

4 The political evolution of health as a human right

Conceptualizing public health under international law, 1940s–1990s

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Cited by health advocates throughout the world, human rights have become a cornerstone of global health governance, foundational to contemporary policy discourses and programmatic interventions (Reubi 2011). Yet human rights are not static concepts. Focused on the politically contingent transformation of human rights, this chapter traces the evolution of health norms as they were developed in human rights under international law and implemented through rights-based global health governance. Contemporary accounts presuppose that public health and human rights always ‘evolved along parallel but distinctly separate tracks’ (Gruskin, Mills and Tarantola 2007: 449), joined for the first time since the advent of the HIV/AIDS pandemic. As this chapter shows, such narratives present an incomplete history of the changing political conceptualizations of human rights for public health. This chapter analyses the contested politics underlying changing conceptions of a human right to health – from the establishment of the World Health Organization through the first decade of the HIV/AIDS pandemic. It assesses the political bases on which health rights have evolved in international law, through the policy documents outlined in Table 4.1, examining how international institutions, national governments and non-governmental organizations have conceptualized human rights law to achieve international health policy.

The foundations of human rights in public health

The international codification of universal human rights for health began in the context of World War Two. With growing calls among the Allied Powers for the creation of a post-War system to protect the individual from state tyranny, US President Franklin Delano Roosevelt announced that the post-war era would be founded on four ‘essential human freedoms’ – freedom of speech, freedom of religion, freedom from fear and freedom from want – with the final of these ‘Four Freedoms,’ freedom from want, heralding a state obligation to provide for the health of its peoples (Roosevelt 1941). Rising out of the war and drawing on the working-class struggles of the late nineteenth and early twentieth centuries, this freedom from want became enshrined in the lexicon of social and economic rights, with the Allied Powers bound together in seeking

Table 4.1 Evolving conceptualization of human rights for public health

<i>Constitution of the World Health Organization (1946)</i>	<i>Universal Declaration of Human Rights (1948)</i>	<i>International Covenant on Economic, Social and Cultural Rights (1966)</i>	<i>Declaration of Alma-Ata (1978)</i>	<i>Global Strategy for the Prevention and Control of AIDS (1987)</i>
<p>Preamble Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic or social condition. Governments have a responsibility for the health of their peoples that can be fulfilled only by the provision of adequate health and social measures</p>	<p>Article 25 (1) Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control</p>	<p>Article 12 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) the provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child (b) the improvement of all aspects of environmental and industrial hygiene (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases (d) the creation of conditions that would assure to all medical service and medical attention in the event of sickness</p>	<p>I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector V. Governments have a responsibility for the health of their people that can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice</p>	<p>Non-discrimination is not only a human rights imperative but also a technically sound strategy for ensuring that infected persons are not driven underground, where they are inaccessible to education programmes and unavailable as credible bearers of AIDS prevention messages for their peers</p>

state obligations that would prevent the deprivation witnessed during the Depression and World War Two (UN Conference on Food and Agriculture 1943).

Developing international human rights law for health through the United Nations (UN), the 1945 UN Charter elevated human rights as one of the principal purposes of the post-war international system, operating through the UN's Economic and Social Council (ECOSOC) to 'make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all' (UN 1945: Preamble). Concurrently elevating health within the UN, state representatives established the World Health Organization (WHO) as the UN's first specialized agency, with the Constitution of the World Health Organization (WHO Constitution) serving as the first international treaty to conceptualize a unique human right to health (Parran 1946).

Advancing human rights to support WHO's authority to coordinate health efforts across nations (International Health Conference 1946), states sought to facilitate international health cooperation, overcoming the political coordination challenges that had limited international health authority under the League of Nations (Borowy 2009). Seen in the preamble of the 1946 WHO Constitution, states framed their post-war health cooperation under the unprecedented declaration, 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being,' defining health positively to include 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity' (WHO 1946). Establishing WHO's authority far beyond that of its institutional predecessors (Masters 1947), WHO's mission was 'extended from the negative aspects of public health – vaccination and other specific means of combating infection – to positive aspects, i.e. the improvement of public health by better food, physical education, medical care, health insurance, etc.' (Stampar 1949). Through a rights-based focus on these underlying determinants of health, states declared in the WHO Constitution that 'governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures' (WHO Constitution 1946).

