO has exhibited a wavering commitment to human rights. Finally, until May 2016 when the 69th World Health Assembly adopted the Framework of Engagement with Non-State Actors, there was no formal infrastructure for TSMOs and other INGOs to engage with the WHO.³⁹

Table 1. 1993 and 2013 HIGO Centrality Measures

	1993 Degree Centrality	2013 Degree Centrality
UNICEF	0.644	0.571
FAO	0.39	0.374
WHO	0.288	0.264
UNFPA	0.153	0.242

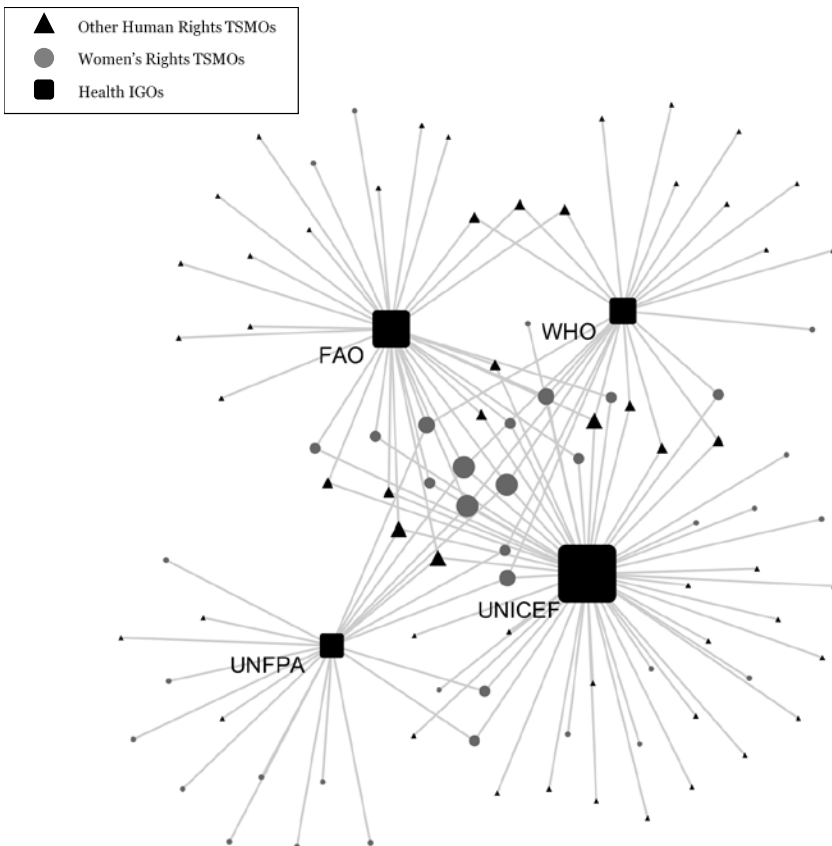
While the *low* centrality of the WHO is surprising, so is the *high* centrality of the FAO. We attribute much of this to the work of an important TSMO, Via Campesina, which has drawn transnational activists' attention to the global food regime and its connections to health through its campaigns for food sovereignty and public access to seeds. Via Campesina has taken a confrontational stance toward neoliberal development, refusing to engage in dialogue with the WTO, World Bank, and IMF. Yet, Via Campesina mobilized extensively around FAO's Committee on World Food Security negotiations, influencing FAO's efforts to become more inclusive of civil society organizations.⁴⁰ In 2013, the FAO and Via Campesina formalized an agreement of cooperation that recognized the role of small-scale food producers as essential to the eradication of world hunger.

Figure 3. 1993 Human Rights TSMO-HIGO Network



UNFPA is a popular connection for women's rights TSMOs. In 1993, not one women's rights TSMO is tied only to UNFPA, as seen in Figure 3. In 2013, however, ten women's rights organizations are linked solely to UNFPA, and not one of these ten is present in the 1993 network, as seen in Figure 4. In contrast, between 1993 and 2013, WHO and FAO see no change in the number of women's rights organizations linking solely to them. This suggests that UNFPA is a popular point of entry for women's rights TSMOs seeking to engage with the UN system after 1993. We also see that, in 2013, half of the well-connected women's rights TSMOs—those with ties to at least two HIGOs—are tied to UNFPA. These patterns likely reflect women's engagement from the Global South in the 1993 UN International Conference on Population and Development in Cairo, which provided UNFPA's steering document, and, more broadly, the rise of an increasingly coherent and networked movement for women's reproductive health rights.⁴¹

Figure 4. 2013 Human Rights TSMO-HIGO Network



The rise of human rights organizing in the Global South is also visible in health governance networks more broadly. Of the TSMOs linked to HIGOs after 1993, 20 percent are headquartered in the Global South, compared to 13 percent of groups in both the 1993 and 2013 networks.

CONCLUSION

Social movements have increasingly organized transnationally and deepened understandings of the intersections of human rights and global health. We have argued that UN agencies increasingly defined health as a human right amid growing global TSMO mobilization against neoliberal globalization. As they did so, more human rights TSMOs formed connections to these agencies. Yet, for human rights groups addressing the right to health, not all health-related IGOs are equally attractive partners. Relatively few TSMOs reported ties to the leading global health institution, the WHO. We view this as largely a consequence of the WHO's lack of formal infrastructure for non-state engagement and of its failure to challenge neoliberal approaches to health policy. Agencies addressing other issues linked to health, particularly UNICEF and the FAO, were more central in our analysis of global health governance networks.

Our analyses only scratch the surface of the changing patterns of inter-organizational dynamics in health governance over the past 50 years. Future research should bring other IGOs into the picture, consider how women's rights and other human rights TSMOs connect to non-governmental organizations, and delve more deeply into the organizational histories of the TSMOs most central in the networks examined here. Research should examine whether the WHO's ongoing effort to reform its managerial structures and mainstream human rights throughout the Secretariat result in new patterns of inter-organizational relations in global health governance in the future.

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¹ Lee, Kelley and Adam Kamradt-Scott, "The multiple meanings of global health governance: a call for conceptual clarity," *Globalization and Health* 10, no. 1 (2014): 28. Like Lee and Kamradt-Scott, we conceptualize global health governance as the institutional actors and arrangements that manage collective responses to health-related issues in an increasingly globalized world.

² Gable, Lance. "The proliferation of human rights in global health governance," *The Journal of Law, Medicine & Ethics* 35, no.4 (2007): 534-544.

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- ¹⁰The market approach had already been favored on the global health agenda, most notably the Rockefeller Foundation (see Borowy, Iris. "Shifting Between Biomedical and Social Medicine: International Health Organizations in the 20th Century," *History Compass* 12, no. 6 (2014): 517-530). The Gates Foundation and international financial institutions used the global malaria epidemic of the early 2000s as an opportunity to reinvigorate vertical models of medical intervention, ultimately weakening national health systems (see Cueto, Marcos "A Return to the Magic Bullet? Malaria and Global Health in the 21st Century," In *When People Come First: Critical Studies in Global Health*, edited João Biehl and Adriana Petryna Princeton, NJ: Princeton University Press, 2013, 30-53.)
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- ¹²For example, see Friedman, Elizabeth Jay. "Gendering the Agenda: The Impact of the Transnational Women's Rights Movement at the UN Conferences of the 1990s," *Women's Studies International Forum* 26, no. 4 (2003): 313-331.
- ¹³Petchesky, Rosalind Pollack. *Global Prescriptions: Gendering Health and Human Rights*. New York: Zed Books, 2003.
- ¹⁴Nygren-Krug, Helena. "The Right to Health: From Concept to Practice," In *Advancing the Human Right to Health*, edited by Jose M. Zuniga, Stephen P. Marks, and Lawrence O. Gostin. Oxford: Oxford University Press, 2013, 42. For instance, core elements of the right to food were established in the United Nations Committee on Economic, Social and Cultural Rights in 1999 (General Comment No. 12); in April 2000, the Commission on Human Rights established the mandate of the Special Rapporteur on the right to food, and in 2004 the UN's Right to Food Guidelines were adopted by FAO Council. The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the

highest attainable standard of physical and mental health was originally established by the Commission on Human Rights in April 2002 by resolution 2002/31.

¹⁵ Keck, Margaret E. and Kathryn Sikkink, *Activists Beyond Borders: Advocacy Networks in International Politics*, Ithaca, NY: Cornell University Press, 2014; Friedman, Elizabeth Jay.

"Gendering the Agenda: The Impact of the Transnational Women's Rights Movement at the UN Conferences of the 1990s," *Women's Studies International Forum* 26, no. 4 (2003): 313-331.

¹⁶ Clark, Ann Marie, Elisabeth J. Friedman, and Kathryn Hochstetler, "The Sovereign Limits of Global Civil Society: A Comparison of NGO Participation in UN World Conferences on the Environment, Human Rights, and Women," *World Politics* 51, no. 1 (1998): 1-35.

¹⁷ Charnovitz, Steve. "Two Centuries of Participation: NGOs and International Governance." *Michigan Journal of International Law* 18 (1997): 183-286; Willetts, Peter. "Civil Society Networks in Global Governance: Remediating the World Trade Organisation's Deviance from Global Norms " In *Colloquium on International Governance, Palais des Nations, Geneva* 20 (2002).

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¹⁸ Buss, Doris and Didi Herman, *Globalizing Family Values: The Christian Right in International Politics*. Minneapolis: University of Minnesota Press, 2003; Petchesky, Rosalind Pollack. *Global Prescriptions: Gendering Health and Human Rights*. New York: Zed Books, 2003.

¹⁹ Mooney, Pat. "Stop the 'Stockholm Syndrome'! Lessons Learned from 30 Years of UN Summits," *Development Dialogue* 47 (June 2006): 203-14; Smith, Jackie and Dawn Wiest, *Social Movements in the World-System: The Politics of Crisis and Transformation*. New York: Russell Sage Foundation, 2012.

²⁰ Smith, Jackie. "Counter-Hegemonic Networks and the Transformation of Global Climate Politics: Rethinking Movement-State Relations," *Global Discourse: An Interdisciplinary Journal of Current Affairs and Applied Contemporary Thought* 4, no. 1 (2014): 1-19; Bond, Patrick. "The Right to the City and the Eco-Social Commoning of Water: Discursive and Political Lessons from South Africa," In *The Right to Water*, edited by Farhana Sultana and Alex Loftus. New York: Routledge, 2012, 190-205; Smith, Jackie, Samantha Plummer, and Melanie Hughes, "Transnational Social Movements and Changing Organizational Fields in the Late Twentieth and Early Twenty-First Centuries," *Global Networks* 17, no. 1 (2016): 3-22.

²¹ People's Health Assembly. "People's Charter for Health," *Journal of Public Health Policy* 23, no. 4 (2002): 387-398.

²² Smith, Jackie, *Social Movements for Global Democracy*. Baltimore, MD: Johns Hopkins University Press, 2008.

²³ Keck, Margaret E. and Kathryn Sikkink, *Activists Beyond Borders: Advocacy Networks in International Politics*, Ithaca, NY: Cornell University Press, 2014; Markoff, John. "A Moving Target: Democracy," *European Journal of Sociology* 52, no. 02 (2011): 239-76; True, Jacqui and Michael Mintrom, "Transnational Networks and Policy Diffusion: The Case of Gender Mainstreaming," *International Studies Quarterly* 45, no. 1 (2001): 27-57.

²⁴ For detailed accounts of case selection and coding procedures see Smith, Jackie "Exploring connections between global integration and political mobilization," *Journal of World-Systems Research* 10, no. 1 (2004): 255-285; Smith, Jackie and Dawn Wiest, *Social Movements in the World-System: The Politics of Crisis and Transformation*. New York: Russell Sage Foundation, 2012.

²⁵ Our two broad categories of human rights organizations also include multi-issue human rights organizations. For example, the women's rights category includes organizations that focus on women and development (e.g., Pan African Women's Organization) and the other human rights category includes organizations that emphasize human rights and the environment (e.g., Practical Action).

²⁶ Smith, Jackie and Dawn Wiest, *Social Movements in the World-System: The Politics of Crisis and Transformation*. New York: Russell Sage Foundation, 2012.

²⁷ Ng, Nora Y. and Jennifer Prah Ruger "Global health governance at a crossroads." *Global Health Governance: The Scholarly Journal for the New Health Security Paradigm* 3, no. 2 (2011)

²⁸ Ibid.

²⁹ Because our primary focus is on the relationships between TSMOs focused on human rights and organizations and agencies of the UN system, we do not closely examine connections between these TSMOs and international financial and trade organizations like the International Monetary Fund (IMF), World Bank (WB), and the World Trade Organization (WTO).

³⁰ Hanneman, Robert A. and Mark Riddle. *Introduction to Social Network Methods*. Riverside, CA: University of California Riverside, 2005. <http://faculty.ucr.edu/~hanneman/>.

³¹ Borgatti, Stephen, Martin G. Everett, and Jeffrey C. Johnson. *Ucinet for Windows: Software for Social Network Analysis*. Analytic Technologies, Harvard, MA. Shannon, Paul, Andrew Markiel, Owen Ozier, Nitin S. Baliga, Jonathan T. Wang, Daniel Ramage, Nada Amin, Benno Schwikowski, and Trey Ideker. "Cytoscape: A Software Environment for Integrated Models of Biomolecular Interaction Networks, *Genome Research*, 13 (2003): 2498-504.

³² Smith, Jackie, *Social Movements for Global Democracy*. Baltimore, MD: Johns Hopkins University Press, 2008; Sklair, Leslie. "Democracy and the Transnational Capitalist Class," *The ANNALS of the American Academy of Political and Social Science* 581, no. 1 (2002): 144-57; Sklair, Leslie. "The Transnational Capitalist Class and Global Politics: Deconstructing the Corporate-State Connection," *International political science review* 23, no. 2 (2002): 159-74; Bruno, Kenny and Joshua Karliner, "The UN's Global Compact, Corporate Accountability and the Johannesburg Earth Summit," *Development* 45, no. 3 (2002): 33-38; Karliner, Joshua. *The Corporate Planet: Ecology and Politics in the Age of Globalization*. San Francisco, CA: Sierra Club Books, 1997; Smith, Jackie, Samantha Plummer, and Melanie Hughes, "Transnational Social Movements and Changing Organizational Fields in the Late Twentieth and Early Twenty-First Centuries," *Global Networks* 17, no. 1 (2016): 3-22.

³³ Gülay Caglar, Elisabeth Prügl, and Susanne Zwingel (eds.). *Feminist Strategies in International Governance*. New York: Routledge, 2013.

³⁴ Ibid.

³⁵ Another explanation could be that during the last decade, women's rights groups focused on health are connecting to the UN through other channels. Indeed, following the mainstreaming of gender there was an effort to recentralize women's concerns under the United Nations Development Fund for Women (UNIFEM), which was succeeded and taken over by UN Women in 2011. It is possible that younger women's rights organizations are electing to link only to UN Women rather than other UN agencies. We do not find much evidence to support this hypothesis, however; in 2013, of the 121 women's rights TSMOs formed after 1991 only two report links to UN Women.

³⁶ We expect a slight lag in our data. Therefore, 1993 should capture the time period prior to the foundational series of world conferences and the nascent stage of mainstreaming initiatives. By 2013, we should see evidence of mainstreaming directives and resulting changes in UN agencies.

³⁷ "UN System Chief Executives Board for Coordination." <http://www.unsystem.org/content/statistics>

³⁸ Ibid.

³⁹ This reform in WHO operations is part of a larger effort of the organization to respond to deepening global health crises and to integrate work in other agencies that relates to health, such as the Millennium Development Goals. In 2008, perhaps in response to the global financial and related food crisis, the WHO began to consider the "social dimensions of health," and in 2011 convened the World Conference on the Social Dimensions of Health. In May of 2012 the World Health Assembly formally adopted the Rio Political Declaration, which called for greater attention to the links between health and development as well as for greater public participation and the strengthening of global health governance (see http://www.who.int/social_determinants/en/).

⁴⁰ McMichael, Philip. "The Land Question in the Food Sovereignty Project," *Globalizations* 12, no. 4 (2015): 434-51; Metzger, Michelle. "Thinking Forward in Global Food Governance—Synthesis Paper," *Canadian Food Studies/La Revue canadienne des études sur l'alimentation* 2, no. 2 (2015): 345-49; McKeon, Nora. *Food Security Governance: Empowering Communities, Regulating Corporations*. New York: Routledge, 2014.

