Human Rights Mainstreaming in the World Health Organization: A Comparative Study of Regional Offices

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I. Introduction

In 1997, United Nations (UN) Secretary-General Kofi Annan mandated the full mainstreaming of human rights into all of the organization’s principal activities and programs as a “cross-cutting” approach. This call spurred the development of an increasingly shared understanding of human rights among UN agencies including within the World Health Organization (WHO). While WHO played an early leadership role in the development of international legal obligations, the agency abandoned rights-based approaches to health for much of its history.

Only recently is the organization returning to human rights and attempting a more systematic mainstreaming of health-related rights. In this effort, WHO refers to human rights standards drawn from international and regional human rights treaties, court decisions, and the general comments and recommendations issued by UN human rights treaty-monitoring bodies. Under a human rights-based approach, these sources and the human rights principles contained therein should structure WHO policy recommendations and form legal platforms for action that address global health challenges (WHO, 2013). Indeed, it is only through the ‘deliberate infusion’ of human rights into all activities and organs that organizations may successfully mainstream human rights (Oberleitner, 2007).

In the development of a rights-based approach to global health governance, WHO has looked to human rights under international law as a basis for public health. The UN Committee on Economic, Social and Cultural Rights (CESCR) is the global authority in developing human rights, including the human right to health. Through lengthy
explanatory processes such as the development of “General Comments,” CESCR has international legal authority to interpret state obligations pursuant to the right to health. While in recent years WHO language appears committed to mainstreaming international human rights legal instruments as developed by the CESCR and other UN bodies, the organization continues to struggle to move from rhetoric to reality and realize its constitutional mandate to ensure “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” Despite recognized faltering progress towards an effective human rights policy, WHO increasingly articulates rights as being central to its operations and mandate. This struggle is starkly reflected in the uneven progress in realizing a human rights-based approach within the agency itself.

Since 1997, WHO has faced obstacles in efforts to mainstream human rights across the WHO Secretariat and in each of its six regional offices: Africa, the Americas, South-East Asia, Europe, the Eastern Mediterranean and the Western Pacific. Without centralized human rights leadership in an increasingly fragmented global health policy landscape, regional health offices have sought individually to advance human rights in health governance and support states in realizing a rights-based approach to health, aided by a large degree of organizational autonomy uncommon within the UN system. The success of these efforts is uncertain and unequal with some regional offices (e.g. the Pan-American Health Organization) recognized for human rights leadership and others falling to the wayside. Current scholarship on human rights and WHO revolves around the agency’s Secretariat and criticisms of its tenuous and uncertain commitment to a human rights-based approach. Scholars have yet to focus on the important dynamics present
within the agency’s regional health governance bodies as they negotiate human rights landscapes largely independent of Geneva. This begs the question: To what extent has human rights rhetoric been translated into rights-based structures, policies and programs in each of the agency’s regional offices?

**Research Questions:**

1. How has each of the six WHO regional offices integrated human rights into their structure, policies and programs?

2. What factors and processes drive and impede the implementation of human rights mainstreaming within WHO regional offices?
II. Literature Review

*The World Health Organization and its Regional Offices*

The World Health Organization, as part of the newly ascendant United Nations system, emerged from the ashes of the Second World War as a response to the recognition that global leadership to protect individual freedoms from the tyranny of the state was desperately needed. In the post-war negotiations that established the United Nations, the topic of international health cooperation came to the fore (Meier, 2009, p. 8). A series of international conferences, unprecedented cooperation among states, and a provision in the nascent United Nation’s Charter led to the thematic outline that would give rise to WHO. As scholars from the period note, “the moment had clearly arrived for the creation of a single world-wide inter-governmental organization for health which would embrace all the activities and functions of the past, the present and the future” (N. M. Goodman, 1952, p. 153). After much political maneuvering, WHO was created on April 7, 1948 with Geneva, Switzerland designated as the agency’s global headquarters. From its inception, WHO was intended to be an autonomous organization free from the politics that hamstrung its predecessor, the Health Office of the League of Nations. Despite original aspirations to institutional independence, external political forces quickly and permanently shaped the agency’s organizational structure, health equity mandate, and implementation of human rights for health (Meier, 2009, p. 204).

As a specialized agency of the United Nations, WHO is not a supra-national ministry of health but rather a “world-wide co-operative” that promotes the attainment of
the highest standard of health. WHO constitutional language lays the groundwork for the agency “to act as the directing and coordinating authority on international health work.” Moving beyond merely preventing the spread of disease, scholars have noted negotiators intended to empower the agency to realize the underlying determinants of health through policy leadership, technical assistance, and the establishment of the individual’s human right to health (Meier & Onzivi, 2014). In working towards this aim, the agency is composed of three principle organs: the World Health Assembly, a legislative body made up of representatives from each member state; the Executive Board, a technical subset of the Assembly; and, the Secretariat, which includes the Director General’s Office. Additionally, the agency contains several specialty units (HIV/AIDS, Policy and Emergencies, Family, Women’s and Children’s Health) and six Regional Offices, each of which has its own Regional Director and several sub-units contained therein.

Throughout the negotiations that created WHO, the need for specialized Regional Offices was affirmed. However, a complex and fragmented pre-war global health landscape complicated their foundation. The agency’s constitution allows Regional Offices to be created *ex nihilo* or, much more controversially, through the integration of preexisting regional bodies. Article 44 of the WHO Constitution provides for the creation of new regional organizations, “The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such an area.” Additionally, Art. 54 establishes the terms under which existing international health governance structures can be incorporated into WHO, stating, “The Pan American Sanitation Organization [present-day PAHO] … and all other inter-governmental regional health organizations in
existence… shall in due course be integrated with the Organization.”