Forming the political backdrop for the continuing evolution of these health obligations, states developed the 1948 Universal Declaration of Human Rights (UDHR) to proclaim the rights that were intended to bind the post-war world under a set of shared norms (Verdoodt 1964). With the UN advancing this 'common standard of achievement for all peoples and all nations' (UDHR 1948), the UDHR sought to define a comprehensive set of interrelated rights to underlie public health (Jenks 1946). With ECOSOC's Commission on Human Rights requesting that the UN's Division of Human Rights assemble a first draft of the UDHR to be put before the Commission (Alfredsson and Eide 1999), the initial draft for the First Session of the Commission on Human Rights Drafting Committee (the Drafting Committee) contained a wide range of provisions relevant to medical care, public safety, social security, and underlying determinants of health (Morsink 1999). Derived from proposals

developed by US legal scholars (Committee of Advisers on Essential Human Rights 1946), many state delegates on the Drafting Committee were determined to recognize the importance of both ‘medical care’ and ‘public health,’ with preliminary emphasis on draft articles declaring that ‘the state shall promote public health and safety’ (UN ESCOR 1947). Reflecting the states represented in the Commission on Human Rights, this expansive rights-based vision of public health systems (at the national and community level) was presented in language similar to the WHO Constitution and in accordance with (1) the expansion of post-war European welfare policy, founded on the notion that ‘social security cannot be fully developed unless health is cared for along comprehensive lines’ (Beveridge 1942); (2) the early development of health rights in Latin America, encompassing ‘the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care’ (Organization of American States 1948); and (3) the recent amendments to the Soviet Constitution, which established guarantees of medical care and ‘maintenance in old age and also in case of sickness or disability’ (Konstitutsiia SSSR 1936: Art. 120). Taken together, the First Session of the Drafting Committee framed a rights-based vision that reflected the experience of national health systems and recognized the importance of international solidarity in addressing determinants of the public’s health.

However, over the three substantive sessions outlined in Table 4.2, the process of revising the UDHR exposed early divisions that would come to define international health policy during the Cold War.

At the opening of the Second Session of the Drafting Committee, the US representative introduced a completely revised text that focused on social security without any direct mention of health, viewing health as a benefit of work (rather than an independent right) and limiting state obligations only to those unable to secure their own ‘livelihood’ (rather than to all individuals). The representative of the Soviet Union objected vigorously to these US proposals, arguing that they were too vague and insisting on detailed delineations of universal obligations, with the US representative responding that ‘no more detailed wording was practicable as different provisions for the protection of health were established in different countries’ (Alfredsson and Eide 1999). While discussions continued to focus on the importance of underlying determinants of health, the Second Session framed this evolving consensus under the broad umbrella of ‘social security,’ with the adoption of specific protections related to mothers and children.

To delineate the aspects of social security crucial to the realization of human rights, the Third Session of the Drafting Committee reintroduced public health and medicine to the draft UDHR, even as these rights came to be framed under a state obligation to secure the conditions for individual work. With China and the Soviet Union seeking to enumerate the specific rights underlying health through obligations for a comprehensive system of ‘social insurance,’ the Chinese representative argued ‘for the inclusion of a set of rights that had been considered being included in this article from the beginning – namely food,