⁴¹ Correa, Sonia and Rebecca Lynn Reichmann, *Population and Reproductive Rights: Feminist Perspectives from the South*. New York: Zed Books, 1994; Higer, Amy J. "International Women's Activism and the 1994 Cairo Population Conference," In *Gender Politics in Global Governance*, edited by Mary K. Meyer and Elisabeth Prügl. New York: Rowman and Littlefield, 1999, 122-41; Petchesky, Rosalind Pollack. *Global Prescriptions: Gendering Health and Human Rights*. New York: Zed Books, 2003.

What Have Rights Got To Do With It?

Evaluating 'Human Rights' As A Practice Within the Global Fund

Sharifah Sekalala and Toni Haastrup

INTRODUCTION

New Global Health initiatives, such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), Global Alliance on Vaccines and Immunisations (GAVI), UNITAID, Joint United Nations Program on HIV/AIDS (UNAIDS), and foundations such as the Bill and Melinda Gates Foundation, have been critical to the increase in global health financing. From 2000 to 2010, global health financing grew by 11.4 percent annually. Although this growth slowed from 2010 to 2015, global health financing is still high, with US\$ 36.5 billion of financing disbursed in 2015. Some of the largest providers have been the US and UK governments (US\$ 13.1 billion and US\$ 4.1 billion, respectively) and the Gates Foundation (US\$ 2.9 billion).¹

The bulk of health financing is administered through global health organizations, making them formidable players in the field of global health.² Much of the previous focus on these initiatives and organizations has been on their efficacy, but, as the editors of this Special Issue argue, the contribution of these global health organizations to advancing other normative areas, such as human rights, has been overlooked. This is particularly important, because we generally know that international organizations can shape important normative practices of actors, including states, at the domestic level.³

In this article, we focus on the inclusion of human rights within the remit of the GFATM. The GFATM is a global health governance organization, which was established in 2002 to disburse funds to developing countries to enable them to fight AIDS, tuberculosis, and malaria. Human rights have always been integral to this, as using a rights approach at the national level can tackle discrimination, which helps people to overcome barriers to contracting these diseases domestically, and enables states to create better access to services. Additionally, human rights approaches not only help to fight against discrimination and stigma but they can also contribute to improvements of social determinants of health, such as food, water, sanitation, housing, and education, all of which are essential in creating effective responses to these diseases. Consequently, the GFATM has sought to integrate human rights within its financing.

Most states that receive GFATM funding are already signatories to numerous human rights treaties, which illustrates some willingness to integrate human rights norms within their health governance practices. However, evidence suggests that there is a still a lack of "sustained behaviour and... practices that conform to ... international human rights norms."⁴

In this article, we want to understand the relationship between states and global health financing organizations and how they seek to advance human rights in their grant programs. We therefore ask: to what extent can global financing institutions shape human rights practices at the domestic level? The article uses the case study of the GFATM's experience of adopting human rights as an institutional norm and analyzes the implications for the institution's new role as a human rights actor within states. In particular, we argue that the institutional design of the institution impacts on the ability of the GFATM to substantively enhance human rights agendas within local health governance contexts.

The article will proceed as follows: we first present a short history of the GFATM and its processes of integrating human rights concerns within its work. Through the application of sociological institutionalism in the following section, the article elaborates on the motivations and implications of the GFATM's practices. The sociological

institutionalism framework can give us a better understanding of the implications of including new norms within global health governance institutions. The final section highlights the tensions between the primary aims of the GFATM as a funding agency, its obligations as a human rights norm entrepreneur, and how it has adapted in these situations. Thus, we argue that the GFATM has had to adapt its institutional system in order to meaningfully promote a human rights agenda in global health governance, particularly at the domestic level. In the conclusion, we underscore the importance of institutional context for understanding the constraints and opportunities for attaining health-related human rights.

ADOPTING HUMAN RIGHTS IN THE GFATM: MOTIVATION AND MECHANISMS

The GFATM is a public private partnership (PPP) and not a traditional international organization. PPPs are defined as “voluntary and collaborative relationships between various parties both State and non-State in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities and benefits.”⁵ As a PPP, the GFATM relies on several UN agencies, which have specific expertise to help in the grant implementation process. These include three ex officio members without voting rights: UNAIDS, the World Health Organization (WHO), and the World Bank, which acts as a trustee to the GFATM. Other organizations—including the United Nations Children’s Fund (UNICEF), the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the United Nations’ Refugee Agency (UNHCR), and the World Food Program (WFP)—all play distinct roles in ensuring health services are delivered to domestic contexts. These UN agencies have human rights obligations under international law and must bear some responsibility for human rights violations on GFATM funded programs.⁶

As a PPP, the legal personality of the GFATM is ambiguous under international law. When international organizations have legal personality, they can conclude treaties, bring claims under international law, and be held responsible for violations of this law (including human rights violations). There is nothing in the GFATM bylaws, however, that indicates that its founders ever intended to give it these powers.⁷

In this context, it is not party to the International Covenant on Economic Social and Cultural Rights (ICESCR), which enshrines the right to health. There is, however, a positive duty under *General Comment No 14* for international organizations to cooperate effectively with States in order to realize the legal obligations that would enable them to maintain a right to health.⁸ This was the view taken in 2012 by the Special Rapporteur on the right to health, who argued that, international funders should ensure that their financial assistance enables countries to achieve the right to health. This is a positive duty and the onus still remains on the state to fulfill any human rights obligations.

Benjamin Mason Meier noted the new era of normativity in global health that allows for consideration of human rights in how the GFATM works with states.⁹ This is manifested through the ways in which global health actors instigate new normative frameworks with the aim of transforming global health governance. Human rights norms are particularly attractive for these global actors because of their universal nature, as most countries have signed the nine core human rights treaties.

From the GFATM’s inception in 2002, it was clear that it espoused human rights values of non-discrimination in its foundational documents.¹⁰ In 2008, the GFATM introduced a Gender Equality Strategy, and in 2009, it approved a Sexual Orientation and Gender Identities Strategy as part of its burgeoning human rights strategies. These strategies demand that countries applying for financing illustrate how the grant attempts to address some of the human rights challenges of women and sexual minorities to create better responses to AIDS, malaria, and tuberculosis.

For any of this to work, it is worth examining how the GFATM understands its own role within the global health governance arena that it seeks to operate. In order to be eligible for grants, countries applying for GFATM programs submit proposals, which are reviewed by a panel of independent experts known as the Technical Review Panel (TRP) and are considered for approval by the GFATM Board. The TRP is a board of independent experts who assess the proposal for things, including potential for impact and soundness of approach. They look at human rights implications of the proposal as part of this process.¹¹

When the GFATM restructured its funding mechanism to include human rights, its aim was to ensure better human rights outcomes in funded projects and create more accountable forms of funding for health outcomes. This would include new stakeholders at the domestic level. These new stakeholders, Key Affected Populations (KAPs), are a central component of the new funding mechanism. As part of the new procedure for applying for funding, each country is given a fixed allocation of resources. The Country Coordinating Mechanism (CCM), which should have a wider number of participants from KAPs, is then tasked with engaging in a country dialogue process. This deliberative process aims to consider the epidemiological data, national health strategic plans and the past performance of health programs in order to draft a concept note and budget. These are then submitted to the GFATM for consideration.¹² The TRP reviews each country submission and may recommend that the country make changes to areas of the concept note in order to prioritize better the needs of the KAPs.¹³

The GFATM has also hired evaluators who are conversant in human rights practice to ensure that members of the KAPs can meaningfully participate in the design, implementation, and monitoring of GFATM-funded programs. To make this possible, the GFATM Board provided US\$ 15 million to support broader inclusion through greater representation when making concept notes. Furthermore, the GFATM tightened its rules, stating that greater participation of civil society and community groups as primary and sub recipients of grants would be essential to better service delivery and implementation of grants.

The broadening of participation has been successful in some countries. For instance, in Morocco, the CCM now has a selection of 5 voting members (out of 33) to represent vulnerable and most-at-risk populations (the other two represent people living with HIV and affected by tuberculosis). Creating broader participation was particularly tricky in a country where there were no existing associations representing these groups, because homosexuality, prostitution, and drug use are all illegal. The successful incorporation of these groups was due to civil society involvement.¹⁴

The GFATM also stipulated minimum requirements human rights standards in Global Funded programs, particularly non-discriminatory access to services; respecting and protecting informed consent; confidentiality and the right to testing and treatment; the use of only scientifically sound and approved medicines and medical practices; not employing methods that constitute torture or cruel, inhuman, or degrading treatment; and the use of medical detention only as a last resort. Furthermore, the GFATM also created more stringent mechanisms for reporting human rights violations.¹⁵ By creating these human rights strategies, and making it fundamental to its routinized practices, the GFATM has been pushing a human rights agenda within health funding for HIV/AIDS, malaria, and tuberculosis.

Yet, despite these many commitments, the PPP structure of the GFATM means that it is not an implementing organization, so it relies on the principle on country ownership, which transfers the role of implementation to domestic actors. This means that countries are supposed to drive the process of deciding their domestic health priorities, with the GFATM acting merely as a financing agent. This aims to make programs more sustainable. Many stakeholders, including donors, activists, and scholars, were critical of the fact that some countries who had received GFATM funding for HIV/AIDS were

persisting with discriminatory laws and policies, which jeopardized AIDS-related programs. There were also serious concerns regarding the long-term sustainability of GFATM funding in countries where human rights were being routinely violated.

So why has the human rights implementation been difficult in the context of this global health institutional configuration? In the following section, we consider the institutional contexts, and especially constraints, in institutional design that impact on the GFATM's ability to influence domestic actors who also function within the global health institution.

ADOPTING HUMAN RIGHTS: INSIGHTS FROM SOCIOLOGICAL INSTITUTIONALISM

New institutionalist theory understands institutions to be formal and informal “sets of *mutual expectations* between people, that have become more or less *enduring*, and that have crystalized into *rule systems*.”¹⁶ The practices that determine the outcome of a particular institution's policies are therefore determined by the routinized behaviors and actions that have been embedded as part of the design of the institution – this is, its core identity.¹⁷

Taking this definition of institutions for granted, the global health institution under consideration includes the GFATM, its funders, and the recipient states it funds.

At the time of institutional design, the founders of the GFATM were mainly concerned with efficient financing mechanisms to recipient countries. Human rights were an additional consideration with regards to the efficiency and sustainability of this new mode of funding. If there was a normative element to the establishment of the GFATM, it was simply to establish the standards through which other global health organizations and initiatives could fund pressing health problems. There was an idea that it needed to deal with notions of discrimination, but the onus was really on other actors and states to achieve this. As part of institutional set up, the GFATM relied on CCMs for implementation and as the means to achieving local ownership. CCMs include a wide range of stakeholders that prepare the funding application to the GFATM.¹⁸ The CCM is intended to ensure local ownership by designing health initiatives that are most suited to local needs.¹⁹

Health financing and local ownership may be considered the GFATM's core organizational norms, since they serve as “standards of appropriate behaviour”²⁰ endogenously and exogenously in its relationship with states. Human rights are central to delivering this financing. In adding on this new norm, however, the GFATM is attempting to renegotiate the standards of appropriate behavior for actors within global health governance structures. In so doing, there is a direct attempt to change states' behavior “through both instrumental choice and social learning to adhere to these new values.”²¹ Further, this adoption of human rights norms raises expectations on the part of the states about the remit of the funder.

Sociological institutionalism suggests that the way through which new norms become transposed is through institutional isomorphism. Institutional isomorphism is the process whereby institutions adopt new practices because it is seen as the right thing to do. Given the proactive discourse around the right to health in the ICESCR and in General Comment 14, the GFATM arguably had a moral obligation, as a health-related agency, to consider what human rights means for its own area of global health governance. However, as an international funder, how far should the GFATM go in assuming responsibility for human rights violations in its funded programs?

While the introduction of new norms like human rights within the GFATM introduced new rules of appropriate behavior, there was no guarantee that other stakeholders would accept them, and we see some evidence of this later when we show how states challenged these norms through half-hearted compliance. In other words, it is possible to deviate from the intended rules, as the ultimate duty-bearer of human rights

obligations remains the state party. For the GFATM's aims to work, they needed to be fully accepted by the CCMs (in principle these are more inclusive than state parties, creating problems in implementation). Consequently, despite the efforts of certain actors (or agents) within the GFATM, there were gaps between norm commitment and compliance.

In the past, this lack of compliance by states that receive global funding manifested itself through domestic human rights failures in implementing GFATM grants. For instance, despite several attempts to try and make the CCMs representative, in order to ensure that the grants included suitable human rights initiatives for these groups, a 2010 survey of all the GFATM grants revealed that only eight percent of representatives on the CCMs came from people living with HIV/AIDS.²² This failure was acknowledged by the then head of the GFATM, Michel Kazatchkine, who argued that, "the lack of support for programs that protect and promote human rights is one of the failures in the response to AIDS."²³

The mismatch between the priorities of the actors within this institution, the GFATM, on the one hand, and the states on the other, can be explained by the actors within that institution. It is assumed that:

actors may be 'rule makers' but take existing rules as a starting point for defining their own identities and interests. Conversely, actors may also be 'rule takers', but nonetheless modify or even overturn those rules from time to time.²⁴

Institutionalization is a dynamic process that demands an understanding of the perspectives of all actors involved. In response to these failures that were critical to achieving effective grant implementation, the GFATM changed its grant model, explicitly committing to human rights in its 2012-2016 strategy.²⁵ As a result, the GFATM now aims to i) integrate human rights considerations through the grant cycle, ii) increase investments in programs that address human rights-related barriers to access, and iii) ensure that the GFATM does not support programs that infringe upon human rights.²⁶ By explicitly asking for the inclusion of human rights considerations within its programs, the GFATM was also demanding that its recipient states take human rights seriously. Increasingly, therefore, we see the role of the GFATM changing to that of a "gatekeeper," creating a series of human rights safeguards, such as greater participation of key minority groups, or efforts to deal with discriminatory laws and policies, before it will allocate funding.

The GFATM inclusion of human rights processes and procedures into the core of what the institution does can be thought of as institutional layering. Institutional layering refers to a process where new elements are attached to old processes, not with the intention of replacing the core elements of an institution but in addition to it.²⁷ In this sense, whereas the GFATM is a funding initiative whose core aim is to fund and promote local ownership, it also champions the inclusion of human rights aimed at transforming the global health governance institution. In other words, it promotes human rights consciousness from states in order to enhance local participation.

According to Van der Heijden, layering is motivated by the desire to close the gap between intentions and outcomes.²⁸ In the GFATM's case, there are huge reputational costs for grants that are not compliant with human rights norms even though the obligation may be on the state party. Thus, the adding of extra human rights obligations on state parties enables the GFATM to realize its core aims and retain its legitimacy. In doing so, the GFATM has contended with several challenges. In the next section, we explore the limitations and adaptations that the GFATM has engaged in as a means to promote human rights.

THE CHALLENGES OF ADOPTING HUMAN RIGHTS BY A GLOBAL INSTITUTION

Although it has achieved a lot in terms of human rights, there are a number of constraints within the institution that make it difficult for the GFATM to achieve all its aims. First, organizations like the GFATM have often faced challenging institutional contexts, due to their reliance on donors and other UN agencies, which can have an impact on institutional capabilities. Second, the organization's focus on local (country) ownership as a model of governance has made it difficult to implement human rights in practice. Third, the organization had to contend with the amorphous nature of human rights, which is at odds with its performance-based funding model. Last, we argue that human rights are holistic, which means that it is hard for an organization to fund some rights at the expense of others.

Challenging Institutional Context

As we discussed above, the institutional design of the GFATM means that it not an implementing agency, relying on its donors to finance it adequately and state parties and other UN organizations to implement grants, which distances it from human rights obligations. All the partners have different agendas, which can make it difficult to prioritize human rights norms sufficiently. However, as an organization, the GFATM bears huge reputational costs if there are human rights violations on any of its grants.