Designating regional arrangements proved the most controversial of any topic discussed at the First World Health Assembly—the venue for member states to negotiate the terms of WHO organizational structure. The United States, for instance, was reluctant to allow the Pan-American Sanitation Bureau (PASB)—headquartered in Washington, D.C. and the primary vehicle for American health diplomacy in the Americas—to be absorbed entirely by the nascent WHO (N. M. Goodman, 1952). Nevertheless, after much debate and strong support from other governments in the Americas, it was agreed that PASB would continue its separate existence with eventual progressive integration into WHO (N. M. Goodman, 1952). This unique dynamic set the stage for modern organizational hierarchies and relationships within WHO. Even today, Regional Offices effectively operate as inter-governmental organizations unto themselves with a considerable level of autonomy.

The extensive decentralization of authority from the Director General’s office to Regional Offices is unique among UN agencies (Hyde, 1953, p. 602). Scholars have noted that devolution of responsibility to Regional Offices occurred largely as an attempt by member states to weaken Geneva’s policymaking apparatus. Indeed, the difficulty of maintaining uniform policies within the decentralized system of WHO was widely recognized by both national delegations and secretariat members (Calderwood, 1963). From the human rights perspective, Meier (2009) is clear that, “these Regional Offices, beholden to national agendas, [confounded] the development of global health governance for the right to health” (Meier, 2009, p. 219). Despite this, the final establishment and
details of regionalization occurred in 1951 with the emergence of six distinct WHO Regional Offices—Southeast Asia, Eastern Mediterranean, Western Pacific, the Americas, Africa, and Europe. As predicted, the WHO Secretariat gradually relinquished authority to these regional authorities with scholars commenting that this “converted [the Secretariat] into advisers without power of decision” (Berkov, 1957, p. 104). Indeed, Regional Office autonomy in many policy-making areas combined with shifting regional political priorities has stymied attempts at global WHO leadership on a variety of levels, including in human rights.

**Understanding Human Rights within WHO**

Broadly speaking, human rights are moral norms that the international community articulates through the development of legal standards that impose responsibilities on state and non-state actors to respect, protect, and fulfill entitlements (Mann et al., 1994). However, the term is contentious, often used in unspecific ways, and is increasingly interpreted as a means of justifying any moral or value-based agenda. Throughout this study, the concept of “human rights” will be referred to regularly and it is worth clarifying how the term will be used.

On one hand, international human rights are simply what international instruments say they are. Global bodies have created an ever increasing number of instruments that delineate various rights and member states are free to sign onto these or not at they wish. Understandably, this approach creates problems on a number of levels as the main human rights documents are only guidelines, many are contradictory, and their meaningful ‘enforcement’ remains elusive. Further, what is considered to be a
human right depends on an individual’s philosophical, political and religious orientation and is highly contextual. Beyond this, the human rights positions that some academics, politicians, non-governmental organizations, and laypeople vocalize and defend as entitlements are often perspectives that few would agree upon. Scholars have noted that this dynamic weakens and demeans the entire concept of human rights and that a global understanding of human rights should instead be emphasized (Oestreich, 2007, p. 20). It is not the intention of this study to add to the confusion with yet another definition. Instead, emphasis will be placed initially on how WHO itself understands and articulates human rights. After further analysis and data collection, that emphasis will shift to identifying how WHO Regional Offices themselves understand and use human rights.

Academics have disagreed on the content and parameters of the human right to health, the human right most important to WHO. At various times, thinkers have proposed, among others, a right to health care, a right to the underlying determinants of health, a right to health status, and a right to human flourishing as the strongest approach to guaranteeing health as a human right (Lakin, 2001). However, the WHO Constitution clearly begins by defining health as “a state of complete physical, mental and social well-being” (WHO, 1946). This is often interpreted as the most authoritative starting point for the human right to health. Article 25 of the Universal Declaration of Human Rights (UDHR) elaborates on the right and Article 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR) formally codifies it. Echoing the WHO Constitution, the human right to health is proclaimed as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” The right to health is also recognized in other treaties that seek to establish prohibitions against

The International Covenant on Economic, Social and Cultural Rights (ICESCR)

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 which would assure to all medical service and medical attention in the event of sickness.

Most recently, the Committee on Economic, Social and Cultural Rights, the UN treaty body responsible for implementing, interpreting and monitoring ICESCR, published General Comment 14. The statement is extensive and intended to fully demarcate the content to the international right to health. It enshrines a clear recognition of the importance of the right to health, stating:

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.”

Clearly influenced by the WHO Constitution, the Committee broadens the definition provided by the first paragraph of Article 12 and ensures that the right to health not be

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confined to the right to health care and that it encompasses the socio-economic
determinants that affect the ability of people to lead healthy lives. Importantly, General
Comment 14 references the work and influence of WHO, even reaffirming that the
agency take due account of the right to health in its programs and leadership. Lakin
(2001) interprets the many references as evidence that “the Committee considers a close
working relationship with the WHO to be a necessary component of monitoring and
developing the right to health.”

The placement and role of human rights in WHO, then, is influenced by a far-
reaching mandate present in the agency’s constitution and normative developments in
human rights treaties such as General Comment 14. While both present challenges to
WHO human rights leadership, it is the mandate and its enormous scope that scholars
contend muddies how human rights are understood within the agency. Oestreich (2007)
ponders the significance of human rights for WHO policy: “Given that health itself is a
human right according to the WHO Constitution, and that health includes social,
psychological, and physical factors, what does a rights approach add to what WHO is
already doing?” As a response, Paul Hunt, UN special rapporteur on the right to health,
advises: “Because there is overlap between human rights targets and socio-economic
progress, there is likely to be a resemblance between human rights indicators and the
standard indicators of socio-economic progress” (Hunt, 2003). In short, Hunt explains
that WHO promotion of health in developing contexts and the actual implementation of
the right to health are likely to manifest in similar ways. The flexibility of the WHO
Constitution lends credence to this viewpoint. Certainly, legal scholars interpret
constitutive treaties as dynamic ‘living instruments’ interpreted in accordance with the
evolving demands of organizations (Alvarez, 2001, pp. 104–110). This perspective coupled with the broad mandate of the WHO Constitution offers considerable latitude to the agency in deciding what constitutes its human rights-based approach.