Table 4.2 Final text from each of the UDHR drafting sessions

Session 1	Session 2	Session 3
<p>Everyone, without distinction of economic and social conditions, has the right to the highest standard of health attainable.</p> <p>The responsibility of the State and community for the health and safety for its people can be fulfilled only by the provision of adequate and social measures.</p>	<p>1. Everyone has the right to social security. The State has a duty to maintain or ensure the maintenance of comprehensive measures for the security of the individual against the consequences of unemployment, disability, old age and all other loss of livelihood for reasons beyond his control.</p> <p>2. Motherhood shall be granted special care and assistance. Children are similarly entitled to special care and assistance.</p>	<p>1. Everyone has the right to a standard of living, including food, clothing, housing and medical care, and to social services, adequate for the health and wellbeing of himself and his family and to security in the event of unemployment, sickness, disability, old age or other lack of livelihood in circumstances beyond his control.</p> <p>2. Mother and child have the right to special care and assistance.</p>

housing, clothing, and medical care’ (UN 1950). Although the United States argued that ‘only the right to housing and medical care should be explicitly stated,’ the US representative came to support the full inclusion of determinants of health, albeit under a state obligation to realize a ‘standard of living,’ with this US agreement obviating the need for any discussion about health rights when the debate moved to the full UN General Assembly (UN 1950).

On 10 December 1948, the General Assembly unanimously (40–0, 2 abstentions) adopted the following text of article 25 of the UDHR:

- (1) Everyone has the right to *a standard of living adequate for the health and well-being* of himself and of his family, including food, clothing, housing and *medical care* and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
- (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

(UDHR 1948: Art. 25(1); emphasis added)

With agreement that human rights for health comprised both the fulfilment of necessary medical care and the realization of underlying determinants of health – explicitly including food, clothing, housing and social services as part of this holistic encapsulation of health determinants – states sought in the ensuing years to translate this declaratory language into binding obligations under international law.

The development of international law for a right to health

As the UN Commission on Human Rights moved to translate the hortatory rights of the UDHR into binding treaties under international law, health rights were transformed through the development of international legal obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR) (Green 1956). However, these processes to codify a human right to health faced conceptual limitations through the political constraints of the Cold War, hobbling efforts to advance public health discourses in human rights law (Tobin 2012).

With the WHO Secretariat initially asserting leadership for developing human rights standards on health, WHO suggested wide-ranging legal language to support the efforts of the Commission on Human Rights in developing an International Covenant on Human Rights. Drawn from the WHO Constitution and language abandoned in the drafting of the UDHR, WHO's expansive proposal for a right to health emphasized: (1) a positive definition of health; (2) the importance of social measures in realizing underlying determinants of health; (3) governmental responsibility for health provision; and (4) the role of public health systems in creating a wide range of measures for what would become 'primary health care' (WHO 1951a). Despite support from European and Latin American states, this WHO proposal was challenged in the Commission on Human Rights, with duelling US and Soviet amendments seeking to eliminate the expansive WHO proposal in its entirety, replacing it with each nation's respective view of health rights (see Table 4.3).

Rather than adopting either of these conflicting amendments – the United States' vague pronouncement of a right without corresponding obligations or the Soviet Union's limited obligations for medical care – states reached a compromise, by which the US proposal was added to the first paragraph of the WHO proposal and the Soviet proposal on medical care was added as an additional obligation on state governments.

By a final vote of 10–0 (8 abstentions) – the abstentions from western states arising in objection to the obligation concerning medical care – the Commission on Human Rights concluded in 1951 with the following draft article for the International Covenant on Human Rights:

The States parties to this Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable. With a view to

Table 4.3 US and Soviet proposals for the right to health

<i>US proposal</i>	<i>USSR proposal</i>
The States Parties to the Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable.	Each State Party hereto undertakes to combat disease and provide conditions that would assure the right of all its nationals to a medical service and medical attention in the event of sickness.

implementing and safeguarding this right, each State party hereto undertakes to provide legislative measures to promote and protect health and in particular:

- 1 to reduce infant mortality and to provide for healthy development of the child;
- 2 to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
- 3 to control epidemic, endemic and other diseases;
- 4 to provide conditions which would assure the right of all its nationals to a medical service and medical attention in the event of sickness.