For instance, in 2012, when human rights were introduced as an explicit norm of the GFATM, the institution also undertook a major restructuring, aimed at cutting costs, in order to try to appease its donors. This led to the departure of the executive director, Michel Kazatchkine. His departure precipitated the departure of many key personnel with human rights expertise and who had developed the gender and sexual minorities programmes.²⁹ This upheaval inevitably harmed implementation in many countries. Subsequently, the GFATM recruited new staff with longstanding expertise in human rights and introduced a Staff Human Rights Task Force.³⁰ The reality of being a funding agency as opposed to an implementation agency means that staff lack the resources necessary to police human rights behavior in all 140 countries at the same time.³¹ To counter this, the GFATM has now given the Office of the Inspector General power to investigate human rights violations.³² In instances where the Inspector General cannot investigate, the GFATM can share information with the relevant UN agencies that may have a normative institutional mandate to investigate.³³

Reliance on Domestic Partners

The ability of an institution to implement human rights norms depends on states buying into the process. However, these states also must deal with competing interests from different stakeholders at the ground level, which makes it hard to use human rights to address inequality, as this approach often involves some redistribution of resources. A human rights focus that sticks to recognizing these vulnerabilities at the domestic level would be particularly problematic in countries where minorities, such as women in largely patriarchal societies, gay and lesbian groups, and drug users, are seeking rights that are currently enjoyed by the majority of citizens, as this often involves redistributing resources from the entrenched majority to minority groups.

Because of these considerations, states often refuse to prioritize human rights considerations when applying for grants from the GFATM. Data from UNAIDS' Fast-Track modeling illustrates that, in many instances, countries are simply not requesting funding for human rights interventions.³⁴ Tinashe Mundawarara, who is with Zimbabwe Lawyers for Human Rights, explained the rationale behind this within the South African context,

arguing that “there is less appreciation of the need to cultivate human rights-based responses in Southern Africa and, hence, less inclination to include them in proposals.”³⁵

The GFATM has, for instance, always tried to get the voices of minority groups in the application process of the grant, so that the human rights approaches countries apply are those that are most useful to communities. However, this process has sometimes been unsuccessful, and, even in those cases where the institution was able to attract more participants, this did not always translate to the prioritization of programs that focused on the specific human rights needs of people from KAPs.³⁶

Moreover, greater participation does not necessarily translate into greater human rights protection, especially in health. Human rights participants and health professionals may have different agendas, and different human rights groups may also have different priorities for resource allocation.³⁷ Human rights advocacy groups are not homogenous. To use an example, a women’s rights group may not automatically support the rights of female sex workers. Because the HIV/AIDS epidemic affects women who contracted AIDS, often from their husbands, sex workers may be perceived as part of the problem. There is thus no incentive to work toward the same outcomes, and they may even work at cross-purposes.³⁸ This raises questions about the practicalities of effecting changes in the context of existing domestic practice. In response, the GFATM is increasingly funding programs to enable traditionally vulnerable groups to access information, health services, and treatment.³⁹

The GFATM has also tried to address the issue of repressive environments by creating spaces for these groups. For instance, the GFATM has arranged to fly representatives belonging to criminalized groups out of their home countries in order to give them the space to consult on human rights issues. This consultation period has been useful in raising awareness about the human rights issues of the LGBT population⁴⁰ in some countries.⁴¹

Other efforts to encourage participation include the introduction of alternative funding and targeted schemes to encourage participation of human rights groups. This includes funding for regional groupings, which has tended to focus primarily on issues affecting KAPs. For instance, in 2016, 15 Regional concept notes were submitted to the GFATM, which dealt with a diverse range of interventions, such as harm reduction for people who inject drugs, and the removal of legal barriers and supportive services for people with disabilities, and community system strengthening.⁴²

In these cases, the GFATM has also used its public role to reaffirm that the commitment to human rights is contingent upon improving legal, policy, and social environments that hinder the scale-up of effective responses to HIV/AIDS, malaria, and tuberculosis. For instance, when Uganda passed its 2014 law on homosexuality, the GFATM was a vocal critique of these anti-discriminatory laws. The GFATM decried the new legislation for providing “significantly tough[er] punishments against gay people” with “grave implications for public health”.⁴³ This kind of signaling is important in the promotion of human rights, as it adds to the universal understanding of what protections are necessary for minority groups in order to make the most of GFATM programs.

The Problem of Measuring Human Rights Effectiveness

As a funding organization, the GFATM prides itself on its “results-based model”. This means that it only finances health initiatives whose results it can measure. This focus on accountability by focusing on performance has been integral to its success as an organization. Its website proudly proclaims that the institution can measure impact in many ways, through the number of lives that are saved and the rate of decline in HIV/AIDS, tuberculosis, and malaria. Under the new funding guidelines, the GFATM wants to see what it calls “smart programming that creates the strongest impact,” which refers to programs that reach the most affected populations.

When the institution approves a grant proposal, countries receive their disbursements in installments. Only when they have illustrated that they have performed adequately can they access the next disbursement.⁴⁴

Previously the GFATM relied on indicators that were not specific to human rights; rather, the focus was on measuring whether interventions worked.⁴⁵ These were known as Key Performance Indicators (KPIs). Unfortunately, these indicators took about 15 months to take effect. When finally approved in mid-2013, the KPIs of the GFATM consisted of 19 indicators, three of them were strategic and 13 were activity-based, and these helped to assess the GFATM's grants against the 2012-2016 Strategy.⁴⁶ The Secretariat reported to the Board against these indicators twice a year. The most closely related strategic objective on human rights was number 4, on promotion and protection of human rights. In response to this, the GFATM measured this criteria against its human rights investments.

Some of the KPIs were criticized for not reflecting the challenges posed by the Fund's strategy or not allowing corrective action when it was found necessary. For instance, strategic action 4.3 on integrating human rights considerations throughout the grant cycle was not measured with a KPI.⁴⁷ Although a report of the Office of the Inspector General found that data collection on KPIs was generally good, even then, they were found by the OIG to be poorly designed, and not a good measure of the impact the Fund was having in the countries it supports.⁴⁸

In response to these concerns, on June 15, 2017, the GFATM board launched the 2017-2022 Strategic Key Performance Indicator Framework. A number of these indicators focus on human rights in relation to the Strategy. KPI 5 tracks coverage of services for key populations, KPI 6 and 7 deal with resilient and sustainable health systems, and KPI 8 and 9 deal with gender and age disparities and human rights barriers to access.⁴⁹ Apart from 12 KPIs that will measure the Fund against its strategic objectives, "the new implementation KPIs will track specific inputs, outputs and outcomes needed to meet those objectives; and the thematic reporting will provide results across the full results chain, drawing on financial, procurement, and programmatic data."⁵⁰

The Realities of Funding a Limited Number of Rights

As a funding institution, the GFATM's focus is not extensive. Due to increasingly limited resources, it has a clear mandate about what it must fund. This in effect focuses on a narrow range of rights. However, it is difficult to separate human rights from the underlying determinants of health. For instance, to ensure that women get tested for HIV/AIDS or malaria during antenatal health visits to counter discrimination, it is necessary to invest in health centers, community awareness to enhance knowledge about services, labor protections that compel employers to give them adequate time off for antenatal visits, and transport services to easily access the health centers. Doing all this is, of course, expensive, and consequently unattainable as a practice of GFATM, despite its obvious benefits. Giving this link between the underlying determinants of health and the ability to shape human rights practice, some scholars have suggested that the GFATM would have to broaden from just three diseases and move toward becoming a "Global Health Fund."⁵¹ The GFATM has tried to address this through the establishment of its new KPIs, which will move beyond focusing on specific projects to a more holistic approach, aimed at ending the three epidemics. Furthermore, the notion of "thematic reporting" will also help the GFATM to measure sector-wide progress, which includes other global health actors who are working toward similar aims at the country level.

CONCLUSION

In this article, we have assessed the uptake of human rights as a norm of the GFATM. Although present in the founding documents of the GFATM, human rights have developed as only a secondary norm of the GFATM. As the analysis shows, the secondary nature of human rights within the GFATM initially created challenges in the transposition of human rights norms within domestic contexts. Through the application of the sociological institutionalist framework of “layering,” we illustrated how the GFATM is countering states’ deviation from human rights norms by strengthening the conditional nature of its funding against much stricter human rights criteria that it wants to see in its grant applications. Furthermore, the GFATM now signs agreements with countries that include five minimum standards for human rights. Anyone who witnesses a human rights violation can report to the Office of the Inspector General, who has an obligation to investigate. These safeguards create much more stringent human rights standards that are prudent for the long-term survival of the GFATM, because the increased accountability embedded in its institutional design exposes it to increased scrutiny. The success of these new norms remains to be seen in practice.

However, the low percentage of resources spent on human rights against total GFATM funding still illustrates the secondary nature of the human rights norm. In 2016, the GFATM was spending approximately 2.3 percent of AIDS funding on human rights initiatives.⁵² This is still very low, and in order to be more effective, this would need to rise substantially. Arguably, this will be a tough sell for its donors, especially in an environment where there is a push back against global responses to health problems. However, human rights remain a normative good, and so cannot be discarded. Indeed, the work of the GFATM will remain crucial to ensuring that human rights is mainstreamed as part of health governance in its recipient countries.

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¹ Institute of Health Metrics. *Financing Global Health 2016*. University of Washington, 2016. http://www.healthdata.org/sites/default/files/files/infographics/Infographic_FGH2016.pdf.

² The Global Fund to fight AIDS tuberculosis and malaria for instance disburses 9.9 percent of all development health assistance. See Institute of Health Metrics. *Financing Global Health 2016: Development Assistance, Public and Private Health Spending for the Pursuit of Universal Health Coverage*. University of Washington, 2016, 12.

http://www.healthdata.org/sites/default/files/files/policy_report/FGH/2017/IHME_FGH2016_Technical-Report.pdf.

³ Finnemore, Martha. “International Organisations as teachers of Norms: The United Nations Educational, Scientific and Cultural Organisation and Science Policy,” *International Organization*, 47 no. 4 (1993): 565- 97; Finnemore, Martha and Sikkink, Kathryn, “International Norm Dynamics and Political Change” In *Exploration and Contestation in World Politics*, edited by Peter J. Katzenstein, Robert O. Keohane and Stephen D. Krasner Cambridge MIT Press, 1998, 247-77.

⁴Finnemore, Martha. "International Organisations as teachers of Norms: The United Nations Educational, Scientific and Cultural Organisation and Science Policy," *International Organization*, 47 no. 4 (1993): 565-97.

⁵UN General Assembly, 60th Session. *Enhanced Cooperation between the United Nations and all Relevant Partners, in Particular the Private Sector – Report of the Secretary General*. UN Doc A/60/214, August 10 2005, para 8.

⁶In General Comment No 2, the Economic and Social Cultural Rights Committee argues that the specialized UN agencies should have an active role in the promotion of human rights particularly in the case of economic social and cultural rights. These duties are based on respect and not violating human rights and would vary considerably depending on the purpose of the international organization. Thus, if we argue that IO's have a duty to promote international human rights law then these organizations have a duty to ensure that their activities in implementing GFATM grants are compliant with human rights. See also Meier, Benjamin Mason and Gostin, Lawrence, O. "Introduction: Responding to the Public Health Harms of a Globalizing World through Human Rights in Global Governance" In *Human Rights in Global Health Rights-Based Governance for a Globalizing World* edited by Benjamin Mason Meier and Lawrence O Gostin. New York, NY: Oxford University Press, 2018, 1-18.

⁷Global Fund. *Bylaws of the Global Fund to Fight AIDS, Tuberculosis, and Malaria*. https://www.theglobalfund.org/media/6007/core_globalfund_bylaws_en.pdf?u=636486807150000000.

⁸General Comment No 14 provides a normative understanding for the obligations of parties under the right to health.

⁹Meier, Benjamin Mason. "Global Health takes a normative turn: The expanding purview of international health law and global health policy to meet the public health challenges of the 21st century." *The Global Health Community Yearbook of International Law and Jurisprudence*, 1 (2011): 86, 98.

¹⁰The third founding principle of the Global Fund stated that it aimed to support proposals for funding that aimed, 'to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS especially for women, children and vulnerable groups.'

¹¹Human Rights is considered by the TRP when looking at soundness of approach and the body is requested to analyse, "whether a proposal addresses issues of human rights and gender equality..."

¹²This was part of a much wider restructuring process, which introduced a new model that was supposed to streamline the process of health financing in order to make it more flexible and ensure that there was better alignment with country budgeting processes. See Global Fund. "Funding Model." Accessed November 23 2016. <http://www.theglobalfund.org/en/fundingmodel/>.

¹³Davis, Sara L.M. "Measuring the impact of human rights on health in global health financing," *Health and Human Rights Journal* 17 no. 2 (2015): 1-16.

¹⁴Bourgoing, Robert. "Morocco's quiet revolution over AIDS and human rights," *AIDSPAN*, September 29, 2014. http://www.aidspace.org/gfo_article/moroccos-quiet-revolution-over-aids-and-human-rights.

¹⁵Global Fund, "Global Fund launches human rights complaints procedure," *Global Fund Press Release*, April 27, 2015. http://www.theglobalfund.org/en/mediacenter/newsreleases/2015-04-27_Global_Fund_Launches_Human_Rights_Complaints_Procedure.

¹⁶Berglund, Sara, Ieva Gange, and Frans van Waarden. "Mass Production of Law. Routinization in the Transposition of European Directives: A Sociological- Institutional Account." *Journal of European Public Policy* 13, no. 5 (2006): 692-716.

¹⁷Hall, Peter A. and Rosemary C. R. Taylor. "Political Science and the Three New Institutionalisms." *Political Studies* 44, no. 5 (1996): 936-957.

¹⁸CCMs typically include a cross-section of representatives ranging from health professionals, NGOs, representatives of people living with HIV/AIDS, representatives of vulnerable affected populations private sector, to government representatives and representatives of International development organisations.

¹⁹GFATM. "What We Do." Accessed May 3, 2017. <http://www.theglobalfund.org/>.

²⁰Finnemore Martha and Kathryn Sikkink. "International Norm Dynamics and Political Change" *International Organization* 52 no. 4 (1998): 891

²¹Checkel, Jeffrey T. "Why Comply? Social Learning and European Identity Change." *International Organization* 55, no. 3 (2001): 553-588.

²² The Global Fund. *Country coordinating mechanism governance and civil society participation*. Geneva: the Global Fund, 2008.

²³ The Global Fund. "Funding Model." Accessed November 22, 2016.

<https://www.theglobalfund.org/en/funding-model/>.

²⁴ Jackson, Gregory. "Actors and Institutions" In *Oxford Handbook of Comparative Institutional Analysis* edited by Glenn Morgan, John Campbell, Colin Crouch, Ove Pedersen, Peer H. Christensen, and Richard Whitley. Oxford: Oxford University Press, 2010.

²⁵ The Global Fund. "The Global Fund Strategy 2012-2016: Investing for Impact."

http://www.theglobalfund.org/documents/core/strategies/Core_GlobalFund_Strategy_en/. See also Hanefeld Johanna and Anuj Kapilshrami. "The Global Fund's New Funding Model - Missed Opportunities for Human Rights?" *Health and Human Rights Journal*, July 18, 2013.

<http://www.hhrjournal.org/2013/07/18/the-global-funds-new-funding-model-missed-opportunities-for-human-rights/>.

²⁶ The Global Fund. "Funding Model." Accessed November 22, 2016.

<http://www.theglobalfund.org/en/fundingmodel>.

²⁷ Thelen, Kathleen. *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*. New York: Cambridge University Press, 2004.

²⁸ Van der Heijden, J. "Institutional Layering: A Review of the Use of the Concept." *Politics*, 31 no. (2011): 9-18

²⁹ McNiell, D. Jr. "Global Fund sees Change, Not all of them welcomed," *New York Times* November 15, 2002.

³⁰ Davis, Sara L.M. S "Human rights and the Global Fund to fight AIDS, tuberculosis and Malaria," *Health and Human Rights Journal* 16 no. 1 (2014): 138 - 139.

³¹ Davis, Sara L.M. "Measuring the impact of human rights on health in global health financing," *Health and Human Rights Journal* 17 no. 2 (2015): 1-16.

³² The Office of the Inspector General was created in 2005 to ensure that the Global Fund invests the world's money in the most effective way possible in the response to AIDS, TB and malaria.

³³ The Global Fund. *The Global Fund Human Rights Complaints Procedure: Responding to Community Concerns*. The Global Fund, n.d.

https://www.theglobalfund.org/media/1216/humanrights_2015-complaintsprocedure_brochure_en.pdf?u=636486807200000000.

³⁴ Oberth Gemma. "Tracking Global Fund investments in human rights programs," *AIDSPAN*, July 13, 2016. http://www.aidspace.org/gfo_article/tracking-global-fund-investments-human-rights-programs.

³⁵ Ibid.

³⁶ Global Fund. *Report of the Technical Review Panel on the concept notes submitted in the third and fourth windows of the funding model*. Geneva: Global Fund, 2015.

³⁷ Sekalala Sharifah Rahma. "Who gets to sit at the table? Interrogating the failure of participatory approaches within a right to health framework," *International Journal of Human Rights* 21, no. 7 (2017): 976-1001

³⁸ Ibid.