The agency’s complex and nuanced relationship with human rights has provoked scholarship and a healthy share of criticism. Lakin (2001) notes that WHO’s first activities were to provide scientific and technical advice with little heed paid to the right to health and other rights. She critiques a perceived lack of a discernible strategy to bolster agency programs that goes beyond a pervading desire to avoid politically controversial subjects. More generally, WHO has not sought to influence the normative development of the right to health and the agency “has given minimal support to the various human rights treaty bodies” (Lakin, 2001, p. 137). Other scholars, too, sharply criticize WHO for ignoring international law as a means of advancing its constitutional mandate (Aginam, 2005). Meier (2009) carefully traces the underlying public health discourses that led to the development and evolution of the right to health in WHO through analyses of historical political, legal, and medical discourses. He concludes that WHO faced limitations in translating public health discourse into human rights law and vice versa, which vitiated the agency’s ability to develop and implement human rights in a meaningful way.

Critically, despite early WHO support for advancing a human rights basis for its public health work after the creation of the UDHR, the agency “intentionally neglected human rights discourse during crucial years in the development of the right to health, projecting itself as a technical organization above legal rights” (Meier, 2009, p. 3).
Human rights were seen as introducing distracting politics into objective health discourse. Building on these ideas, Meier (2010) argues that WHO’s historical lack of interest in harnessing international law for global health translates to particular disinterest in adopting a human rights-based approach to public health (Meier, 2010).

Other perspectives focus less on the agency’s historical failures and more on future opportunities for and challenges to human rights promotion. Scholars note that neo-liberalist health reforms in the global South, trade liberalization and limited technical capacity in WHO Regional Offices pose continued challenges to WHO human rights leadership (Onzivu, 2011). Despite these limitations, evolving mechanisms offer opportunities for WHO to better promote human rights. Hope for these efforts may be drawn from WHO successes at meeting challenges in other realms, such as the fight against smallpox, polio, tetanus, and other ailments (Onzivu, 2011). Beyond this, it is important to recognize that WHO recognizes and formally articulates how global health policies and programs impact the enjoyment of human rights, linking rights abuses to poor health outcomes (WHO, 2002). Some evidence points to renewed enthusiasm at the global and regional levels to strengthen the human rights unit and collaborate within the United Nations system, especially with the Office of the High Commissioner for Human Rights (WHO & OHCHR, 2008).

However, it should be noted that little scholarship exists on analyzing the varied approaches to human rights that exist within WHO. The paucity of analysis exists despite the recognition of recent scholarship showing a renewed WHO interest in promoting human rights as a cross-cutting issue and the potential for a human rights framework to
address criticisms of WHO’s governance of global health challenges (Onzivu, 2011, pp. 227–228). While the actions of the WHO Secretariat and the agency’s poor historical track record have provoked analysis, intra-agency understandings of human rights remain poorly understood. As mentioned previously, the organizational hierarchy of WHO facilitates a large degree of autonomy for Regional Offices, allowing the bodies to act as independent global health actors in many settings. Recent literature has only begun to delve into the subject. Meier and Onzivu (2014) highlight the creation of human rights officer positions in each regional secretariat and note the disparity in human rights success among regions, but do not offer much analysis of the factors that underpin achievement.

At the cutting edge, Meier and Ayala (2014) analyze regional health governance for human rights using documentary analysis and qualitative interviews to assess rights-based approaches within the Pan-American Health Organization (PAHO), the WHO Regional Office for the Americas. They generalize their conclusions to identify several “institutional determinants” of successful mainstreaming of human rights into regional health governance structures. Their meticulous analyses of these structural factors catalyze rights-based approaches in PAHO concludes by stating that the study offers “lessons to other WHO regions in efforts to mainstream human rights” (Meier & Ayala, 2014, p. 371). However, if those lessons are to ever meaningfully be applied, similar understandings should be cultivated from each of the remaining five Regional Offices and the specifics of a ‘human rights-based approach’ must be made clear.
Mainstreaming Human Rights and a ‘Human Rights-Based Approach’

Kofi Annan’s 1997 call for all UN agencies to adopt a ‘cross-cutting’ approach to human rights was a departure from the 1945 model where UN bodies developed specialized and independent understandings of human rights. Instead, Annan offered a universal mainstreaming approach common to all UN agencies irrespective of technical specialization (Oberleitner, 2008). Though, while Annan sought to cultivate a singular understanding of mainstreaming, its substantive definition remains contentious. Broadly speaking, mainstreaming human rights within an organization refers to the ‘deliberate infusion’ of human rights into all activities, organs, and policies (Oberleitner, 2007). Drawing on understandings solicited from all UN agencies, UNESCO defines this human rights-based approach instead as “… the formulation of goals and implementation processes in human rights terms” (Frankovits, 2006). More explicitly, the Office of the High Commissioner for Human Rights understands “the process of human development…” to be “… normatively based on international human rights standards and operationally directed to promoting and protecting human rights” (United Nations, 2006). The U.K.-based Overseas Development Institute refers to a rights-based approach to development in aspirational terms, where mainstreaming “sets the achievement of human rights as an objective of development” (Maxwell, 1999). Others have gone a step further to contextualize a ‘rights-based approach’ as one that “seeks social change, not mere service provision” (Oestreich, 2007, p. 39). Most scholars, however, agree that at its most basic, a human rights-based approach explicitly follows human rights and accepts legal obligations grounded in human rights treaties (Hamm, 2001).
While the intent of human rights mainstreaming is easily expressed, the process itself is widely misunderstood and lacks procedural clarity, even amongst technocrats. Often, opposing or competing understandings of human rights complicate how organizations implement rights-based approaches. Scholars note that successful implementation is determined by whether human rights are incorporated as a comprehensive legal framework that delineates entitlements, duties, and responsibilities or simply as an additional variable introduced to preexisting policies and programs (Oberleitner, 2008). It is clear that moving beyond ‘do good, feel good’ rhetorical exercises requires meeting the “far-reaching legal and practical implications” of human rights mainstreaming (Oberleitner, 2007, p. 105). From a practical perspective, mainstreaming human rights is a demanding process—requiring training staff, remapping bureaucratic systems, changing mindsets, acquiring human rights expertise in implementation, monitoring and evaluation programs, and much more.