(Commission on Human Rights 1951)

Providing simultaneously for the general recognition of a right to health in an opening paragraph with an enumeration of state obligations in subsequent paragraphs, the revised draft of the right to health was the most detailed draft among the economic, social and cultural rights, reflecting state obligations to progressively realize a wide range of health determinants (Toebes 1999). While a right to health continued to lack the support of western medical associations, which were lobbying against government 'socialist' control of medical practice (World Medical Association 1951), the WHO Secretariat received support from its Executive Board (over the objections of the US Representative) to take a continuing leadership role in the UN's efforts to develop the legal language of the right to health (WHO 1951b).

With the Cold War superpowers continuing to be divided on the conceptualization of rights in the International Covenant, states were pressed to replace the unified International Covenant on Human Rights with two separate human rights covenants – one on civil and political rights and the other on economic, social and cultural rights (UN General Assembly 1952). Indicative of the political debates of the Cold War, the comprehensive vision of rights laid out by states in the UDHR had unravelled along ideological and economic lines, with the superpowers (and their respective spheres of influence) split on both a belief in the universality of economic and social rights and the feasibility of realizing these rights (Alston 1979). With the United States advocating the advancement of international legal obligations only for civil and political rights (those classic civil liberties already protected by western states' national constitutions), US representatives dismissed 'aspirational' social and economic rights (including a right to health) as a basis for a just world (UN 1952). This unbending international disagreement on the nature of rights and divided UN framework of two covenants notwithstanding, states continued to meet together in the Commission on Human Rights, finalizing the drafting of health obligations for inclusion in what would become the ICESCR.

Although WHO initially sought an expanding role for human rights in addressing underlying determinants of health – working with states to define health comprehensively, in line with the WHO Constitution's proclamation of

health as ‘a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity’ (Commission on Human Rights 1952) – states came to reverse this early expansion of the right to health (Farley 2008). As the Soviet states withdrew temporarily from WHO in the late 1940s and early 1950s, denying socialized medicine a voice in World Health Assembly debates (Manela 2010), an unchallenged American influence (driven by US funding restrictions on the WHO Secretariat and a unified voting bloc of North, Central and South American states) succeeded in constraining WHO’s efforts to advance a human right to health under international law (Goodman 1952). Reflecting a 1953 transition to WHO leadership more conducive to US influence, the WHO Secretariat abandoned its early efforts to develop expansive international legal language for public health – projecting itself as a ‘technical organization’ (Candau 1954), neglecting ‘social questions’ (WHO 1956), and finding legal rights ‘beyond the competence of WHO’ (WHO 1959). This WHO abdication of human rights authority enabled state efforts to weaken human rights norms for health (Meier 2010). Without WHO leadership, UN preparations for finalizing the right to health resurrected political debates on the inclusion of: (1) a definition of health; (2) the idea of ‘social well-being’; and (3) the ‘steps to be taken’ by states (UNGA 1955). Following the six-year effort of the Commission on Human Rights to transform the UDHR into legally binding obligations, the debate then moved to the UN General Assembly to adopt the ICESCR’s conceptualization of a right to health.

Through the 1957 debates of the General Assembly, state challenges to the ICESCR article on the right to health prevailed in eliminating from paragraph one both the definition of health and any reference to ‘social well-being,’ under the contradictory rationales that the definition was either unnecessarily verbose or irreconcilably incomplete. Narrowing state obligations in paragraph two, state challenges also succeeded in substituting ‘the improvement of nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene’ with the less specific ‘improvement of all aspects of environmental and industrial hygiene’ (with this later addition coming through the advocacy of the International Labour Organization) (UNGA 1957). On 30 January 1957, the General Assembly voted in favour of an amended right to health (54–0, with 7 abstentions), with the right to health retaining the following legal language in the years leading up to the 1966 adoption of the ICESCR:

- 1 The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 2 The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;

- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

(UN General Assembly 1966)

With WHO continuing to avoid a rights-based approach to health, as human rights had become a basis for Soviet criticism of capitalist inequalities in health (Evang 1967), the UN's comprehensive 1968 review of human rights efforts included only perfunctory generalities on WHO's role in advancing the right to health – that:

Through its programme of technical assistance, WHO is helping countries achieve the objectives set forth in the preamble to its constitution, and thus the full range of its activities are relevant to human rights by assisting countries to make a reality of their people's right to health.