³⁹ International Council of AIDS Service Organizations (ICASO) and the International treatment preparedness coalition (ITPC). *Global Fund Country Coordinating Mechanisms: A Prescription for Change in a Time of Promise... and Peril*. ICASO, 2012, 5

⁴⁰ LGBT stands for lesbian, gay, bisexual, and transgender

⁴¹ This was particularly successful in Cambodia, South Sudan, Uganda and Vietnam. See Davis, Sara L.M. "Measuring the impact of human rights on health in global health financing," *Health and Human Rights Journal* 17 no. 2 (2015): 6.

⁴² These are some of the initiatives that were approved for Sub Saharan Africa. For more information see Baran, Charlie. "Update on the second wave of regional concept notes." *AIDSPAN*, June 7, 2016. http://www.aidspace.org/gfo_article/update-second-wave-regional-concept-notes.

⁴³ The GFATM stated that excluding marginalised groups would compromise efforts to stop the spread of AIDS in Uganda where 5.4 percent of the adult population is infected with HIV. See "Global Fund Deeply Concerned over Anti-Gay Law in Uganda" *Reliefweb*, February 26, 2014.

<https://reliefweb.int/report/uganda/global-fund-deeply-concerned-over-anti-gay-law-uganda>.

⁴⁴ The Global Fund. "Performance-based Funding," Accessed May 2, 2015.

<http://www.theglobalfund.org/en/about/grantmanagement/pbf/>.

⁴⁵ The GFATM has introduced a Key Performance indicator for human rights.

⁴⁶ The Global Fund Corporate KPI Framework for 2014-2016, as approved by the Global Fund Board in November 2013.

⁴⁷ The Global Fund, Office of the Inspector General. *The Global Fund Key Performance Indicator Framework*. Doc. GF-OIG-16-009, March 29, 2016.

https://www.theglobalfund.org/media/2650/oig_gf-oig-16-009_report_en.pdf?u=636488964540000000.

⁴⁸ Lloyd, Mary. "Global Fund Board approves new framework to monitor the Fund's performance," *AIDSPAN*, June 21, 2016. http://www.aidspace.org/gfo_article/global-fund-board-approves-new-framework-monitor-fund%E2%80%99s-performance.

⁴⁹ The Global Fund, 35th Board Member Meeting. *2017-2022 Strategic Key Performance Indicator Framework*. Doc. GF/B35/07A, April 26-27, 2016.

https://www.theglobalfund.org/media/4230/bm35_07a-2017-2022keyperformanceindicatorframeworknarrative_report_en.pdf?u=636488964120000000.

⁵⁰ Lloyd, Mary. "Global Fund Board approves new framework to monitor the Fund's performance," *AIDSPAN*, June 21, 2016. http://www.aidspace.org/gfo_article/global-fund-board-approves-new-framework-monitor-fund%E2%80%99s-performance.

⁵¹ However, they realize that this is contingent on increased donor funding. Ooms, Gorik, Wim Van Damme, Brook K. Baker, Paul Zeitz, and Ted Schrecker. "The 'Diagonal' Approach to Global Fund Financing: A Cure for the Broader Malaise of Health Systems?" *Globalization and Health* 4, no. 1 (2008): 6-6.

⁵² Oberth Gemma. "Tracking Global Fund investments in human rights programs," *AIDSPAN*, July 13, 2016. http://www.aidspace.org/gfo_article/tracking-global-fund-investments-human-rights-programs.

The World Bank and The Right to Health: A Study of the Institution's Rights-Based Discourse

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While the World Bank has integrated rights-based principles in the implementation of some health programs that it finances, it continues to deny a formal legal obligation for human rights. Employing thematic and discourse analyses, this study analyzes the ways in which rights-based approaches are incorporated into World Bank health development discourse, examining achievements, obstacles, and opportunities. We describe the evolution of human rights discourses in the World Bank's health engagement, beginning at the time of its establishment before it was formally involved in health sector lending. We find five key institutional factors that challenge the advancement of rights-based approaches in the World Bank's health work: unresolved legal obligations stemming from the institution's founding documents, the World Bank's economist-dominated culture, its staff's lack of knowledge about human rights application and policy, opposition by some country stakeholders, and competition with emerging development banks. Despite this, there are three opportunities for integrating right to health approaches within the World Bank: internal research activity supporting human rights commitments in development, pressure exerted by NGOs and civil society through their monitoring of the institution, and the establishment of the Nordic Trust Fund, which serves to increase staff awareness of human rights and its application to their work. Given the World Bank's historical legal resistance to a rights-based approach, we end by arguing for an ethical demand for health equity, which may be effectuated by a policy framework rather than a legal "right to health" approach.

INTRODUCTION

Over the last several decades, the World Bank has played a central role in global health development lending and practice and is increasingly recognized as a prominent global health governance leader.¹ While the Bank has had an impact on the health of those residing in low and middle-income countries (LMICs),² it is also critiqued for its human rights record. Philip Alston, the United Nations Special Rapporteur on extreme poverty and human rights, has proclaimed the World Bank to be a "human rights free zone";³ an estimated 3.4 million people were economically or physically displaced by Bank-funded projects between 2004 and 2013;⁴ and individuals affected by Bank-funded interventions report not feeling safe to ask questions or express their feelings about the impacts that World Bank projects have on their well-being.⁵

The Bank's human rights discourse, however, is neither clear-cut nor well understood. There are instances where World Bank health programming and policies are perceived as fundamentally supporting or detracting from a rights-based approach. On one hand, the Bank is committed to improving the wellbeing and health of the poor in LMICs, given its pledge to help countries achieve universal health coverage and as reflected in its "twin goals" of ending extreme poverty and promoting shared prosperity, which contribute to the realization of social and economic rights. On the other hand, the Bank is historically resistant to adopting a formal rights-based framework due to guidelines laid out in the institution's founding documents, which explicitly prohibit the institution from meddling in a state's internal political affairs.

We examine the Bank's rights-based discourse in its engagement with global health over time. While the World Bank was absent in global health efforts in the first several decades following its establishment, it presently manages an active Health, Nutrition, and

Population (HNP) portfolio of \$11.5 billion,⁶ has been the world's leading funder of programming and policies that address HIV/AIDS,⁷ and plays one of the most significant roles in global health cooperation.⁸ An understanding of the Bank's "right to health" discourse is critical given its pivotal role in the global governance of health and in its determination of health investments, institutional developments and policies of LMICs, and the broader global health agenda.

We begin by discussing the origins and meaning of a "rights-based" approach, considering the implications that a commitment to a "right to health" might have in practice for the World Bank before describing the methodology employed in this study. We then describe the evolution of right-based approaches in the Bank's health discourse and analyze the factors that present opportunities for advancing rights-based approaches in the Bank, as well as those that have historically challenged its institutional advancement. We conclude by arguing that the World Bank's embrace of an ethical demand for health equity, rather than the pursuit of a rights-based discourse, will better enable the Bank to deliver improved health development outcomes, given that such a reconceptualization transcends the identified challenges that persistently impede institutional advancement of rights-based approaches.

METHODOLOGY

Framework for Understanding the "Right to Health"

The "right to health"—enshrined in the Constitution of the World Health Organization (1946), the International Covenant on Economic, Social and Cultural Rights (1976), and the Declaration of Alma-Ata (1978), among other formal documents—is understood as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁹ It is both a freestanding right and constitutive of other rights, given that its realization is a precondition to the enjoyment or definition of rights related to various types of economic, political, social, cultural, and civil rights.¹⁰ Practically, a rights-based approach to development seeks to ensure that human rights criteria (i.e., affordability, accessibility, acceptability, quality, and availability) and principles (i.e., accountability, participation, non-discrimination, sustainability, and access to information) are accounted for during the course of development.¹¹ In addition, rights-based approaches support rights-holder capacity to claim their human rights and duty-bearer ability to meet their responsibilities.¹² We accounted for these criteria, principles, and obligations in our analysis of the World Bank's "right to health" discourse.

Data and Analysis

We adopted a two-level case study methodology of the World Bank and its HNP Department. Unlike quantitative methodologies, the case study method is ideal for this research question given that we seek to study a complex social phenomena, have no possibility of controlling the events that unfolded, and are interested in answering "how" and "why" questions.¹³ In order to minimize bias and increase the validity of our findings, we triangulated across various sources of data that were drawn from different sources and at different times.¹⁴ This included archival data, World Bank strategies and reports, peer-reviewed literature, as well as relevant reports and statements from the media, NGOs, other international organizations, and civil society monitoring World Bank activity. We also conducted semi-structured interviews with key-informants within the World Bank: from the Legal Department, Nordic Trust Fund, and the HNP Department.

Employing thematic and discourse analyses, this study analyzed the ways in which rights-based approaches are incorporated into World Bank health development discourse,

examining achievements, obstacles, and opportunities. We constructed a historical narrative of key events and conducted a discourse analysis¹⁵ of relevant Bank statements and formal strategies by analyzing the conscious and unconscious agendas and meanings of selected texts. We also undertook a thematic analysis¹⁶ of the collected data. We used an iterative process in developing the codes,¹⁷ with the coding evolving as additional data were collected. Initial codes for analyzing global health discourse at the World Bank were based on the identified human rights criteria (affordability, accessibility, acceptability, quality, and availability) and principles (accountability, participation, non-discrimination, sustainability, and access to information). This enabled us to examine how discourse derived from World Bank publications, speeches, and decisions reflected the Bank's rights-based actions and policy decisions (or lack thereof) in its health policies and programming. Initial codes for analyzing the factors shaping the opportunities and challenges for the Bank's rights-based progress were based on a policy determinant framework,¹⁸ which describes five general types of factors that are hypothesized or have been found to influence implementation outcomes: 1) characteristics of the implementation object (in this case, human rights); 2) characteristics of the user/adopter (the history, internal policies, and culture of the World Bank); 3) characteristics of the end users (the nation states and populations affected by World Bank intervention); 4) characteristics of the context (the global political and policy environment, including the actions, policies, and strategies of other international financial institutions, international organizations, and NGOs); and 5) the characteristics of the strategy or other means of facilitating implementation (the research conducted, legal opinions crafted, and entities/policies constructed internally by the World Bank that are relevant to human rights).

THE EVOLUTION OF RIGHTS-BASED APPROACHES IN WORLD BANK DISCOURSE

The World Bank's Governance, Establishment, and Early Years (1945-1960s)

An understanding of the World Bank's rights-based discourse in health requires an examination of the institution's governance and establishment, well before its engagement in health lending. Established in July 1944 and beginning operations in 1946, the World Bank's original goal was to finance the post-war European country economy, focusing on large physical capital and infrastructure projects. A specialized agency of the UN, the World Bank Group is composed of five "member institutions". The largest of these institutions are the International Bank for Reconstruction (IBRD), which offers loans to middle-income countries, and the International Development Association (IDA), which offers concessional loans and grants to the world's poorest developing countries. Both institutions share the same leadership and staff and have a mandate to assist development efforts in their member states. The World Bank's 189 country shareholders are represented by a Board of Governors, which is composed of member countries' ministers of finance or ministers of development.¹⁹ These governors delegate specific duties to the Bank's Board of 25 Executive Directors (ED), who are responsible for selecting the President for a five-year, renewable term and approving all institutional loans and policies.²⁰ ED designations are based on member state financial contributions (e.g., the United States is represented by one ED, while forty-seven sub-Saharan African countries are collectively represented by only two EDs).²¹

At its establishment and over the first couple decades of its existence, the World Bank was explicitly resistant to considering human rights. As stipulated in its Articles of Agreement, the institution's founding documents, the World Bank saw itself as an economic development agency and clearly forbid the institution from intervening in any country's internal political affairs or engaging in decision-making based on political considerations.²² Article VIII, Section 5(f) of the Articles of Agreement states that:

The Bank, its President, officers and staff shall not interfere in the political affairs of any member, nor shall they be influenced in their decisions by the political character of the member concerned. Only economic considerations shall be relevant to their decisions. Such considerations shall be weighed impartially in order to achieve and carry out the purpose and functions of the Bank.²³

The World Bank's unwillingness to uphold principles of human rights in its policies and lending practices became particularly evident in the 1960s, when the institution decided to – in defiance of a series of UN resolutions – approve several loans to Portugal and South Africa, despite their respective colonial and apartheid policies.²⁴ The World Bank overlooked the human rights violations occurring in these countries and cited its apolitical character for its decision to move forward with its loan support.²⁵

The World Bank's Increasing Engagement in Politics and Interest in Health (1970s)

Robert McNamara's presidency (1968-81) marked several unprecedented shifts in World Bank policy – having direct implications on its health and human rights discourses. Under his leadership, the Bank moved from project to policy-based lending,²⁶ began venturing into areas of social development that aimed to improve the health and well-being of LMIC populations, and became centrally engaged in areas of national politics and law that historically were understood to be outside of the scope of its Articles of Agreement (i.e., the promotion of “good governance” as critical to development),²⁷ recognizing that such “political” efforts were fundamental to ensuring the success and sustainability of development initiatives. Despite these transformations, the World Bank resisted acknowledging a formal link between political and civil rights, economic development, and good governance.²⁸

Two policy areas and one approach – population, environment, and basic needs respectively – emerged during this time and served as precursors to the World Bank's involvement in health. We examine how developments in each of these areas reflected and shaped the institution's right to health discourse.

The World Bank's Population Projects Department (PNP) began operations in September 1969 and provided the Bank's first population loan to Jamaica in 1970.²⁹ As noted by Dr. Kanagaratnam, PNP's first director, the Bank decided to enter the population field primarily because “it became convinced that the attempt to raise living standards in a great many developing countries was being seriously undermined by population growth.”³⁰ Instead of advancing a population agenda because of a concern for the intrinsic sexual and reproductive rights of women in LMICs, the Bank's involvement in this area was largely instrumental: seeking to “achieve fertility decline in the quickest and most effective way consistent with the realization of national socio-economic development objectives.”³¹

The Bank's interest in the environment also developed during the 1970s. The relationship between the Bank's development initiatives, the environment, and the health and well-being of the populations that were impacted was of particular concern to the appointed environmental advisor, Dr. James Lee.³² He drew attention to the traumatic effects that Bank supported projects were having on indigenous populations in LMICs. Dr. Lee's concern and outside NGO pressure to address the situation ultimately led the Bank to develop a tribal policy and practical handbook, which member countries resisted because it infringed upon their sovereign rights regarding their people.³³

In 1976, the basic needs approach (BNA) in development emerged, introduced by the International Labor Organization's World Employment Conference,³⁴ and was rapidly taken up by the World Bank because historical policy approaches that focused on maximizing GNP per capita were not facilitating the automatic “trickle down” of economic growth to the poor.³⁵ BNA, which promotes the satisfaction of basic material needs for food,

material, health, shelter, etc. before moving on to other “higher” needs, was seen as a means of directly addressing poverty reduction among the most vulnerable populations.³⁶ An approach that continues to dominate development discourse, some scholars characterize BNA as a forerunner to the human rights approach (HRA). However, there are several fundamental differences: BNA focuses on inputs and meeting needs, while HRA focuses on processes, outcomes, and realizing rights; BNA addresses proximate causes of problems, while HRA addresses structural causes; and in a BNA, individuals are “objects of development interventions” and “deserve assistance,” while in HRA, individuals are “empowered to claim their rights” and are “entitled to assistance.”³⁷

Establishment of the Health, Nutrition, and Population Department (1980s – mid-1990s)

Health became a formal area of institutional focus in October 1979 with the establishment of the Population, Health, and Nutrition Department, which was ultimately renamed as the Health, Nutrition, and Population (HNP) Department.³⁸ A background paper for the 1980 World Development Report³⁹ identified five factors that led to the World Bank’s increased interest in and commitment to health, one of which was a concern for human rights and meeting the basic needs of the poor that arose in the mid-1970s.⁴⁰ In fact, the World Bank’s lending in health and the social sector broadly and also its incorporation of poverty reduction strategies are cited in Bank publications as major contributions to advancing social and economic rights in LMICs.⁴¹

However, the Bank’s motivation for health lending was also largely instrumental. As described by the World Bank’s Independent Evaluation Group, its involvement in health was expressed as a means to an end, rather than an end itself (e.g., an intrinsic concern for population rights), given that the institution sought to improve HNP outcomes in order to increase poor productivity and national economic growth.⁴² Furthermore, HNP’s establishment and early years coincided with the advancement of three Bank-wide policies that represented a fundamental derogation from a rights-based discourse: the promotion of structural adjustment lending, user fees, and privatization.