As Oberleitner (2007, 106) notes, human rights mainstreaming follows a winding road, challenged by a variety of institutional factors, including: “the great range of actors in the UN system; uncertainties on how to integrate legal norms into policy- and program-type activities; little understanding of the implications of human rights law; and doubts about the precise aim of mainstreaming.” Drawing on the experience of UNFPA, Frankovits (2006) offers a list of persistent challenges that face organizations attempting to mainstream human rights within programs and policies. Factors of particular import include: the perception by staff that the process of mainstreaming is merely a fad imposed by headquarters; the lack of understanding of international human rights law and the definition of a human rights-based approach; the rejection of certain rights by
communities focused on traditions and cultural practices that run contrary to human rights norms; the belief by technical staff that mainstreaming will not prove more effective than established practices; the lack of NGO partners and affiliates with adequate human rights experience; and much more.

Two recent works offer the most compelling scholarship on human rights mainstreaming within inter-governmental organizations (IGOs) like WHO. Oestreich’s 2007 *Power and Principle: Human Rights Programming in International Organizations* describes how three UN-related IGOs mainstreamed human rights. Through a small-N comparative case study, Oestreich compares the efforts of the United Nations Children’s Fund (UNICEF), the World Bank, and WHO. Although limited by a small sample size, the study hypothesizes factors that contribute to the adoption of human rights by IGOs commensurate with theoretical models: agency independence, external learning and the influence of epistemic communities of professionals, organizational interests vis-à-vis stakeholder desires, and the power of principles ideas.

In his analysis of WHO, Oestreich focuses on consistent environmental pressure and the departure of ‘true believeers’ including the late Jonathan Mann, a physician of considerable repute in the early fight against HIV/AIDS and an administrator for WHO, as factors that debilitated the rights agenda at WHO (Oestreich, 2007, p. 118). Tracing WHO history, he identifies several other factors that impede human rights mainstreaming, including: ostensible tensions between human rights and public health; the failure of the Alma-Ata Declaration; faltering senior leadership; and internal pressure from technical staff who argue that human rights frameworks hamper the ability of WHO
to cooperate with states by politically charging the agency’s work. According to Oestreich, “the most striking lesson of the current state of human rights within WHO might be the clear need for leadership at the top of the organization to bring about effective change” (Oestreich, 2007, p. 155). Despite noting the central importance of leadership, Oestreich fails to comment on WHO Regional Offices and the ways in which Regional Directors independently advance human rights-based agendas. In such a thorough case study, this is a major shortcoming.

Similarly, Oberleitner (2007)’s book *Global Human Rights Institutions* provides a cursory analysis of human rights mainstreaming in several IGOs, including WHO. The author focuses on the gap between WHO rhetoric and reality. While lauding recent action on human rights, including greater cooperation with the UN Special Rapporteur on the Right to Health, the appointment of human rights advisors, and a new health and human rights focused publication series, the author concludes that transitioning from rhetoric to reality will require the joint cooperation of member states and the agency’s leadership (Oberleitner, 2007, p. 127). Once again, the study overlooks the successes and failures encountered by WHO regional health governance structures. Indeed, a scholarly analysis comprehensive of the Regional Offices would offer a more interesting, complete and nuanced perspective on human rights mainstreaming in WHO and other IGOs.

Not only is targeted scholarship on human rights mainstreaming within WHO Regional Offices sorely needed, but so too are multi- and inter-disciplinary approaches that allow for the emergence of new paradigms on organizational change. Analyses of Regional Offices with their intersecting layers of history, politics, and varying
organizational structures are the ideal medium to stretch the boundaries of knowledge and contribute meaningfully to an evolving field in which much has yet to be explored.

III. Methods

I. Research Objective

The goal of the study is to ask questions and draw conclusions of theoretical interest for purposes of explanation. Accordingly, a focus is placed on identifying variables with some leverage for policymakers to enable them to influence future regional health governance outcomes. I employ a qualitative approach grounded in both documentary analysis and semi-structured stakeholder interviews.

II. Research Design

The study uses a qualitative multiple case-study design that allows for structured, focused comparison between WHO regional offices through holistic, single-unit analysis (Yin, 2014, p. 50). The study design meets the burden for Lijphart’s definition of an inductive case study, whereby new variables and causal mechanisms are inductively identified (Lijphart, 1975). To reiterate, this study will address two primary research questions:

1. How has each of the six WHO regional offices integrated human rights into their structure, policies and programs?

2. What factors and processes drive or impede the implementation of human rights
mainstreaming within WHO regional offices?

Analysis of germane documents from or about each regional office primarily informs the first research question. Semi-structured interviews with key human rights stakeholders in each office setting lend clarity to both the first and second line of investigation. Categories and dimensions of inquiry were drawn from the theoretical framework, previous literature and the research problem. Within each case, the results of the document analysis and semi-structured interviews lead to the development of intra-case themes presented in the form of a new theoretical framework. Compared across cases, the dimensions of inquiry and emergent theories will inform the comparative case method as a whole. Analyses incorporate replication, not sampling logic, with data collection tools designed to arrive at conclusions of theoretical interest (Yin, 2014, p. 57).

III. Research Methods and Data Sources

A) The Comparative Case Method

The comparative case method is ideal for assessing the process of human rights mainstreaming in the six differentiated but similar contexts of WHO regional offices. Case studies, as a research strategy, focus on understanding the dynamics present within single settings (Eisenhardt, 1989). Multiple case studies allow for the amalgamation of these dynamics to search for cross-case patterns. The methodology lends itself well to theory development, allowing researchers to achieve high conceptual validity and identify the measures that best represent the theoretical concepts in question, heuristically isolate new variables and hypotheses, understand the operation of causal mechanisms,
and increase capacity for understanding causal complexity (George & Bennett, 2005, p. 75).