(UN 1968)

Yet with WHO noting as early as 1968 that 'people are beginning to ask for health, and to regard it as a right,' this calculated neglect of human rights would soon turn to active engagement, returning to the political promise of international human rights as a means to realize international health cooperation (WHO 1968).

The implementation of human rights through primary health care

Concurrent with an expansion of human rights in UN governance in the 1970s (Morgan 2010), the WHO Secretariat came to see human rights principles as a normative foundation on which to frame public health policy, leading to international efforts to implement human rights through 'primary health care' – addressing health care in addition to the underlying social, political, and economic determinants of health (Litsios 1969). Recognizing the limitations of medical care in preventing disease and promoting health (WHO 1973), WHO turned to political efforts to structure national health systems for primary health care (Evang 1973). As developing nations entered the UN system and banded together under the Non-Aligned Movement, this new political force sought to influence the World Health Assembly, bring health policy in line with a New International Economic Order, and shift WHO efforts to support a rights-based approach to equity through primary health care (Chorev 2012). While primary health care had long garnered technical backing within the WHO Secretariat, the ideological support of human rights brought these technical health discourses to the fore of international health debates. With political support from developing states, WHO employed international negotiations, articles, and conferences to conceptualize human rights as a means to realize equity through underlying determinants of health (Mahler 1973).

With a 1973 change in the leadership of the WHO Secretariat, which paralleled developing country pressures to address international health inequities through national health systems, the Secretariat sought to revitalize human rights as a basis for WHO authority, extolling human rights obligations as a clarion call for the advancement of primary health care (Cueto 2004). Reflected in inter-agency studies and international debates, WHO sought to apply human rights frameworks and advocacy to realize underlying determinants of health, looking to a wide range of human rights standards to govern the public health implications of, among other things: human experimentation (WHO 1974); torture (Howard-Jones 1976); gender inequity (Sipilä 1979); and medical education (Torelli 1980).

An expansive concern for the wide range of human rights that underlay health notwithstanding, the WHO Secretariat gave preeminent focus to the human right to health, arguing that 'this provision is of primary importance from WHO's point of view, and the whole body of WHO activities is based on the right and principles contained therein' (WHO 1975). As international consensus developed around the primary health care policies necessary to implement the right to health, such human rights implementation framed a multisectoral approach to 'health in all policies' (Vigne 1979). To establish such rights-based policies, there was growing agreement that WHO had the political authority to coordinate these multisectoral actors in elaborating international legal obligations for underlying determinants of health (Roscam Abbing 1979).

Seeking a human rights framework to address inequities in economic determinants of health, meeting the political expectations of developing member states and placing greater emphasis on international development policies (Pannenberg 1979), scholars and practitioners began to focus on international economic arrangements that would assure 'health for all' (Commission on Human Rights 1973). Advancing economic growth as a means to realize the right to health, WHO focused on social and economic development as integral to public health (Eze 1979). Grounded in the WHO Constitution, subsequent international treaties, and the UN's debate on a human right to development, this socioeconomic approach to health aligned with public health scholarship on underlying determinants of health, provided a basis for incorporating human rights in international health policy, and formed the basis of what WHO officials referred to as 'the onset of the health revolution' (Lambo 1979).

WHO's 'Health for All' strategy provided a framework for its efforts to influence human rights implementation through socioeconomic development, structuring primary health care as a means to address underlying determinants of health. Officially defined by the World Health Assembly in 1977, and widely regarded as WHO's 'main thrust' in implementing human rights for public health (Taylor 1991), the Health for All strategy sought 'the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead socially and economically productive lives' (World Health Assembly 1977). With developing states in the World Health Assembly viewing

the inequitable distribution of resources for health to be a violation of human rights, this WHO strategy examined health within the broader social and economic context of development, finding that '[h]ealth is not a separate entity but an integral part of national development' – a view that led the WHO Secretariat to seek the national and international redistributions that would advance public health (Mahler 1978).