Throughout the 1980s and 1990s, the Bank compelled countries to implement structural adjustment policies.⁴³ At the time, the Bank believed that structural adjustment would lead to poverty reduction through trade liberalization, increased competition from the private sector, and devaluing of overvalued currencies.⁴⁴ In reality, between 1980 and 1992, world debt rose from \$0.5 trillion to \$1.2 trillion, with many of the countries adopting structural adjustment policies shouldering the greatest debt.⁴⁵ Moreover, the policy led to growing health inequalities and disrespect for the human rights of LMIC populations,⁴⁶ resulting in half a million young children dying over a one year period.⁴⁷

At around the same time, the World Bank highlighted user fees, which involves levying a fee for using public sector health services, as an instrument for mobilizing resources.⁴⁸ Research concerning user fees has since revealed that the policy resulted in a decline of service utilization, especially among women and socioeconomically deprived populations.⁴⁹ Despite the World Bank claiming that it does not support user fees in its 1997 sector strategy,⁵⁰ many NGOs and health experts continue to blame the World Bank for its introduction, advancement, and failure to put out a policy that rejects its use.⁵¹

Finally, privatization in World Bank policies began growing during this time. Loans with privatization as a condition tripled between 1990 and 2002, despite the World Bank advancing that it does not force privatization on the poor.⁵² Critics expressed concern about the negative effects that the institution’s backing of privatization was having on LMIC health,⁵³ since successfully working through private-sector providers necessitates intricate health information systems and administrative capabilities that a majority of LMICs typically lack.⁵⁴ Privatization also promotes the fragmentation of the health system, which makes a state’s implementation responsibilities more difficult and “complicates oversight

and the promotion of a rights-based approach to health.”⁵⁵ In fact, private healthcare institution aims often diverge considerably from human rights principles.⁵⁶

The Wolfensohn Era: A Shift in Human Rights Discourse (mid-1990s – mid-2000s)

Under the leadership of President James Wolfensohn (1995-2005), the World Bank increasingly became one of the world's largest global HNP financiers, with annual commitments of \$1.3 billion in 1999.⁵⁷ Despite making significant contributions to health services and policies across the world and becoming a central actor in global health policy debates,⁵⁸ it was also increasingly critiqued for undermining rights-based principles in its health initiatives. For example, the DALY (disability-adjusted life year), a measure of overall health and life expectancy of different countries, was introduced by the World Bank in 1993,⁵⁹ and was widely criticized for violating rights-based principles by discriminating against the disabled, young, and elderly, as well as women and future generations.⁶⁰ In addition, the rights-based criteria and principles of quality and accountability were perceived to be undermined, since the World Bank's Operation's Evaluation Department concluded that only 64% of HNP projects were satisfactorily completed between 1975 and 1998, with most of health projects insufficiently “defining and monitoring progress toward HNP development objectives” and accounting for and addressing health determinants generally.⁶¹ Also, the Bank's health work was insufficiently open to outside scrutiny, detracting from rights-based principles of access to information and accountability, given that as of 1998, there had only been two reviews commissioned externally by the Bank of its health activities.⁶²

Despite these critiques, Wolfensohn's presidency catalyzed unprecedented discussion on human rights more broadly within the World Bank. For example, his appointment coincided with the early years of the Inspection Panel, established in 1993. The Panel investigates – when prompted – the World Bank's compliance with its own procedures and policies as a means to safeguard people and the environment impacted by its projects.⁶³ Because it empowers those marginalized by World Bank projects, the Inspection Panel forced the institution for the first time to confront and address cases that raised human rights concerns. Several Panel decisions concerning underlying determinants of health have highlighted instances in which World Bank procedures and policies may necessitate the Bank to account for human rights issues.⁶⁴ These cases have directed the institution to: consider the wider consequences of human rights violations, not just when they have a direct economic effect on the project;⁶⁵ evaluate a country's general state of human rights and governance when planning and carrying out its projects;⁶⁶ and account for the human rights protections covered in a country's constitutions or laws and ensure that institutional funding does not violate a country's international human rights commitments.⁶⁷

A second key development during Wolfensohn's tenure was the legal opinions of General Counsels Ibrahim Shihata (1983-2000) and Roberto Dañino (2003-2006), which created the legal space for the institution's engagement in topics that were once considered too political and recognized the relevance of human rights within the World Bank's development work.⁶⁸ Both recognized that the “Articles of Agreement permit, and in some cases require, the Bank to recognize the human rights dimensions of its development policies and activities.”⁶⁹

Dañino and Shihata also advanced that the World Bank may help a country realize its own human rights legal obligations (in the instance that it communicates such a desire), given that these commitments “have an economic impact or relevance,” and that the Bank should take human rights into consideration when “a country has violated or not fulfilled its obligations” – again in the instance that they have an economic impact.⁷⁰ However, Dañino went further in an internal legal opinion that he distributed on his last day as General

Counsel, advancing that the World Bank should disengage in “egregious situations, where extensive violations of human rights reach pervasive proportions” – no longer requiring an economic impact justification.⁷¹ His legal opinion, however, would have little impact. Given long-standing disagreements about human rights among Bank staff and leadership, the opinion was not presented to the Bank’s Board of Directors, representatives in the Legal Department were reluctant to discuss it openly among themselves, and the succeeding General Counsel Ana Palacio (2006-2008) interpreted it as permitting but not requiring the Bank to act in relation to human rights.⁷²

The World Bank’s 1998 publication *Development and Human Rights: The Role of the World Bank*,⁷³ which commemorated the fiftieth anniversary of the Universal Declaration of Human Rights, also signaled an increasing institutional recognition of human rights. The report recognized that national growth requires some respect for human rights, human rights progress in the World Bank should be measured by the extent to which economic growth occurs with increased citizen realization of economic and social human rights, and that the institution should support the human rights goals of the United Nations, its parent organization.⁷⁴ While human rights advocates considered the report’s message to be “good for public relations but devoid of practical effect,”⁷⁵ a growing collection of World Bank research emerged subsequent to its publication that advanced a link between the promotion of civil liberties and rights and stronger economic performance.⁷⁶ Also, subsequent to the report’s publication, Wolfensohn circulated a proposal for a Comprehensive Development Framework to World Bank staff, calling for a “holistic approach to development” that acknowledged the protection of “human and property rights” and a comprehensive framework of laws as critical for equitable development.⁷⁷

The Present: The World Bank’s “Right to Health” Discourse (mid-2000s – present)

Over the last decade, there has been renewed optimism, as well as pessimism, concerning the World Bank’s progress in advancing rights-based approaches in health as reflected in several recent developments.

One of the greatest points of optimism for the advancement of rights-based approaches in the Bank was the establishment of the Nordic Trust Fund (NTF) in 2009. Originally proposed in 2006, it was created with contributions from Denmark, Iceland, Norway, Finland, Sweden, and Germany as an internal “knowledge and learning initiative” to assist in showing Bank staff how human rights relate to their work and goals.⁷⁸ To overcome initial opposition from the Bank’s leadership,⁷⁹ lawyers working on the trust funds’ plan of action strategically advanced an instrumental approach to rights and a focus on pilot projects instead of advocacy for an institution-wide human rights policy.⁸⁰ Totalling \$34.8 million, the NTF educates World Bank staff about human rights issues and provides Bank teams, through a grant program, the financial and technical support to examine the role of human rights in their work. Several of the 122 grants supported by the NTF have explicitly sought to advance “right to health” discourse at the Bank by examining the operationalization of gender in health, considering what a human rights approach can offer maternal and reproductive health projects, and producing standards of practice that add a human rights perspective in adolescent sexual and reproductive health projects.⁸¹

Representing “a break from the Bank’s past leadership,”⁸² Jim Kim’s appointment as World Bank president in 2012 also created optimism among many global health and human rights advocates. Unlike past Bank leaders that have typically been experts in finance, economics, or politics,¹ Kim is a clinician and anthropologist, with extensive humanitarian global health experiences as the co-founder of Partners in Health, and was

¹ James Wolfensohn was another exception; he was a lawyer by training.

previously a major critic of the World Bank.⁸³ Despite expanding the institutional boundaries of the World Bank's mandate⁸⁴ and being outspoken in his rhetoric concerning the "right to health,"⁸⁵ human rights proponents argue that Kim's advancement of institutional discourse on human rights has fallen short.⁸⁶

Some of the criticism toward Kim is associated with the World Bank's revision of its safeguard policies, which he oversaw and made official on August 4, 2016. While the newly approved Environmental and Social Framework (ESF)⁸⁷ explicitly references human rights in its overarching vision statement, its language presents human rights as aspirational values and is non-binding – excluding any human rights commitments and standards.⁸⁸ In addition, the new policy effectively shifts responsibility and liability for harms away from the Bank and onto borrower countries that often lack the political will, as well as the financial and technical ability, to ensure that monitoring and/or grievance mechanisms operate effectively to protect vulnerable populations.⁸⁹ Also, the new ESF shifts much of the World Bank's due diligence on projects until after they are approved.⁹⁰ Despite these criticisms, ESF incorporated some important reforms to the previous ad hoc and burdensome policies, such as requiring stakeholder engagement throughout the project lifecycle and placing greater focus on strengthening borrower frameworks and capacity building.⁹¹ In fact, one of the ten Environmental and Social Standards (ESS) explicitly addresses the "health, safety, and security risks and impacts on project-affected communities" (ESS4), with special attention to vulnerable populations.⁹²

During the development of the ESF, the World Bank's human rights reputation was significantly tainted by its handling of the Uganda Transport Sector Development Project (UTSDP). In 2015, the Bank initially dismissed problems reported by the community related to community safety, sexual violence, child labor, and insufficient compensation for those who lost land to the project.⁹³ Of particular concern was the sexual abuse and exploitation of women and children in the community by unmonitored project construction workers, resulting in an increase in unintended pregnancies and women contracting HIV/AIDS. The Inspection Panel ultimately initiated an investigation,⁹⁴ prompting the Bank to eventually cancel the project, suspend all new lending to the government of Uganda, and institute remediation measures.⁹⁵ Especially concerning to human rights and health advocates were: the Bank's failure to account for the local context and accordingly classify the risk of the project appropriately, its initial denial and slow response to serious allegations raised by the local community, and the Bank's absence of a systematic method for providing support to the individuals impacted by the project.⁹⁶

Finally, the World Bank's recent support of governments to achieve universal health coverage (UHC) is favorable to the advancement of institutional rights-based approaches⁹⁷ given that UHC may be viewed as rooted in the right to health, as set out in the International Covenant on Economic, Social and Cultural Rights.⁹⁸ In support of UHC targets in Sustainable Development Goal (SDG) 3, the World Bank has committed \$15 billion over the next five years to undertakings fundamental to UHC.⁹⁹ Despite this commitment to UHC, the World Bank is accused of undermining the human right to universal health care given its promotion of public-private partnerships (PPPs) in health.¹⁰⁰ A 2016 Independent Evaluation Group report on healthcare PPPs found several problems with the ways in which the Bank has implemented PPPs in the health sector. Especially concerning was little evidence demonstrating that PPPs actually helped improve access to health services for poor communities.¹⁰¹ In addition, human rights advocates are concerned with the Bank's approach to universal healthcare coverage, which involves the creation of health insurance schemes that allow people to access healthcare facilities, but that works through insurance schemes that are typically only available to people working in the formal sector (not the most marginalized individuals in LMICs working in the informal sector).¹⁰² These advocates prefer a policy of universal healthcare provision, which dictates that a government guarantees the provision of healthcare services to all, irrespective of income

and status. Finally, critics raise concerns with the impact that the Bank's blanket promotion of performance-based financing has on advancing UHC, given some emerging evidence that it does not necessarily improve the practice of health workers and the performance of health facilities.¹⁰³

FACTORS SHAPING WORLD BANK RIGHTS-BASED DISCOURSE IN HEALTH

The World Bank's right-based discourse in its global health initiatives is shaped by several institutional factors. Five institutional factors have historically challenged a World Bank commitment to the issue. A principal barrier to human rights integration in the World Bank is the Articles of Agreement. The World Bank's founding member countries purposefully restricted its mandate to economic activities as a means to protect country sovereignty. By explicitly prohibiting the World Bank's engagement in political activity, the Articles of Agreement have historically thwarted the Bank's involvement with human rights, which have been understood as "political considerations." Interpretation of the Articles, which is determined by a majority vote among the Executive Directors, have not altered with respect to engagement with human rights issues even as various legal counsels have taken no issue with the World Bank's engagement with political issues such as governance, corruption, citizen security, justice, and the rule of law.¹⁰⁴ Human rights—of all the political issues that the World Bank engages in—continues to be classified as "political" rather than economic. Furthermore, the human rights taboo continues to be "policed" within discussions in the Executive Board and the broader institution by the Legal Department.¹⁰⁵

A second factor challenging human rights mainstreaming concerns the World Bank's institutional culture, which is dominated and largely influenced by an economist perspective. Economists occupy most senior management positions and their way of thinking reigns, influencing how institutional goals are crafted and justifications articulated within the institution.¹⁰⁶ From an economist perspective, rights are "perceived as being rigid, anti-market, and overly State-centric."¹⁰⁷ Accordingly, there is an uneasy tension in balancing the World Bank's inherent aim of efficiency (swiftly designing and implementing projects with little obstructions and impediments) and an explicit commitment to human rights (making these projects participatory, transparent, etc.). This institutional culture has challenged incorporation of human rights into the World Bank because doing so "forces employees into a struggle between principles and pragmatism, creating a tension between normative, intangible values and goals, and practical ways to solve problems."¹⁰⁸

A third factor challenging the World Bank's engagement with human rights is the lack of knowledge that staff have concerning human rights application. As reported by the NTF Progress Report, "World Bank teams...are not well informed about how human rights could be applied in their work...and are uncertain about how human rights can help provide better concrete answers" ¹⁰⁹ Evidence of this lack of knowledge was substantiated in an internal 2009 survey, which revealed that World Bank staff see human rights as relevant to their work but are uncertain how to integrate human rights in their work. Specifically, the survey found a staff knowledge gap around the definitions, laws, institutions, and standards governing human rights.¹¹⁰ While a 2013 follow-up survey found some improvement in staff knowledge and awareness of human rights,¹¹¹ the UN Special Rapporteur on extreme poverty and human rights has noted the persistence of this challenge: "Human rights are not well understood by a great many officials within the Bank. They have a passing acquaintance, but no real sense of the overall picture."¹¹²

A fourth factor impeding the World Bank's engagement with a rights-based approach is country resistance. While some key World Bank stakeholders are supportive of a formal policy on human rights, other countries such as China strongly oppose it.¹¹³ Some countries oppose the World Bank's engagement in human rights on the grounds that it interferes with state sovereignty, while others resist it because they already face challenges

with gender equality and/or accounting for the existing, basic governance indicators required by the World Bank.¹¹⁴ These countries are concerned that a rights-based approach at the World Bank would expose their human rights records and require them to undertake rigorous assessments as part of the loan process. In addition, some member countries believe that a formal World Bank endorsement of human rights could result in demands for political “democracy” that could threaten non-democratic governments and unnecessarily destabilize states lacking democratic institutions.¹¹⁵ Relatedly, there are some within the Bank that advance that a human rights discourse needs to be avoided because the World Bank is already viewed as commanding Western values and interests on non-Western countries, and that a human rights discourse would further complicate existing sensitivities.¹¹⁶

The final challenge to adopting rights-based principles concerns the World Bank’s emergent rivalries from other development banks that are increasingly being supported by its traditional backers.¹¹⁷ These new multilateral investment banks (e.g., the Asian Infrastructure Investment Bank and the New Development Bank, both launched in 2014) and emergent national development banks in countries such as Brazil, China, and India currently do not have the same social standards as the World Bank. Accordingly, there are rising suspicions and legitimate fears that the World Bank will increasingly be swayed from integrating human rights requirements in their lending in order to remain competitive and be perceived as the most efficient institution, with the fastest speed of fund disbursement and least project requirements offered to country borrowers.¹¹⁸

Despite these challenges, three factors are likely to support the World Bank’s future engagement in rights-based approaches in its health initiatives. The first is the work of the NTF, which sidesteps the World Bank’s lack of institutional policy on human rights by improving project-level rights protection. Although NTF cannot lobby for official World Bank policy changes, it provides an important platform to increase awareness about human rights and to showcase the application of a rights-based approach in projects within the organization. This can be an important catalyst in expanding acceptance for and operationalization of human rights policy at the World Bank.