For the purposes of this study, the “population” is the six WHO regional offices (Southeast Asia, Eastern Mediterranean, Western Pacific, the Americas, Africa, and Europe or SEARO, EMRO, WPRO, PAHO, AFRO, EURO). The study sought to select a sample of regional offices based on theoretical, not statistical, significance (Eisenhardt, 1989, p. 537). As Pettigrew (1988) noted, given a limitation on the number of cases that can be studied, it is important to select cases in which the process of interest is “transparently observable.” Several obstacles in scheduling and availability of key informants within WHO Regional Offices also contributed to the selection strategy. Working closely with Dr. Benjamin Mason Meier, the research team leveraged professional and personal contacts to secure key informants from three offices: PAHO, AFRO, and SEARO. These three offices make up the three primary case studies under evaluation.

B) Document Analysis

This study understands documents to be “… the umbrella term to refer to a wide range of written, visual, digital and physical material relevant to the study at hand” (Merriam, 2009, p. 139). WHO documents were mostly in the public domain and included — external and internal communications, memoranda, policy statements, meeting minutes, and other media.
Documents were gleaned from the Internet, WHO online cataloguing services, and through key-informants who often had access to internal documents or grey literature. Additionally, the researcher collaborated with WHO librarians in Geneva, Switzerland and Brazzaville, Republic of the Congo to locate and analyze older (non-digitized) data. Advisor Benjamin Mason Meier’s personal contacts working at the intersection of health and human rights in WHO settings were also particularly helpful in providing guidance.

Merriam notes that “using documentary data is not much different from using interviews or observations” (Merriam, 2009, p. 150). Data collection remains guided by the same theoretical framework and I took to heart the recommendation to “keep an open mind” and “[be] open to any possibility [for] serendipitous discovery.” Regardless of its origin, all data was adequately authenticated through cross-referencing different catalogues and online databases. Through the development of organizational matrices, I contextualized information and developed theoretical chain of events underlying the decision-making processes regarding human rights mainstreaming in each regional office.

Yin (2014) recommends researchers establish narrative compilations—or databases consisting of bibliographies, cross-references, or other classifications to assist in the classification of material. The research established a narrative compilation for each case, culminating in the formation of case-specific chains of evidence (Yin, 2014, p. 126). In this spirit, following verification, documents were catalogued by institutional determinant, research significance and origin using the software Mendeley. Through
structured use of tags, key words and basic database management, a revolving personal database of material was formed, facilitating thematic analysis.

**C) Semi-structured interviews**

Best practices for conducting interviews will be adapted from Merriam’s (2009) *Qualitative Research: A Guide to Design and Implementation* in which she highlights important interview techniques, including detail on asking good questions, establishing rapport and neutrality, and developing effective key-informant guides. Great care was taken to identify the complexities in the interaction between interviewer and respondent. This ensured a more informed analysis of interview data.

Semi-structured interviews were held over the telephone and over Skype with WHO staff in roles related to human rights mainstreaming to collect qualitative data on the factors and processes that drive human rights promotion in each office. Occupying a middle ground between rigidly structured interviews inappropriate for this type of qualitative inquiry and unstructured interviews, the format allowed for flexibility in exploring the complex nuances of human rights promotion in WHO regional offices (Merriam, 2009, p. 91). An emphasis was placed on exploring ideas as they arose, leading to discussions guided by the results of the document analysis and theoretical framework (Merriam, 2009, p. 89).

Recorded using QuickTimePlayer and uploaded to a DropBox shared with Dr. Benjamin Mason Meier, interviews ranged from a minimum of 50 minutes to a maximum of 90 minutes. Follow-up questions and requests for documentation mentioned during
interviews was conducted via e-mail. A general key-informant guide was developed in conjunction with the theoretical framework and then adjusted slightly to fit the parameters of each regional office.

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<tr>
<th>Name</th>
<th>Position</th>
<th>Office</th>
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<tbody>
<tr>
<td>Mr. Javier Vasquez</td>
<td>Human Rights Advisor</td>
<td>PAHO</td>
</tr>
<tr>
<td>Mr. Davison Munodawafa</td>
<td>Acting Focal Point</td>
<td>AFRO</td>
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<tr>
<td>Ms. Benedicte Briot</td>
<td>Human Rights Advisor</td>
<td>SEARO</td>
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**Ethical Considerations**

Previous scholarship has noted strong ethical concerns about case study research whereby unethical case writers are able to selectively portray data to specific ends (Merriam, 2009, p. 52). Therefore, it is imperative that the researcher be aware of biases that may skew the final presentation of data. This speaks to a broader responsibility of researchers to faithfully and objectively place data in context and make truthful and earnest conclusions. In the context of this study, I sought to structure interview tools and analyze data in an ethical manner consistent with University best practices. Harkening to the words of Stake (2005), I took to heart the notion that, “Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict” (Stake, 2005, p. 459).
It is important to predict the unanticipated effects of interviewing in particular and ensure respondents feel respected and comfortable (Merriam, 2009, p. 231). In the context of this study, I took care to not overlay my personal feelings about the human issues possibly at stake (Merriam, 2009, p. 231). Additionally, the future dissemination of this research will take place within the context of previously agreed upon parameters.

Ensuring that strict ethical guidelines frame scholarship is a critical component of certifying the trustworthiness of the study. To contribute valuable information to the field that is believable and truthful, I sought to ensure internal validity through triangulation, checking interviewees, and clarifying research biases and assumptions (Merriam, 2009, p. 234). As Merriam (2009) notes, “The best a researcher can do is to be conscious of the ethical issues that pervade the research process and to examine his or her own philosophical orientation vis-à-vis these issues.”

**Instruments:**

The primary interview guide (Merriam, 2009; Yow, 1994) consisted of 10 questions (**Appendix A**), and was based partly on prior literature (especially Meier & Ayala, 2014, Oberleitner, 2008, and Oestretich 2007). For each individual case study, questions were adapted for context. However, the spirit behind questions across cases remained similar to facilitate cross-case analyses.