Elevating a rights-based approach to international health policy that had been wanting since the right to health was first proclaimed in the WHO Constitution, WHO and UNICEF convened the International Conference on Primary Health Care in September 1978. Held in Alma-Ata, USSR (now Almaty, Kazakhstan), this Conference brought together public health and development actors to address the policies necessary to realize the health determinants outside the control of the health sector (Mower 1985). Returning to the UDHR's promise of interconnected human rights for public health, WHO conceptualized a multisectoral model for primary health care, seeking social justice in the distribution of health resources. With representatives from 134 state governments, the Conference adopted the Declaration on Primary Health Care (a document that has come to be known as the Declaration of Alma-Ata), through which political representatives detailed the international rights-based consensus that primary health care was the key to advancing public health throughout the world (WHO 1978).

Reaffirming the human rights principles of the WHO Constitution, Article I of the Declaration of Alma-Ata outlined that:

[H]ealth, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

(Ibid)

Delineating the national policies necessary to implement human rights through primary health care, the Declaration of Alma-Ata outlined government obligations to reorient national social and economic development strategies to promote equity in health, laying out specific multisectoral obligations for:

- (1) education concerning prevailing health problems
- (2) promotion of food supply and proper nutrition
- (3) an adequate supply of safe water and basic sanitation
- (4) maternal and child health care, including family planning
- (5) immunization against the major infectious diseases
- (6) prevention and control of locally endemic diseases
- (7) appropriate treatment of common diseases and injuries
- (8) the provision of essential medicines.

(Ibid, § VII)

Intended to guide states in progressively realizing the right to health, the WHO Secretariat supported these national efforts to address underlying determinants of health through technical assistance, analysis, and monitoring, with the World Health Assembly developing formal guidelines for national policy under its 1981 Global Strategy for Health for All by the Year 2000 (WHO 1981).

Through the political advancement of such rights-based obligations, the Declaration of Alma-Ata conceptualized a programmatic vision for implementing human rights in primary health care; however, such obligations to realize distributive justice never took hold in national health policy (Taylor 1992). While this international health policy initially found support from the developed states (Bourne 1978), the rise of neoliberal economics – and with it, reflexive government opposition to health spending – closed any opportunity for WHO to advance primary health care (Chorev 2012). Developed states came to resist WHO's focus on primary health care, opposing the economic redistribution demands of developing states and scaling back international support for health policy under the mantle of 'Selective Primary Health Care' (through a narrower focus on growth-monitoring, oral rehydration, breastfeeding, and immunization) (Cueto 2004). Yet even as states stepped back from implementing human rights through expansive obligations for primary health care (WHO 1983), such rights-based standards endured in the politics of health policy, reconceptualized through a rights-based approach to public health in the international response to HIV/AIDS.

The operationalization of human rights in the public health response to HIV/AIDS

Despite a lack of political support for primary health care, human rights remained applicable to the advancement of public health, even as this implementation shifted from national health systems to individual health needs. WHO programme staff continued to refer to the normative standards of human rights throughout the early 1980s (Gunn 1983), and as a result, the Secretariat was politically poised to operationalize a rights-based approach to health with the advent of the HIV/AIDS pandemic. As developed states reduced their budgetary support for WHO primary health care programmes (Dietrich 1988), these same states increased their 'extrabudgetary' support for WHO's efforts to prevent and control the spread of the pandemic in the decade following the first reported case of AIDS (Vaughan *et al.* 1996). With these prevention efforts grounded in individual autonomy for health, WHO's rights-based approach to AIDS found support among transnational networks of non-governmental advocates, working closely with the WHO Secretariat to understand the risks for transmission, educate the public on prevention, and slow the spread of HIV.