A second factor is the continued NGO pressure on the World Bank to engage in human rights principles in its work.¹¹⁹ The World Bank’s development of its initial safeguard policies in the 1980s is largely attributed to the pressure that NGOs applied.¹²⁰ Presently, organizations such as Human Rights Watch, the International Consortium of Investigative Journalists (ICIJ), the Bretton Woods Project, and the Bank Information Center serve as important accountability mechanisms by monitoring and reporting on the negative impacts that some World Bank projects have on the human rights of certain populations. By uncovering the adverse impacts that some World Bank projects have on human rights, these NGOs not only contribute to improvement of the institution’s existing accountability mechanisms (i.e., the Inspection Panel and the safeguard policies), but they also help create the evidence for considering an alternative, more sustainable channel of accountability: an explicit institutional commitment to human rights.

Finally, the growing body of research within the World Bank that concerns human rights represents a potential opportunity for greater World Bank engagement. Some of this research comes out of the World Bank’s Development Research Group, which has published studies on the use of legal strategies in bringing about social change and achieving economic and social rights,¹²¹ the determinants of compliance with human rights treaties,¹²² the relevance of human rights indicators for development,¹²³ and the benefits, risks, and limitations of human rights-based approaches to development.¹²⁴ This research builds on studies conducted by the World Bank in the past, which have found large and statistically significant effects of civil liberties on investment project rates of return.¹²⁵ Collectively, this work provides important evidence for the institution to consider a stronger commitment to human rights in its operations.

DISCUSSION

Despite growing recognition of the relevance of human rights to its work, the World Bank continues to lack systematic and formal integration of rights-based approaches into its health policies and programming. The World Bank's evolving engagement with rights-based discourse is fundamentally shaped by a deep-seated friction between its legal obligations, as set out in the Articles of Agreement, and its changing practical mandate, as reflected in the goals and type of health work that it pursues. While the institution's NTF, its monitoring by NGOs, and growing research supporting human rights commitments in development are promising for better integrating rights-based approaches in the World Bank's health work, five key institutional factors persist in challenging its advancement: unresolved legal obligations, the institution's economist-dominated culture, its staff's lack of knowledge about human rights application and policy, opposition by some country stakeholders, and competition with emerging development banks.

Given the World Bank's historical *legal* resistance to a rights-based approach, we argue for an *ethical* demand for health equity, which may be effectuated by a policy framework rather than a legal "right to health" approach. A rights-based approach is often understood within a legal framework, with a delineation of responsibilities based on legal commitments and liability for satisfying the rights of individuals through judicial processes.¹²⁶ In contrast, an ethical approach demarcates requirements based on moral obligations and accountability for ensuring justice and equity for individuals and populations.

While the judicialization of the right to health has been promoted by some scholars as a means to secure better health outcomes for the most marginalized,¹²⁷ we argue that it is an insufficient and ineffective means to promote health equity at the World Bank. For one, legal right to health approaches are critiqued for regularly not empowering individuals, as intended, and contributing to or reinforcing paternalistic practices.¹²⁸ Because human rights are considerably dependent on existing societal power relations, human rights systems have historically benefited those with the most power.¹²⁹ In fact, male-dominant understandings of human rights are mainstream, and states ultimately hold legal power over people.¹³⁰ Accordingly, powerful actors, including financial institutions such as the World Bank, are prone to reinforce the status quo in their pursuit of "rights-based" approaches,¹³¹ especially since the most marginalized communities are either out of reach or lack the power to effectuate legal, rights-based approaches.

Second, and relatedly, legal right to health approaches often may unintentionally deepen existing inequalities for access to healthcare.¹³² For example, right to health litigation in Brazil has compromised the advancement of health equity because it disregards resource restraints that can only be supported at the cost of universality. Accordingly, only a small number of individuals are granted this unlimited right to any benefits – over the rest of the population. Furthermore, health inequity is perpetuated where it is often the most privileged communities that are the ones that access the judiciary, an accessibility that marginalized communities (whose health conditions are comparatively worse and who have less than adequate access to other social determinants of health) typically do not possess.¹³³

Third, right to health approaches tend to be top-down and one-size-fits-all in nature.¹³⁴ In practice, they often pay insufficient attention to circumstantial social, political, and historical conditions and tend to generalize.¹³⁵ In fact, right-based approaches are critiqued for often detracting from implementation "when policy making becomes an end in itself and does not follow its operationalization in a culturally sensitive manner."¹³⁶

Accordingly, we contend that an ethical demand for health equity—rather than a legal demand for a right to health—will better enable the Bank to deliver improved health development outcomes, given that it is in line with the Bank's political economy perspective and transcends the identified challenges that have persistently impeded institutional

advancement of rights-based approaches.¹³⁷ In line with its political economy lens, the World Bank is designed to implement structural interventions to advance ethical demands for health equity – interventions that change finances, incentives, and power systems often well beyond the health sector.¹³⁸ Furthermore, the World Bank is in the best position to effectuate policy—rather than legal changes—given its significant engagement with and influence on policymakers in LMICs, representing various ministries.¹³⁹ Finally, application of an ethical approach to health equity is in accordance with current World Bank reforms and initiatives. This includes the NTF, which is prohibited from advancing legalistic right-based modifications to Bank policy, but has been instrumental to creating normative change in the institution by building knowledge and best practices around the incorporation of right-based principles in the institution's programming. Relatedly, the World Bank's implementation of its new Social and Economic Framework—a policy, not legal, framework—will be instrumental to advancing ethical, rather than legal, demands for health.

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International Health Assistance and Human Rights in Ethiopia

Hiwote Fantahun

This article examines the responsibility of external funders to ensure respect for human rights in their health assistance in highly repressive and politicized countries, using Ethiopia as a case study. Ethiopia's experience is particularly instructive, as it is highly dependent on international assistance for health, and ruled by one of the most repressive regimes in the world today. International assistance, even though has played a vital role in improving health outcomes in Ethiopia, has been a tool to discriminate among populations based on their political affliction, as revealed by research findings on major World Bank-administered programs. Bank safeguards were inadequate to prevent or detect such discrimination. The article recommends that health program funders consider countries' enabling legal and policy environment as a major factor in their funding decisions, recognizing the importance of a holistic approach to human rights to protect the right to health.

Ethiopia is one of the top recipients of international health assistance, yet also one of the world's most repressive countries.¹ The question, then, is whether—in such a repressive regime—health assistance can be provided in a way that is not undermined by the political repression. The answer, at least for Ethiopia, is that it cannot. This commentary demonstrates how health aid is politicized, and how donor approaches to accountability are insufficient in Ethiopia, and, indeed, undermined by donors taking a technical rather than political framing to the issue. Yet, there are steps providers of assistance could take to lessen the risk of aid being misused.

HUMAN RIGHTS AND RIGHT TO HEALTH IN ETHIOPIA

Ethiopia has ratified major international treaties recognizing civil, political, and socio-economic rights.² The Ethiopian constitution obliges the government “to allocate ever-increasing resources for public health and other social services with equal access to every citizen.”³ Yet, domestic legislation that runs counter to international and constitutional human rights obligations of the state serve the government as a tool to crush dissent, suppress freedom of expression, and frustrate human rights-related work in the country.⁴

INTERNATIONAL HEALTH ASSISTANCE

From emergency food aid to agricultural imputes, from primary education to building government institutions, aid to Ethiopia is an endeavor worth billions of dollars. International health assistance has played a vital role during the past two decades in helping Ethiopia improve health outcomes.⁵ Even though the total national health expenditure has increased, government's contribution is declining, substituted by international health assistance.⁶

International cooperation is sanctioned by international human rights law.⁷ These instruments do not explicitly state the nature of this duty, although principles governing extraterritorial obligations require, at the very least, that it should not contribute to impairing people's rights.⁸ This commentary focuses on non-discrimination and accountability, two core principles of the right to health, in relation World Bank-led multi-donor projects that have been implemented in Ethiopia over the past ten years.

International Health Assistance: Discrimination

In 2014-2015, Ethiopia received US \$3.6 billion in Official Development Assistance, a quarter of which was allotted for health.⁹ The World Bank's contribution (\$0.8 billion) for the same period is the highest of any funder, followed by that of the United States (\$0.7 billion) and the United Kingdom (\$0.5 billion).¹⁰ The Bank plays an important role in setting the framework for donor engagement through its country partner strategy (CPS), and in administrating their contributions to joint programs.

Among active multi-donor programs led by the World Bank is the Promoting Basic Services (PBS) program. The PBS, now in its third iteration (which runs until January 2019), was first approved in May 2006.¹¹ PBS was established partly with the objective of preventing "a reversal in gains made in human development (through) delivery of critical basic services to the poor...in the midst of political governance and macroeconomic fragility."¹² The program annually transfers an average of \$1 billion to the federal government in block grants. Projects under this program, designed to support the delivery of service in the agriculture, education, health, and road sectors, are implemented nationwide.

A second World Bank-led project, the Productive Safety Net Program (PSNP4), launched in 2005 and running until 2020, providing regular food or cash transfers to food insecure households in chronically food insecure districts benefiting more than 8 million people.¹³ The program channels on average half a billion dollars to the government annually.

Human Right Watch have published a series of investigative reports that outline how the Ethiopian government utilizes PBS, PSNP4, and other similar programs as political weapons to control the population, punish dissent, and undermine political opponents. These reports record systemic exclusion of people from accessing emergency food aid, agricultural imputes, and farmland based on their real and perceived political membership.¹⁴

The PBS also supports Ethiopia's flagship health extension program, paying the salaries of the 38,000 community health workers who go door-to-door to deliver health services such as immunization; malaria, TB, and HIV prevention and control; family planning; and civic education.¹⁵ These workers receive mandatory political instructions from the ruling party two evenings per month.¹⁶ More disturbingly, perhaps, allegations of discriminatory population control through long-acting contraceptive and deceptive sterilization targeting the ethnic Amhara women are becoming frequent. The region, which is predominately inhabited by the Amhara, arguably the most politically disfavored group under the current regime, exhibits the highest uptake of contraceptives of all the nine regions of the country, other than the capital city Addis Ababa.¹⁷ Scholars are calling for a thorough and impartial investigation to the allegations.¹⁸

International Health Assistance: Accountability

Monitoring and evaluations mechanisms implemented for the PBS focus mainly on administrative and financial aspects of accountability. The 2008-2011 World Bank country assistance strategy introduced social accountability mechanisms to improve the interface with government.¹⁹ The Bank's Independent Evaluation Group concluded that such schemes are of limited impact in the context of restrictive laws governing the media and civil society.²⁰

The World Bank implements social and environmental safeguards with the objective of preventing and mitigating undue harm to people and their environment in development processes. The current safeguards are concerned with forests, pest control,

dam safety, natural habitat, involuntary resettlement, and indigenous people. However, only the indigenous people safeguard has an explicit human rights policy objective.²¹

In September 2012, 26 representatives from the Anuak community in the Gambela region challenged the PBS III before the World Bank Inspection Panel.²² They claimed that the World Bank is responsible for forceful eviction from their land by PBS-sponsored Ethiopian government officials. The Panel vindicated the Bank of wrongdoing, affirming that the eviction was conducted under a separate government villagization program, which happens to run concurrently with PBS III. The Panel, however, recognized the failure of the program to trigger the Bank's applicable safeguard on protecting the rights of indigenous peoples at the appraisal and during implementation of PBS III.

CONCLUSION

The World Bank monetary and technical assistance to developing countries is of vital importance to economic progress and human development. Yet, respect for fundamental human rights is a necessary condition for development.

Despite a decade of double-digit economic growth, Ethiopia is unable to adequately feed several million of its people. The government's brutal response to citizens' attempt to exercise their civil and political rights often results in destruction of resources and livelihoods, putting social development gains at risk of reversal. PBS was a reaction from the international donor community to prevent such setback in the aftermath of the landmark 2005 national election. A decade later, Ethiopia is currently experiencing similar unrest, which has already claimed hundreds of lives.²³

The World Bank should thoroughly incorporate human rights into its social safeguard mechanisms. Such mechanisms would enable the Bank to assess national laws and policies in terms of the Bank's ability to operate in a manner that is consistent with these universal obligations. For example, the introduction of Civil Society law by the Ethiopian government has not only unduly limited freedom of association but also the integrity of the social accountability mechanisms implemented by PBS.²⁴ Human rights safeguards would have led the Bank to pressure the government to revise such legislation, or discouraged passing it in the first place. If international assistance providers continue to support the Ethiopian government with no mechanism to challenge its human rights records, their actions will contribute to continuing, deepening repression in the country.

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World Bank, Human Rights and Health: A Commentary

Desmond McNeill

The World Bank is reluctant to engage with human rights – generally, and more specifically in relation to health. Why? And what is to be done about it? This commentary summarizes the debate, showing that insiders and critical outsiders largely agree: the answer lies mainly in the instrumentalism of the organization and of economics. A recent Lancet viewpoint sets out how states may reconcile priority setting with the right to health. This commentary proposes that a similar approach may be applied in the World Bank: i.e., to set in motion a deliberative process within the organization to establish principles for ensuring fair allocation of resources devoted to health, derived from the core principles of human rights.

The World Bank (WB) has been criticized for its reluctance to engage with human rights. In this commentary, I shall summarize and assess the debate, first in broad terms and then more specifically in relation to global health.

The WB confronts human rights (HR) issues in a wide range of situations. At one extreme, a WB funded project causes direct and demonstrable harm to an identifiable group. At the other extreme, a policy promoted by the WB causes—or is said to cause—harm to a group; but the group is disparate and the causal chain is far more difficult to establish. An example of the former is of indigenous people that suffer displacement as a result of a new dam directly supported by the WB. An example of the latter is that of people whose livelihoods suffer as a result of a structural adjustment policy mandated by the WB. The differences are not only with regard to how readily identifiable is the affected group, and the clarity of the chain of causation. Importantly, from a human rights perspective, there is the question of whether there is a failure of the duty to respect, protect, or fulfill various human rights.

The WB has not been at the forefront in promoting HR. Instead, it has adopted a rather conservative approach despite external criticisms. But in the 1990s, as the issue of 'good governance' rose on the international agenda, the situation began to change. General Counsel Ibrahim Shihata issued opinions that cracked opened the door to a more positive approach. In 2006, his successor, Roberto Dañino, circulated a legal opinion that was rather radical by WB standards.¹ But when James Wolfensohn was replaced by Paul Wolfowitz, and Roberto Dañino by Ana Palacio, a more restrictive line was adopted. The WB Nordic Trust Fund, concerned specifically with HR, financed work at the WB to be undertaken "under the radar."² And there is some evidence that Jim Kim, elected WB President in 2012, has made a difference. But the organization has continued to be an HR laggard by comparison with other UN agencies.³ The WB acknowledges the significance of human rights in cases such as resettlement projects; but in general their policy is that HR is the responsibility of states, and the WB's task is to be supportive of state efforts.

Why is the WB so reluctant to engage with human rights? To answer this, I draw on three authoritative accounts: a report by the UN Special Rapporteur on Extreme Poverty and Human Rights and two journal articles.

Alston (2015)⁴ identifies six reasons.

1. Institutional culture: functional, technical – staying above the political fray.
2. Misplaced legalism: the Articles of Agreement
3. Cultural relativism: "may be perceived as imposing Western values ..."
4. Shadow of sanctions: "they involve politics rather than economics"

5. Turning the WB into a HR cop: because of sanctions mentality – “a not altogether unfounded fear”
6. Competition with other lenders: putting WB at a disadvantage.

McInerney-Lankford (2009)⁵ identifies four:

1. Legal or mandate constraints: “HR are inherently political, and therefore, outside ...”
2. Political resistance and value-based objections: controversial, divisive potential, including at the level of governing bodies.
3. Disciplines and approaches: “economists, social scientists and sectoral or technical experts” compared with lawyers. Evidence-based compared with normative precepts. Burden on operations.
4. Institutional arrangements reflecting these “cleavages”.

And Sarfaty (2009)⁶ may be summarized as follows:

1. Articles of Agreement
2. Clash of expertise (economists/lawyers, also non-economic social scientists); turf battles
3. “framing HR norms to adapt to the Bank’s culture”.
4. Sharp division within the Board.

In summary, a critical and professionally engaged outsider, a reflective insider, and an independent researcher all largely agree on the diagnosis. What then is the prescription? What is to be done when the legal and moral arguments for HR confront the WB’s reticence and pragmatic, instrumental counter-arguments?