The study addressed the following topics:

- Background on human rights mainstreaming in the regional context;
- Regional technical staff capacity building;
• Regional office leadership support for human rights;

• Regional legislative body support for human rights;

• Influence of Member States;

• Relationship between human rights unit and regional human rights bodies;

• Relationship with civil society organizations;

• Importance of technical (legal) expertise;

• Relationship with WHO HQ;

• Defining human rights success.

Appendix C presents a more detailed matrix that contrasts the questions asked across regions.
IV. Findings:

Factors & Related Literature Review:

In seeking to isolate the institutional determinants that influence the implementation of human rights in regional health governance, this study refers to the most recent literature on the subject. In particular, reference is made to Meier & Ayala's 2014 analysis of the Pan American Health Organization and subsequent review of the structural factors leading to the Bureau’s application of human rights. The study yielded four factors that the authors hypothesized as generalizable to other global health institutions implementing rights-based agendas:

a) Human rights leadership;
b) State support for human rights;
c) Legal expertise;
d) Technical unit commitment;

After careful consideration and analyses of more recent data from PAHO and the inclusion of data from two additional WHO regional office settings, the institutional determinants and subsequent theoretical frameworks have shifted. While the contexts that gave rise to the changes will be explored later within the case studies, it is important to note that the institutional determinants have become:

a) Human rights leadership;
b) State support for human rights;
c) Human rights expertise;
d) Technical unit commitment;
e) Staff perception and understanding of human rights;
Table 1: Definitions of institutional determinants of human rights mainstreaming in regional health governance

<table>
<thead>
<tr>
<th>Determinant:</th>
<th>Definition:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Human rights leadership</td>
<td>Positive action taken by executive leadership to wield structural influence in order to promote human rights.</td>
</tr>
<tr>
<td>B. State support for human rights</td>
<td>Member state willingness to pursue opportunities to establish human rights within organizations, e.g. advancing rights-based normative legislation in regional organizations.</td>
</tr>
<tr>
<td>C. Human rights expertise</td>
<td>Institutional and staff capacity to meaningfully apply rights-based approaches and understand the linkages between health and human rights.</td>
</tr>
<tr>
<td>D. Technical unit commitment</td>
<td>Technical team support for human rights and understanding of the programmatic advantages of human rights law to technical programs.</td>
</tr>
<tr>
<td>E. Staff perception and understanding of human rights</td>
<td>Employee understanding of human rights in relation to the organization’s mission, culture and values.</td>
</tr>
</tbody>
</table>

To better explain these determinants and their implications, this study refers to prior literature to contextualize data and situate findings within a broader narrative on global health governance.

**Human rights leadership**

Robert Cox’s essay on the ‘executive head’ is one of the most cited understandings of leadership within international organizations. In underlining the importance of leadership, Cox is clear: “the quality of leadership may prove to be the most critical single determinant of the growth in scope and authority in an international organization.” Within the context of international organizations, executive leadership can create new consensus among stakeholders and levy both formal and informal powers to shift institutional frameworks (Cox, 1969). Acting as a bridge, these executive
influencers can shift dialogue within organizations. Leadership has become a central explanatory factor for organizational change, especially in breaking new ground on human rights within the United Nations system,

Within the UN system, Secretariat leadership has long been viewed as a key factor influencing organizational promotion of human rights best exemplified over the term of UN High Commissioner for Human Rights Mary Robinson from 1997 to 2002 (Robinson, 2006). Robinson refocused the position from administration to advocacy, realigning the global human rights agenda to carry out Kofi Annan’s mainstreaming mandate. However, leadership from the top is not only a form of “norms entrepreneurship,” whereby a small group of committed individuals work to introduce new organizational platforms, but also a valuable mechanism of structural influence (Kamradt-Scott, 2004). Thoughtful leadership can introduce long term strategies and build new organizational cultures, even at the expense of short-run political capital (Zaleznik, 2008). Leveraging these many facets, the varied supports provided by organizational leadership allows human rights to flourish even within technically focused organizations such as WHO (Meier & Ayala, 2014).

The relationship between the WHO Secretariat and leadership reveals several issues facing international institutions and the place of leadership in particular. WHO operates within a complex international system replete with a Rolodex of influential stakeholders including private and public financiers, bickering member states, and a continually narrowing political operating space. The executive head—at both the Secretariat and regional levels—must build support within the international bureaucracy,
bolster member state institutional confidence, and forge alliances (Harman, 2011). Success in these areas builds legitimacy. Legitimacy empowers executive leadership to set agendas and influence strategy and direction. These contributing factors to leadership were critical in ensuring the successes and failures of previous WHO Secretariat-level efforts to advance rights-based health reforms (Meier, 2013).

Similarly, within WHO regional offices, the support of the local executive head—the Regional Director—provides a crucial platform from which to advance rights-based agendas. Indeed, “the most striking lesson of the current state of human rights within WHO might be the clear need for leadership at the top of the organization to bring about effective change” (Oestreich, 2007, p. 155).

**State support for human rights:**

In international organizations where states wield decision-making authority, divisions over the issue of human rights can halt progress on advancing rights-based agendas (Sarfaty, 2009). For instance, despite widely acknowledged commonalities between the Millennium Development Goals and human rights commitments, UN Member States effectively separated these themes to serve their political interests (Alston, 2005). Conversely, in environments where states apply rights-based approaches in national contexts—such as through a constitutional codification of the right to health—they will exert pressure on regional organizations to reflect these values (Meier & Ayala, 2014). State support within organizations advancing contentious norms is understood as “simultaneously the most powerful and the least dependable aspect” (Sikkink, 1993, p. 423). Therefore, in many ways, human rights success at the organization level hinges on
engaging states and winning their support.