The HIV/AIDS pandemic transformed human rights for global health as non-governmental advocates looked explicitly to these rights in framing health policy. With governments responding to the emergent threat of AIDS through traditional public health policies – including compulsory testing, named

reporting, travel restrictions, and coercive isolation or quarantine – human rights were seen as a reaction to intrusive public health infringements on individual liberty and a bond among HIV-positive activists (Bayer 1991). Facilitated by academic discourse in Europe and the United States, advocates in the gay community and among people living with AIDS conceptualized human rights claims in opposition to restrictive public health measures (Mann and Carballo 1989). Where national legislation restricted the freedoms of these vocal minorities, human rights advocacy served to protect the vulnerable (Gruskin and Tarantola 2005). With improved understanding of heterosexual transmission and developing country prevalence, the rapid identification of a generalized pandemic created a pressing imperative for disease prevention and control through rights-based policy (WHO 1985). Supporting community-based advocacy in responding to this new threat, individual rights-based freedoms buttressed international health rights, framing social approaches to addressing underlying determinants of health.

In this period of burgeoning fear and advocacy, the establishment of WHO's Global Programme on AIDS (GPA) marked a turning point in the operationalization of individual human rights in public health policy – viewing discrimination as counterproductive to public health goals, abandoning coercive tools of public health, and applying human rights to focus on the individual behaviours leading to HIV transmission (Fee and Parry 2008). By focusing on underlying social determinants of HIV risk, human rights could play a supportive role in the public health response, as human rights violations were understood to be a key driver in the spread of the disease (Mann 1987a). The 1985 creation of WHO's Special Programme on AIDS – renamed and expanded in 1986 into the GPA – operationalized human rights in WHO programming through strategies to combat HIV discrimination, promote social equity, and encourage individual responsibility (Meier, Brugh and Halima 2012). Without medical treatment or biomedical prevention, the GPA sought to address social behaviours, with the promotion of human rights linked to the protection of public health (Mann and Kay 1991). Although human rights scholarship had long recognized the infringement of individual rights as permissible – even necessary – to protect the public's health, the GPA saw the respect of individual rights as a precondition for the public's health in the context of HIV prevention and control (Fee and Parry 2008). Quickly expanding within the WHO Secretariat, GPA staff, made up of the first epidemiologists to study HIV, recognized that discrimination had limited the public health response. They sought to develop a rights-based approach, providing the health education and supportive environment for individuals to take responsibility for changing their behaviours and thereby reduce their risk of infection (Mann 1987b). Memorializing this public health consensus to prevent HIV-related discrimination, the 1987 publication of 'Social Aspects of AIDS Prevention and Control' proclaimed that the HIV positive 'should remain integrated within society to the maximum possible extent and be helped to assume responsibility for preventing HIV transmission to others' (WHO 1987a). Emblematic of a tightening political relationship

between WHO and non-governmental organizations to advance human rights, the GPA sought repeatedly to 'bring together the various organizations, particularly those organizations of the UN system and related organizations involved in human rights to discuss the relationship between AIDS, discrimination, and human rights' (WHO 1987b). With the GPA linking human rights organizations with HIV/AIDS advocates, this non-governmental interaction led to a deepening of human rights assessments of HIV prevention and control efforts – within the UN and across national governments (Mann and Kay 1991).

Tying together the efforts of international institutions, national governments, and non-governmental organizations under a universal framework for action, WHO's 1987 Global Strategy for the Prevention and Control of AIDS (Global Strategy) conceptualized universal human rights principles to prevent HIV transmission and reduce the impact of the pandemic (WHO 1987c). The Global Strategy focused on principles of non-discrimination and equitable access to care, stressing the need for public health programmes to respect and protect human rights as a means to achieve the individual behaviour change necessary to reduce HIV transmission. By leveraging behavioural science to develop HIV prevention campaigns, the Global Strategy emphasized rights-based access to information, education, and services as a means to support personal responsibility among vulnerable individuals (Mann 1987a). Through this Global Strategy, human rights framed the international HIV/AIDS response, with the Global Strategy serving as a normative basis for the development of international guidelines, national policies and non-governmental action.