I am not a lawyer, but my impression is that interpretations of international HR law are here not sufficiently unanimous as to require the WB to do much more than at present. As Hammonds and Ooms⁷ point out, however, donor members have state obligations by virtue of being states parties to the International Covenant on Economic, Social and Cultural Rights (ICESCR) (although the United States itself is of course not party). History has shown that the Articles of Agreement can be interpreted with more or less conservatism, depending on the leadership of the President and the Board.

The moral arguments for human rights are strong; but to make a difference, they need to be translated into practice. And it is here that the problem arises, at least for many WB staff, and especially the economics-minded. (While economists may not be in the majority numerically, the economic mindset is dominant). They ask the question: “what would this mean in practice?” Alston offers the following answer, which creates a useful basis for discussion:

Recognition of their (people in extreme poverty) human rights does not guarantee them food, education, or health care, but it does acknowledge their dignity and agency, empower them and their advocates and provide a starting point for a meaningful debate over the allocation of societal resources in contexts in which their interests have been systematically ignored.⁸

Acknowledging the dignity and agency of the very poor is, the WB might claim, what it already does – in the sorts of grand statements that are frequently made.⁹ Empowering those in extreme poverty is a more specific action, and it may well be that the WB could and should do more than it currently does in this respect. But from the perspective of the instrumental economist, perhaps the most significant implication derives from Alston’s

final point concerning the allocation of scarce resources. What might be the outcome of the “meaningful debate” that Alston calls for—in relation to health—with which this commentary is particularly concerned? Could a HR approach have significant implications for such key issues as minimum guaranteed standards of health care and access to medicines? Or is the economist’s ‘trade-off’ mindset incompatible with HR?

The latter view is clearly and emphatically stated by William Easterly, an ex-WB economist, when he refers specifically to the health sector – and to the question of priority setting, which is where utilitarian and pragmatic economists are most clearly at odds with many ethicists. In his article in the *Financial Times* entitled “Human rights are the wrong basis for healthcare,” he cites an evaluation by the WB in 2009 which “faulted the bank for allowing Aids treatment to drive out many other programmes”, arguing that the “right to health” may have cost more lives than it saved. The “‘right to health’ ... skews public resources towards the most politically effective advocates, who will seldom be the neediest.” Instead, Easterly advocates a pragmatic approach, “directing public resources to where they have the most health benefits for a given cost” – in other words, that which is in accordance with a utilitarian philosophy.

This line of argument is rejected in a recent viewpoint in the *Lancet*, co-authored by a group of experts in the philosophy of global health.¹⁰ They recognize that “as countries progress towards UHC (universal health coverage), they are forced to make difficult choices about how to prioritise health issues and expenditure,” but reject the “sceptical position ... that ... priority setting and the right to health are irreconcilable.” They argue that the former should not be simply equated with a “utilitarian drive to maximize health benefits across a given population,” nor the latter seen as “simply the claim that all individuals ought to have access to any medical treatment they might need regardless of cost.” They quote General Comment 14:

With respect to the right to health, equality of access to health care and health services has to be emphasized... Inappropriate health resource allocation can lead to discrimination that may not be overt.

They present three interrelated arguments for their approach, of which I find the second the most compelling: “rights can provide a powerful framework for dealing with issues of discrimination, exclusion and power asymmetries ... Importantly, ‘rights talk’ forces attention on issues of equity. Thus, if priority setters were, misguidedly, to seek only a utilitarian maximization of population health, then rights would provide normative and legal resources for a critique.” The approach they propose for implementation derives precisely from making this “rights talk” effective – by establishing “substantive and procedural principles for ensuring fair allocation of resources devoted to health” that are “decided through a transparent and participatory process.” This implies, if I interpret it correctly, that the utilitarian calculations of the economist, based on “expert knowledge,” would be integrated within a deliberative process based on certain principles of justice, derived from human rights. The most significant outcome of such an approach is likely to be increased equity: the inclusion of, indeed primary focus on, those in greatest need. Such a deliberative process would no doubt be challenging, as it would address highly political issues of distributive justice. The merit would be that these issues were brought out into the open. But it must also be recognized that such processes could also be perverted by powerful forces – just as human rights law has to some extent served those more, rather than less, privileged – as Easterly notes, and Rumbold et al. acknowledge (citing work by Norheim and Wilson in Costa Rica where “more than 70% of the court-mandated provisions concerned medications judged to be of low priority”).

The merit of the Rumbold et al. position is, I believe, that it is grounded in moral philosophy and seeks to be applicable in the real world. But the question remains as to what

distinguishes the WB from its member states: is it more, or less, morally responsible for human rights than they are? I have argued elsewhere,¹¹ building largely on the work of Iris Young (2006), that the moral responsibility of the WB derives from its considerable “response-ability”: in other words, the very power that the WB is able to exercise, by virtue of its financial resources and expertise, means that it is capable of acting to alleviate human suffering to an extent that others are not; this ability in itself imposes a special moral responsibility.¹²

Alston, among many others, has called for a WB policy on human rights. In his view, the use of a legal opinion for dealing with this is “not just an odd choice. It is an inappropriate one.” From the perspective of a political economist like me, the WB’s choice is very understandable; it is a pragmatic response to a politically challenging issue. But could one not expect more?

It is here relevant to quote the WB press release announcing the 2016 new Environmental and Social Framework, which “makes important advances in areas such as transparency, non-discrimination, social inclusion, public participation, and accountability.... The framework helps to ensure social inclusion, and explicitly references human rights in the overarching vision statement.”¹³ Here again, HR are used to relate to the rather specific issue of “protecting people and the environment” in WB-funded investment projects. But the terms used—‘transparency’, ‘non-discrimination’ etc.—are very similar to those of the *Lancet* viewpoint, and HR are explicitly cited.

A bold, and in my view constructive, step would be for the WB to extend such an approach to the organization as a whole, following the approach that the authors of the *Lancet* viewpoint propose to be applied to states; i.e. to set in motion a deliberative process within the WB to establish “principles for ensuring fair allocation of resources devoted to health” – derived from the core principles of human rights.¹⁴

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What Future for Global Health Governance and the Right to Health in the Era of New Generation Trade and Investment Agreements?

Meri Koivusalo and Katrina Perehudoff

New generation trade agreements mark a new era in the contentious relationship between the right to health and global trade objectives. This article delineates three of the unique qualities of new generation agreements and the contemporary challenges they pose to the global governance of health. Specifically, new generation agreements encompass new fields not traditionally included in trade deals, enable forum shopping and alternative governance structures, and legitimize corporations as participants in normative and regulatory processes while condoning a new standard of state accountability to corporations. This article examines opportunities to enhance coherence between human rights and new generation trade agreements. These measures include recognizing and complying with the right to health and human rights law in trade agreements, strengthening the policy space to protect and promote health and human rights considerations in trade and investment negotiations, and establishing a Framework Convention on Global Health as a new reference for rights-based global health governance.

INTRODUCTION

New generation trade agreements mark a new era in the contentious relationship between the right to health and global trade objectives. This article explores how new generation trade agreements have encroached on global governance for health and the potential for the fullest enjoyment of the right to health. This paper also examines whether and how international human rights law and principles can bolster global governance for health in light of the challenges posed by new generation trade agreements. The term “new generation trade agreements” emphasizes their novel and far-reaching focus on issues “beyond-the-border,” including investment protection, and regulatory governance. Recent notable examples are the Trans-Pacific Partnership (TPP) and the Transatlantic Trade and Investment Partnership (TTIP), which are bilateral or plurilateral trade deals that aim to govern not only the trade in goods, but also investment, trade in services, and regulatory cooperation. Although many aspects of new generation trade agreements have long been part of international trade negotiations, new generation deals i) extend deeper into national policies and affect the governance of services, investment, regulatory principles, and cooperation; ii) have more comprehensive coverage, with a push for top-down and opt-out measures with limited exclusions from these arrangements; and iii) include investment arbitration or dispute settlement and oversight on compliance, consequently strengthening their role and relevance in domestic affairs far beyond that of other international agreements.

The authors first show examples where conflicts have historically emerged between trade and health. The second part of this article investigates the meaning and implications of human rights and the right to health obligations of states in the context of global trade. The third section delineates the unique qualities of new generation trade agreements and the contemporary challenges they pose to the global governance of health. The fourth part identifies opportunities for greater coherence between human rights and new generation trade agreements.

GLOBAL HEALTH GOVERNANCE AND TRADE

In contrast to international development and United Nations (UN) agencies, the World Health Organization (WHO) has a stronger normative role and mandate in global health policy making. WHO inherited specific tasks for medicines standardization, epidemic control, and quarantine measures from the League of Nations and the International Office for Public Health.¹ The role of WHO has always been associated with trade policies, albeit in the context of controlling disease transmission.² Additionally, WHO shares with Food and Agriculture Organization (FAO) of the UN the responsibility for standards, guidelines, and codes of practice adopted by the Codex Alimentarius Commission.³

The establishment of the World Trade Organization (WTO) in 1995 raised concerns about the future of WHO's role in global health governance. These concerns were triggered by questions about the legitimacy of public health measures, and by negotiations on services trade and intellectual property rights. One of the most debated WTO agreements in the field of public health has been the Agreement on Sanitary and Phytosanitary Measures (SPS), which addresses how and on what basis governments can regulate public health matters. Another example is the WTO dispute settlement case on asbestos, a known carcinogen, that directly challenged European occupational health regulation and a ban of asbestos on the basis of the WHO International Agency for the Research on Cancer's (IARC) assessment of carcinogenicity.⁴ The Agreement on Technical Barriers to Trade (TBT) has drawn attention to the labeling of products such as tobacco notably through a trade-related dispute on clove cigarettes.⁵ Services negotiations have resulted in fewer dispute settlement cases under WTO than trade in goods; however, the dispute settlement case on gambling shows that trade-related obligations could have consequences for bans on trade in services, which may be interpreted as setting a zero quota, which would be impermissible under market access requirements.⁶

The most controversial WTO agreement influencing global health governance is the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS). Intellectual property (IP) disputes and concerns about access to medicines have shaped WHO's role and position as a global normative actor in pharmaceutical policy. While some WHO member states and nongovernmental organizations sought a stronger role for WHO on access to medicines and regulation, the pharmaceutical industry and sympathetic member states have opposed this change.⁷ Forum shopping, made possible by the International Conference on Harmonization (ICH), is viewed as a means to limit and counteract WHO's role in standard-setting in pharmaceutical policy.⁸

Conflicts between trade and health priorities have come to a head in the field of tobacco policy. In 2001, the WHO Tobacco Free Initiative published a paper on confronting the tobacco epidemic in the era of trade liberalization.⁹ This contributed to negotiations on the WHO Framework Convention on Tobacco Control, which entered into force in 2005. In 2014, investment liberalization and protection became a new concern for tobacco control.¹⁰ Bilateral trade agreements and so called TRIPS-plus requirements have also become reflected as a concern for health policy and debated under WHO Commissions, intergovernmental working groups, and plans of action on public health and intellectual property rights.¹¹

The negotiation of the FCTC forms the hard end of global health law, as it remains the sole convention negotiated under WHO.¹² The International Health Regulations (IHR) are based on Article 21 and represent legally binding regulations. WHO has also actively engaged with trade-related matters in the field of mobility of health care professionals, where a global code of practice has been negotiated on the international recruitment of healthcare personnel.¹³ While WHO codes have weak enforcement mechanisms, the codes remain authoritative recommendations. WHO codes can help governments legitimize their

action in the context of national regulatory measures to protect public health and their position against powerful corporate or foreign state interests.

In global governance and trade, WTO agreements have become the floor when compared to bilateral and plurilateral agreements, such as the Trade in Services Agreement (TiSA). Bilateral agreements and plurilateral agreements have become vehicles to advance trade terms beyond what has been achieved under WTO agreements, with often implicit or explicit aims to eventually take these under the auspices of WTO. New generation trade agreements have gained the most attention in the context of the recent TTIP and TPP negotiations. This article focuses on TTIP and TPP, as the negotiating texts are accessible and likely to be revisited in the future in other agreements, even though negotiations are currently stalled.

The focus on regulatory cooperation and rules is thus likely to challenge *how* future standards and regulation are set, for which purposes, and on what institutional and legal bases. Thus, while new generation trade agreements may “restore” the right to regulate, they may exert influence on the policy space for governments to regulate for health.¹⁴ As discussion has so far been focused on conflicts between trade and national policy priorities, we seek to point out their role not only in shaping national policies, but influencing where and how global health policies and standard-setting takes place. While they do not “oppose” WHO’s constitutional role, they create an alternative, more strongly enforced regime for global governance, which draws from interests of global industries and priorities of global trade and investor interests.

HUMAN RIGHTS LAW AND RIGHTS TO HEALTH

The right to the highest attainable standard of health, first articulated in the WHO Constitution,¹⁵ is now enshrined in multiple UN treaties, among them the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), which is legally binding on the 165 ratifying states.¹⁶ The right to health, together with all human rights, impose specific obligations on governments and bestow universal entitlements on individuals by virtue of their intrinsic worth and human dignity.

The value of international human rights law to global governance is threefold. First, human rights are inclusive, universal, and interdependent in scope,¹⁷ which allows complex systems of global governance to be refocused through the lens of individuals and whether they can enjoy their right to health. Second, international human rights law is a legally binding set of rules to which governments should be held to account. Legal recognition enhances the permanency of rights, and their implementation and enforcement. Third, a rights-based approach, enshrined in human rights law, considers the individual an active member of decision-making processes rather than a passive consumer, which is often the case in a market-oriented paradigm.¹⁸ Individuals are empowered to take an active role in policymaking, implementation, and enforcement in line with human rights principles of non-discrimination, transparency, consultation/participation, monitoring, accountability, and redress.

The scope of human rights obligations vis-a-vis global trade can be distilled from authoritative “general comments” by the Committee on Economic, Social and Cultural Rights (CESCR), a UN body of human rights experts that interprets and clarifies the scope and content of these entitlements.

The notion that trade agreements must be compatible with and not limit the enjoyment of human rights has persisted in the CESCR’s jurisprudence since 1999.¹⁹ For example, bilateral or multi-layer international agreements could harmonize contributory social security schemes for migrant workers, enhancing social protection for this vulnerable group.²⁰ However, this guidance is not necessarily heeded in practice.

States are instructed to ensure that international agreements they enter into do not adversely impact rights, such as to health or to water.²¹ Human rights violations occur when governments fail to account for these rights in trade deals.²² The CESCR specifically cautions that “agreements concerning trade liberalization should not curtail or inhibit a country’s capacity to ensure the full realization of” the rights to water or to social security.²³ The CESCR has additionally established that any higher protection standards in national or international law, such as for intellectual property, must not impede the enjoyment of other human rights without justification, such as the provision of essential medicines as part of the right to health.²⁴

In contrast to traditional IP-focused trade agreements, the novel terms in new generation trade agreements are largely unaddressed by international human rights law. These human rights obligations are legally binding on states and can be enforced through domestic courts, where permitted by law, and recently in an international forum under the Optional Protocol to the ICESCR, which is described in more detail later.

The CESCR also offers guidance for international organizations and their members. Member states must fully consider the rights to water and social security in the organization’s actions.²⁵ The CESCR encourages the incorporation of international human rights law and principles into the workings of international organizations, and effective cooperation between the WTO and states, specifically to implement the right to health and social security.²⁶

NEW GENERATION TRADE AGREEMENTS AND GLOBAL HEALTH GOVERNANCE

Global trade policies are all too often at odds with national public health interests. In trade negotiations, nation states are set against one another to reach an agreement that is perceived to represent a rules-based compromise between a variety of national interests. Yet less attention has been paid to how new generation trade agreements affect the policy space for health at both the global and the national levels. Indeed, common health policy interests are often in conflict with those of commercial policy.²⁷ Furthermore, new generation trade agreements can be seen to serve corporate interests to the detriment of public health regulation.²⁸ In contrast to the more mundane export interest squabbles, health-related concerns are more systemic and globalized, as national governments pursue universal health coverage and the right to health. Furthermore, the control of antimicrobial resistance and the prevention of epidemics increasingly hinges on well-functioning health care systems. Thus, a global perspective on the conflict between trade and health agendas is warranted. Some global and national health policies aim to restrict and limit commercial activities that are related to the manifestation or transmission of disease, such as tobacco control to prevent non-communicable diseases. Public health policy also aims to ensure a high level of health protection, including for access to medicines and occupational health and safety. Thus, new generation trade agreements and their enlarged focus on regulation have implications for the health policy space at national and global levels.²⁹

New generation trade agreements affect global health governance in three ways: i) expanding the reach of trade agreements to new fields not traditionally encompassed by trade deals (e.g., regulatory cooperation and principles, investment protection, services); ii) enabling forum shopping and alternative governance structures (e.g., International Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (ICH), labor, environmental and gender chapters); and iii) legitimizing corporations as participants in normative and regulatory processes while condoning a new standard of state accountability to corporations. The authors will first examine these three aspects before discussing the potential and limits of human rights in this context.