This ties in to emerging ideas where intergovernmental organizations are seen to serve as venues for interstate socialization. State participation in forums that promote human rights can have dramatic and positive effects on states’ human rights practices (Greenhill, 2010). In fact, in multilateral environments that promote interaction between governments, states copy and learn from forms of behavior exhibited by other. States may therefore come to respect human rights as the consequence of a “logic of appropriateness” model, rather than one based on “logic of consequences” (March & Olsen, 2004). Thus, compliance with human rights becomes the norm, and not merely an attempt to appease the most powerful states in the system.

These tendencies underscore the importance of state human rights ‘champions’ operating at the regional level for human rights successes. Within WHO, scholars have identified that transitioning from rhetoric to reality for human rights requires the joint cooperation of member states and the agency’s leadership (Oberleitner, 2007).

**Human Rights Expertise:**

Human rights expertise in regional global health governance is a key institutional determinant of success in human rights promotion. Previous literature on rights-based approaches has identified legal expertise as a key component therein (Meier & Ayala, 2014). However, this study generalizes that metric to isolate both a legal and a non-legal dimension.
Legal component:

Over the past several decades, there has been increased activity around formalizing human rights and legalizing their presence internationally and within international institutions more generally (Jinks, 2002). When legal scholars discuss legalization, they often refer to the notion used within international relations literature. Namely, that legalization pertains to a type of institutionalization characterized by three components; obligation, precision, and delegation (Abbott, Keohane, Moravcsik, Slaughter, & Snidal, 2000). By the same reckoning, legalization describes “a particular set of characteristics that institutions may (or may not) possess.” However, more recently, scholars have reimagined this understanding in the context of international organizations. Specifically, a more precise understanding of legalization focuses on the extent to which norms are perceived as having a “legal” status, often in relation to existing legal systems such as the international human rights regime (Sarfaty, 2009).

For WHO and its regional offices, the benefits of legalization include bolstering the credibility of normative commitments, increasing compliance with international norms, and providing a highly rationalized method of resolving interpretive disagreements and incongruities (Jinks, 2002). However, the increased legalization of human rights within the UN system must be met with increased legal capacity in the settings required to translate legal norms into policies and programs. Legal expertise, therefore, provides a path through which human rights move from rhetoric to implementation (Meier & Ayala, 2014).
Organizations that do not invest in legal capacity have been perceived as less effective at implementing human rights law (Oestreich, 2007, pp. 46–48). Scholars have pointed specifically to legal expertise as an essential component of aligning organizational policies with human rights mainstreaming (Oberleitner, 2007). Lawyers and legal staff are essential in translating human rights law into rights-based policies, especially with recent trends towards institutional contexts with higher degrees of legalization (Taylor, 1992). Conversely, in international organizations where lawyers are not empowered to work on issues of human rights, outcomes are seen to suffer (Sarfaty, 2009). In the context of regional global health governance, human rights success means building staff capacity to translate public health standards into public policy, and institutionalizing rights-based legislation.

That said, human rights are not merely legal concepts, although this framing has been effective in the context of other technical international institutions (Sarfaty, 2009). In critiquing “entirely law-dependent views of human rights,” Amartya Sen also emphasizes the normative and ethical dimensions instead (Amartya Sen, 2001). These secondary dimensions are of primary importance in understanding non-legal dimensions of human rights expertise.

Non-legal component:

In addition to legal expertise, other efforts to capacitate non-experts are successful in engraining complex understandings of human rights. Human rights education, for instance, can change even entrenched mindsets and change working behaviors (Lohrenscheit, 2002). Education can focus on the moral and ethical dimensions of
promoting rights that often resonate more deeply than discussions based on legal standards (Flowers, 2000). Further, educational and training activities are easily adapted to local and organizational contexts, providing entry points for deeper learning congruent with preexisting frameworks of analysis (Tibbitts, 2002). While often admonished as an exercises in futility, simply raising awareness about human rights where understanding is lacking is associated with an increased willingness to engage on rights issues and change organizational cultures (Mihr, 2009). Training, education and capacity building is nevertheless an effective means of improving human rights expertise.

Within international organizations, human rights capacity building has led to variety of positive outcomes for both participants and the organization. For instance, scholars have linked rights-based trainings at both the global and country level to improved human rights outcomes (Nelson & Dorsey, 2003). Within the context of WHO, capacitating staff in children’s rights has been particularly successful. Through an integrative approach that translates human rights principles such as accountability, universality, indivisibility, and nondiscrimination into training courses and learning modules, staff perception of rights has improved (Türmen, Troedsson, & Stahlhöfer, 2001). These trainings have increased awareness at all levels of the organization, including within regional offices. Post training surveys demonstrated an increased comfort with human rights and understanding of how to apply a human rights-based perspective to health programs for children (Türmen et al., 2001). The trainings also galvanized human rights activity at a regional level. For instance, staff within the South-East Asian regional office have developed a comprehensive, region-specific advocacy document on children’s rights. The regional office for the Eastern Mediterranean
prepared national workshops in Lebanon and Morocco following a regional training on children’s rights.

**Technical unit commitment:**

The support of technical unit and teams within organizations is viewed as essential to human rights mainstreaming (Meier & Ayala, 2014). Large international organizations with technically focused sub-units often internalize—or mainstream—norms in different ways. For instance, different UN agencies responded to calls from the Secretary Gender to mainstream gender throughout the organization differently. Agencies with a “natural alliance” between their mandate or scope of work and the directive (e.g. UN-Women) adapt more quickly and are more likely to contribute to organization-level promotion efforts (Charlesworth, 2005). “Internalization” refers to the acceptance of a norm by actors within the organization who are persuaded of its merits and validity through such processes as social learning, framing, and deliberation. Goodman and Jinks refer to these mechanisms as persuasion. They distinguish persuasion from coercion and acculturation, which entail the adoption of norms without belief in their content, and as a result of social and cognitive pressures (R. Goodman & Jinks, 2004). Especially in environments where member states are unlikely to advance rights-based agendas, the role of internal advocates such as technical units in introducing sensitive topics like human rights on their own becomes more important (Sarfaty, 2009).
Staff perception and understanding of human rights:

Working at the individual level, small groups of people or individuals within organizations working together are able to affect, change and realign institutional norms. When new norms are introduced into an organization, their ultimate adoption depends largely on their fit with the preexisting institutional culture. In international technical organizations such as WHO and World Bank, employees from different professional groups often have distinct interpretive frames that they use to define the norm, analyze its relevance to the organization’s mission, and then apply it in practice (Sarfaty, 2009). For effective internalization and eventual adoption, staff must adapt norms to existing organizational values and practice—that is, they must “vernaculize” norms (Sarfaty, 2009). Conversely, staff can obstruct mainstreaming efforts by declining to participate in human rights programs they do not feel align with their technical training (Oestreich, 2007).