From non-governmental advocacy to international health policy, the states of the World Health Assembly unanimously endorsed the Global Strategy as a political framework for 'urgent and vigorous globally directed action' to address HIV/AIDS (World Health Assembly 1987). Taking up this call for action in the UN General Assembly, UN delegates debated issues of infectious disease for the first time, with presentations from both the WHO Director-General and GPA Director conceptualizing HIV prevention and control as a human rights imperative (Mann 1987c). Confirming the role of interconnected human rights in speaking to intersectoral determinants of HIV, the UN General Assembly resolved 'to ensure ... a coordinated response by the United Nations system to the AIDS pandemic,' directing all UN agencies to assist in WHO's efforts (UN General Assembly 1987). With WHO continuing to draw on political collaborations with non-governmental advocates, the GPA sought to develop international guidelines to discourage national policies that infringed on human rights, including international travel restrictions (WHO 1987d), mandatory HIV testing (WHO 1987e) and HIV-based employment discrimination (WHO 1988b). In upholding WHO's rights-based authority, the World Health Assembly reaffirmed in May 1988 that 'respect for human rights and dignity of HIV-infected people, people with AIDS and members of population groups is vital to the success of national AIDS prevention and control programs and of the global strategy' (World Health Assembly 1988). Providing global leadership under the World Health Assembly's directive 'to issue guidance on

the prevention and control of AIDS on a continuing basis,' the WHO Secretariat worked with international, national, and non-governmental stakeholders to develop evidence-based guidelines to ensure global collaboration against this unprecedented threat (Mann and Tarantola 1998).

To support national HIV/AIDS policy, WHO operationalized universal rights-based frameworks to coordinate national plans, prevention programmes, and resource mobilization for HIV (Gruskin *et al.* 2007), bridging non-governmental organizations and national governments in developing health legislation, training programme staff, and coordinating international donors (Mann and Kay 1991). Despite tensions between WHO staff and national ministries, with national governments often hesitant to report AIDS cases, WHO's GPA persevered in working with the vast majority of states to support the adoption of national policies based on rights-based principles of dignity, equality, and non-discrimination. Complemented by financial support to build governmental capacity and non-governmental involvement, these policy reforms overcame the iniquitous legislation that had limited individual rights, promoting rights to realize disease prevention goals (Gostin 2004). Creating a dialogue by which states could share rights-based practices, WHO brought together representatives from 148 nations in 1988 for a World Summit of Ministers of Health on Programmes for AIDS Prevention (WHO 1988a). The resulting London Declaration on AIDS Prevention encapsulated a rights-based political consensus to catalyze national policy, with WHO authority supporting international coordination and cooperation in the design, implementation, and monitoring and assessment of these national HIV/AIDS programmes (Mann and Kay 1991).

In this effort and in the years to come, evolving conceptions of human rights continued to frame policy for the prevention, treatment, and care of HIV. Although a shift in the WHO leadership diminished the Secretariat's ability to promote a rights-based approach to health – leading the director of the GPA to resign in protest, stymieing WHO authority for furthering human rights, and leaving WHO's entire AIDS programming in a state of disarray (Garrett 1994) – this focus on a rights-based approach to health persisted (Gruskin *et al.* 2007). Even as WHO lost programmatic authority for HIV/AIDS, overtaken by the 1994 establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the human rights framing of public health continued through this transition and remains to the present day – galvanizing political attention to create a human rights basis for global health.

Conclusion

As various actors have taken up human rights as a basis for health policy, they have conceptualized human rights in new and different ways to meet their political needs. This unsteady evolution – throughout the foundation, development, implementation and operationalization of human rights – has highlighted the politically contingent nature of the human rights imperative in public health. With international institutions, national governments and non-governmental

organizations continuing to reconceptualize human rights for global health, human rights have been extended over a wide range of communicable and non-communicable disease threats, transforming human rights to set universal norms for social, political and economic determinants of health. To ensure that these human rights efforts continue to frame public health under international law, it will be necessary to understand the role of politics in conceptualizing rights to realize the highest attainable standard of health.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CIOMS	Council for International Organizations of the Medical Sciences
ECOSOC	UN Economic and Social Council
GPA	World Health Organization's Global Programme on AIDS
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social, and Cultural Rights
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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