New Generation Trade Agreements as a New Global Constitutional Reference ("Hard Law")

New generation trade agreements establish frameworks to regulate and protect the interests of global industries on one hand and as means to limit national regulatory policy space that could restrict trade on the other. Indeed, it has been claimed that WTO obligations, or "hard law," should trump public health policies even in the case of tobacco and the FCTC.³⁰ However, such claims are highly contested. While the challenges for domestic policies are evident,³¹ there is no reason why this should be the case for global agreements and priorities. However, as long as trade negotiations are held from a commercial—rather than a health—perspective, there will be little to contest. In WHO, the challenge of "stagnation" is reflected in lengthy and arduous World Health Assembly meetings, intergovernmental working groups, and inertia concerning normative global health policy issues, most notably with respect to pharmaceuticals.

Negotiations under the services agenda on the mutual recognition of qualifications, the trade in health services and mobility of patients and health providers, and the portability of social insurance are all likely to affect the governance of health systems. While many countries have opted out of including health services under trade agreements, the negative listing of services commitments (or use of more general obligations covering all sectors in new generation agreements) limits the scope for their exclusion.³² Furthermore, new generation trade agreements do little to address or strengthen global regulatory measures for human trafficking and illegal trade in human organs.³³ New generation trade agreements have emphasized the enforcement of IP rights and action on counterfeited goods, while simultaneously complicating the control of falsified and substandard products.

One aspect of the new "hard law" is related to the legitimacy and the practice of investment arbitration. The globalization of investment protection through new generation trade and investment agreements is perhaps the most important aspect of these agreements. Arbitration cases on tobacco,³⁴ access to medicines,³⁵ and health services³⁶ have already challenged domestic public health regulation. However, the greatest ramification for health policy is anticipated to be the resulting regulatory chill and reluctance of governments to act as a result of the threat of arbitration³⁷.

Enabling Forum Shopping ("Competence and Legitimacy")

As long as trade agreements focus on trade barriers there may be spillover implications. However, regulatory measures or sector-specific chapters in trade agreements transform these deals into alternative forums with far greater implications for global governance.

The ICH is an example of forum shopping enabled through global normative policies.³⁸ While harmonization has its benefits, it can also lead to lower standards when led by commercial—rather than health—priorities³⁹. Furthermore, while the focus of the ICH is currently limited, it has the potential for expanding its relevance in the future. Evidence suggests that enhancement of harmonization has taken place at the expense of safety standards. For example, the ICH management of the regulatory standards for carcinogenicity testing concern reducing the testing requirements, rather than harmonizing inconsistent standards, across regions.⁴⁰ The changing role and legitimacy of the ICH (currently known as International Council for Harmonization) as part of trade policies challenges WHO's role not only as a forum for the harmonization of limited technical standards, but potentially also its role in establishing broader normative guidelines and priorities in pharmaceutical policy. The European Union will likely promote the ICH in trade agreements due to its close links with the European Commission. However, WHO

matters and health-related regulatory policies remain the territory of member states' ministries of health. The European Union proposal and inclusion of ICH in trade agreements as a main reference organization creates an alternative agency comparable with WHO, which has now become the "residual" option. New generation trade agreements define ICH as the primary agency and avenue for harmonization and guidelines, without reference to the focus of these guidelines. For example, EU proposal for TTIP Article 5 of Annex on medicines requires:

3. The Parties *shall implement all ICH and VICH guidelines unless those would be ineffective or inappropriate for the achievement of their legitimate objectives.* Each Party should duly consider, when developing or implementing requirements, guidelines and procedures for the authorisation of medicinal products that are not harmonised by ICH or VICH, the scientific or technical guidelines developed by the other organisations mentioned in Article 4.⁴¹

In the same way, the International Standardization Organization (ISO) has become legitimized as the standard-setting reference agency under WTO agreements, negotiations on new generation trade agreements seek to focus on *how* and *where* technical standards, requirements, and licensing are set for services and establishment. Furthermore, new generation trade agreements expand the roles of technical standards and standardization from matters addressed between industries, to providing less restrictive measures for trade as alternatives to public regulatory measures.⁴²

Another avenue for forum shopping is based on the inclusion of new chapters and clauses addressing social, environmental, labor, and gender issues as part of trade agreements. While this can be seen as means to improve trade policies and enhance the scope for enforcement (e.g., International Labor Organization conventions), it can also be seen as means to i) make trade agreements more socially acceptable, ii) limit ambition, reduce or undermine existing regulations achieved in other fora with focus on basic obligations, and iii) create a process where trade agreements are considered as appropriate forums for regulatory action on all issues.

Legitimizing Corporations as Participants in Normative and Regulatory Processes, and Condoning a New Standard of State Accountability to Corporations for Their Policy Measures

The European Union proposals for regulatory cooperation and principles in TTIP and provisions on regulatory coherence in TPP include, as a starting point, early information and engagement with stakeholders.⁴³ These proposals represent in essence slight modifications to the United States' practices of regulatory impact assessment, stakeholder consultation, and participation in the policy process.⁴⁴ The regulatory impact assessment requirements impose a substantial burden of proof on governments, which are duty-bound to take measures for transparency and stakeholder consultation. This informs stakeholders when, where, and how governments seek to restrict markets or impose regulation early in the policymaking process.

The rules on regulatory cooperation build on the practices of the United States and on initial market access rules that require public policies to show the necessity of the particular measure and that it is the least restrictive on trade and investment. New generation trade agreements essentially shift the burden of proof from corporations to public regulators, as well as make markets the norm – and public services and public regulation the exception. This is reflected also in the chapters on investment and state-owned enterprises for TTIP.⁴⁵

While stakeholder consultation could in theory stimulate public participation in the process of policy-making, stakeholder groups are likely to have very different capacities to participate in global forums. Large coalitions and corporate participation in trade negotiations tend to result in policymaking “stickiness,” with a default preference for less trade restrictive policies. Corporate representatives gain entry to these processes as participants, and they have substantial resources at hand to shape the discussions for their benefit. Industries and their consultancies can easily outspend (directly or indirectly) non-governmental organizations and international agencies participating in the same process. For example, the tobacco industry was excluded from the negotiations of FCTC.⁴⁶ It would be legitimate to question the extent to which corporate stakeholder engagement is geared more toward undermining rather than contributing to regulatory processes.

One view of investment protection is as a government watch-dog – to ensure that new legislative proposals are aligned with key stakeholder interests. While investment agreements do not directly limit the scope of global health governance, they do restrict the policy space at the national level as well as strengthen accountability toward investors in comparison to health policy priorities and public interest. Until now, the focus on investment protection procedures has concentrated on clauses that limit expropriation, yet it is likely that fair and equitable treatment (FET), or minimum standards as it is defined in TPP, will form an equally important avenue for pressure toward governments. Investment arbitration has implications for the role of public health priorities in both national and global governance. In addition to the case of tobacco, increasing concern is cast on pharmaceutical policies and the scope and potential to use compulsory licensing or limit data exclusivity to ensure the affordability of medicines.⁴⁷ This potential has been anticipated in the proposed TPP expropriation clause, which specifically enshrines a public health exception to investment arbitration as follows:

For greater certainty and without limiting the scope of this subparagraph, regulatory actions to protect public health include, among others, such measures with respect to the regulation, pricing and supply of, and reimbursement for, pharmaceuticals (including biological products), diagnostics, vaccines, medical devices, gene therapies and technologies, health-related aids and appliances and blood and blood-related products.⁴⁸

NEW GENERATION TRADE AGREEMENTS AND HUMAN RIGHTS - FRIENDS OR FOES?

The role of human rights as part of trade agreements gained ground in the 1990s and the early 2000s, as human rights compliance was considered in European Union trade agreements.⁴⁹ Human rights and social clauses as part of trade deals have been implemented predominantly in trade agreements with poorer countries.⁵⁰ The role and relevance of human rights is, however, dependent on how they relate to other chapters and to the existing legal framework in countries. Furthermore, the European Union has diluted human rights obligations in the EU-Canada Comprehensive Economic and Trade Agreement (CETA) to the extent that questions have been raised whether the proposed text complied with the EU's policy that all economic agreements must contain a human rights clause.⁵¹ This example raises the question of whether and to what extent new generation trade agreements represent a departure from the EU emphasis on human rights in trade deals. UN Special Rapporteurs on the right to health have drawn attention to specific implications of trade agreements, such as access to health care and medicines.⁵² In this context, attention has been drawn to Article 103 of the Charter of the United Nations, which stipulates that “in the event of conflict between the obligations of the Members of the United Nations under the present Charter and their obligations under any other international agreement, their obligations under the present Charter shall prevail.” Moreover, the Vienna

Convention on the Law of Treaties states that treaties have to be taken into account that apply between countries. In a similar vein, the UN Independent Expert on the promotion of a democratic and equitable international order, Alfred-Maurice de Zayas, has emphasized “the priority of the international human rights regime, including the International Covenants as well as FAO, ILO, UNICEF and WHO conventions over conflicting obligations under trade and investment agreements.”⁵³ His report also changes the perspective from directly addressing conflicts with the right to health of individuals toward the role and capacity of governments to ensure policy space and democratic accountability for realizing human rights.

The approach in new generation trade agreements remains uncharted territory for human rights despite extensive guidance on the contours of human rights obligations by the CESCR. First, authoritative interpretations of the right to health have long held that states are obliged to protect health rights from encroachment by third parties and to take steps to regulate the business environment to support third parties’ discharge of their human rights obligations.⁵⁴ Now, new generation trade agreements tread into these sovereign waters of states and strain their right to regulate, for example to control tobacco consumption or control costs of pharmaceuticals. The most challenging issues for rights articulation arise from government measures, which seek to control costs or limit markets under the notion that human rights obligations could be met by spending more.

Second, corporate actors increasingly infiltrate the trade policy space that has historically, and appropriately, been limited to state-to-state action for negotiation, agreement, implementation, and enforcement. Human rights principles enshrined in international law derive their force on national governments from their legally binding nature and representation as a global consensus of (minimum) moral imperatives.⁵⁵ However, business actors fall outside of the traditional accountability relationship between the state and an individual.

Third, extra-judicial arbitration on matters of national public policy also pose significant challenges to the application and implementation of human rights principles. Extra-judicial arbitration (i.e., ISDS) that minimizes, if not entirely eliminates, transparency, public participation/consultation, and accountability of the proceedings is anathema to a human rights approach. Even when such proceedings are open to consultation with third parties, well-resourced corporate interests may dwarf public interest representatives in number and expertise.

Extra-judicial arbitration serves to assess investment disputes, a method that allows corporations to allege a public policy measure violates their investment rights. Concerns have been raised about the weight, if any, accorded to a state’s human rights obligations when adjudicating these claims. However, the prominent investment dispute filed by cigarette manufacturer Philip Morris against the government of Uruguay’s plain packaging law offers some hope for the salience of human rights in international arbitration. The 2016 decision by the International Centre for Settlement of Investment Disputes affirmed that governments have the discretion to take measures to protect the right to health, thereby establishing an important precedent on human rights over commercial interests.⁵⁶ Yet, the absence of explicit human rights considerations in new generation trade agreements risks offering only muted protection and promotion of human rights out of benevolence rather than legal obligation.

Ultimately, the danger exists that human rights law is under-equipped to address the novel terrain of new generation trade agreements. Because only states, and not corporate actors, are legally bound by international human rights law, authoritative guidance on human rights responsibilities of corporate actors is derived from the consensus document, Guiding Principles on Business and Human Rights (the ‘Ruggie Principles’). The Ruggie Principles were endorsed by the Human Rights Council in 2009.⁵⁷ These novel guidelines reinforce the state duty to protect against human rights abuses by third parties,

including business actors; to establish corporate actors' responsibility to respect human rights; and to advocate for improved access to effective remedies for abuses. However, no forum exists to ensure corporate accountability to and enforcement of these responsibilities.⁵⁸ Without legal recognition and an accountability mechanism, the force of human rights on business actors is significantly diluted when compared to the implications for governments.

In summary, the foci of new generation trade agreements on regulatory measures and investment protection pose new challenges from a human rights perspective. Regulatory measures encroach on states' obligations to regulate to protect the right to health. Corporate actors, who play an increasingly prominent role in new generation agreements, have human rights responsibilities despite scarce opportunities for their enforcement. Investment protection through extra-judicial arbitration sidesteps domestic law and courts, effectively muting any accountability mechanisms or human rights practices built into them. Trade and investment agreements no longer affect only specific policy measures, but now encompass regulatory processes more deeply and broadly to the extent that they can evolve to replace existing institutions and forms of governance.

Human rights law remains under equipped to address the novel terrain of new generation trade agreements in two manners. One, legitimizing corporations as actors dilutes the force of human rights framework, which is weak in addressing matters outside of the state-individual relationship. Two, extra-judicial arbitration on matters of national health policy effectively removes dispute settlement from democratic oversight of the national judiciary or other domestic body and thereby reduces, if not eliminates, important aspects of a human rights approach: transparency, participation, and accountability. Extra-judicial arbitration minimizes attention to the state's human rights obligations toward health and maximizes the focus on state-corporation interaction.

An important tension between human rights and trade rules concerns the degree to which they can be enforced and in which fora. To address these tensions, the right to health needs to have legal implications beyond rights-based approaches to health.⁵⁹ Dispute settlement in WTO and investment arbitration has not been open to human rights arguments. Furthermore, the arbitration process is not open, transparent, or balanced in relation to access to justice. Investment arbitration may also be more about power and accountability than formal judicial measures or access to justice in principle, i.e., the large financial threat of arbitration can in practice be of more concern for policy-makers than a potential violation of human rights obligations without effective sanctions.

HUMAN RIGHTS IN SUPPORT OF GLOBAL GOVERNANCE FOR HEALTH

Despite little consideration for human rights as part of global trade law, human rights do open a potential avenue to address conflicts in global health governance. While new generation agreements and international arbitration may undermine the relevance of human rights obligations, this risk can be mitigated by strengthening the role, interpretation, and position of human rights law in the context of global trade, and specifically within new generation trade agreements and in dispute settlements.

New generation trade and investment agreements, exemplified by the current TPP and TTIP negotiating text, raise concerns for global health governance and the full realization of human rights. The challenge for WHO is one of both governance and existence if trade and investment agreements shape the broader framework for public policies. Possible avenues of action include i) recognizing and complying with the right to health and human rights law in trade agreements;⁶⁰ ii) strengthening the policy space to protect and promote health and human rights considerations in trade and investment negotiations and dispute settlements;⁶¹ and iii) establishing a Framework Convention on Global Health as a new reference for rights-based global health governance.⁶² The Framework Convention on

Global Health⁶³ could bridge a number of health priorities and support a public health approach to a range of issues, from access to and rational use of medicines to sustainable health care financing and the control of antimicrobial resistance.⁶⁴ A Framework Convention on Global Health could also introduce much-needed enforcement mechanisms, solidify the role and responsibilities of non-state actors such as corporations, and adopt a rights-based approach to address the challenges in new generation trade agreements. If an international convention is required to protect the national policy space for health and to promote human rights, then there should be a strong preference to establish it under WHO's auspices. WHO's constitutional obligations and normative track-record on health could form a robust starting point for negotiating such a convention. As a convener, WHO could ensure coherence between the convention and the current normative and regulatory global health policies.

It is likely that none of these measures will alone be sufficient, and thus these initiatives should be seen as complementary measures.

In addition, the ICESCR Optional Protocol offers the potential to address breaches of the right to health that manifest as result of state action in the context of trade agreements. The ICESCR Optional Protocol is a landmark international enforcement mechanism of social rights before a quasi-judicial body that is empowered to make recommendations to ratifying states.

Until now, global governance for health has been insufficiently supported by the restricted scope of human rights in trade agreements. Going forward, building the relationship between the right to health and global governance for health will require further investigation into how regulatory processes relate to human rights and on what basis governments are required to act to honor their human rights obligations. Human rights can be an important trigger for governments to ensure health protection and universal health coverage in the face of new generation trade agreements.

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