At the individual level, “true believers” are able to support organizational efforts at reform and build coalitions to overcome internal obstacles to human rights (Oestreich, 2007). The quintessential example is the late Jonathan Mann, a physician of considerable repute in the early fight against HIV/AIDS and an administrator for WHO. He is credited with helping to bring about an human rights paradigm shift, seeking to change elements of WHO bureaucracy that stymied rights promotion (Mann et al., 1994). Successful transformation, then, is made viable not only through “the extent to which organizational forms are participatory, but also whether changes in legal and regulatory contexts empower organizational members” (Aldrich & Ruef, 2014, p. 33).
Kamradt-Scott (2004) theorizes about norms entrepreneurship within WHO. Specifically, he explores how a small group of committed individuals within WHO introduced a new norm in global communicable disease control. Accessing “norm life cycle” theory, Kamradt-Scott traces how norms emergence through entrepreneurs and organizational platforms that push a norm over a tipping point whereby the new norm is accepted. In order for norms to gain traction within a broader context, they must be adopted by certain “critical states” who become de facto norm leaders (Finnemore & Sikkink, 1998, p. 901). Other stages in the process include the norms cascade, where governments adopt norms without external pressure, and the internalization of norms whereby its acceptance becomes unconscious (Kamradt-Scott, 2004). In the WHO context, leadership from the Director General and Secretariat effectively negotiated resistance, existing organizational culture, and bureaucracy to bring about norm change on a global level. The success of these norms entrepreneurs in changing WHO perspectives on communicable disease control has clear ramifications for how the agency and its Regional offices adopt and articulate rights-based approaches.
Table 2: Institutional determinants of human rights within PAHO

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Key findings</th>
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</table>
| A. Human rights leadership   | • Director’s Office supported the early adoption of a human rights advisor and several expansions of the rights agenda within PAHO  
• RD often expends political capital to overcome Member State resistance in pursuit of rights-based normative advances (e.g. 2012 LGBT Health Resolution)  
• Secretariat leadership is viewed as “essential” in affording human rights legitimacy within the Bureau. |
| B. State support             | • American states express health related rights in national policy debates and frequently advance these same norms regionally  
• Member States facilitate rather than hinder regional health and human rights advancements (e.g. 2010 HHR Resolution) |
| C. Human rights expertise    | • Legal expertise is emphasized, allowing for the effective translation of human rights law into policymaking, consultations with governments, and interfacing with IACHR and UN system.  
• PAHO develops staff capacity through mandatory health and human educational modules. |
| D. Technical unit commitment | • Technical teams interpret human rights within their own program areas and independently press governments to adopt reform (e.g. Mental Health where human rights advocacy restructured psychiatric care throughout the Americas)  
• Units instrumental in the Bureau’s “horizontal” mainstreaming approach, where building technical unit capacity leads to regional norms changes (e.g. Adolescent and Youth Strategy) |
| E. Staff perception          | • PAHO staff understand the need for rights-based policies and programs and work individually to fulfill their obligations. |
I. History and Origin of the Pan American Health Organization, WHO’s Regional Office for the Americas

The Americas is an anomaly among WHO Regional Offices, serving as both the health agency for the Organization of American States (OAS) and, after the founding of WHO following the Second World War, the WHO Regional Office for the Americas as the Pan-American Health Organization (PAHO). The Regional Office is also the oldest permanent international health body in the world. First established in December 1902 as the Pan American Sanitary Bureau (PASB), the agency sought to control communicable diseases, coordinate quarantine regulations across the Americas, and ensure the health security of regional trade to ensure the free flow of goods and services. Headquartered in Washington, D.C., the Bureau advanced health regulations to protect public health, forming the basis for future international action in this area (Cueto, 2007).

Staffed primarily by professionals from the U.S. Public Health Service, the Bureau’s mandate would continue to expand in the years prior to the Second World War guided by the Pan American Sanitary Code (ratified in all member states by 1936). Early partnerships with the Rockefeller Foundation and other regional organizations spurred public health innovation and knowledge creation (Fedunkiw, 2007). During these early years, Member State political and financial support bolstered the Bureau’s efforts to prevent the spread of disease. However, the Bureau’s structure and mandate would shift dramatically following the establishment of the United Nations and the WHO, the UN’s first specialized agency. Following the 1946 International Health Conference and establishment of the WHO Secretariat in Geneva, attention turned to the question of the Americas.
While other WHO regions lacked autonomous regional health structures, PASB was well established, well funded and well entrenched in the region’s geopolitical makeup (Calderwood, 1963). Pressure from the United States and the PASB Director led to arrangement unique to the Americas; states in the Hemisphere would contribute to both WHO and PASB (Hyde, 1951). This set the stage for continued independence and, in 1958, the Bureau took up a new name: the Pan American Health Organization. Serving a dual mandate as both the WHO Regional Office for the Americas and the specialized health agency of the OAS, these unique historical circumstances would allow the Office to independently advance rights-based approaches to health. Representing 35 member states (not including two observer states, four associate members and three participating states), PAHO brings together every country in North and South America. Headquartered in Washington, D.C.

II. Health, Human Rights and the Development of PAHO Governance

Human rights within PAHO are grounded in a history unique to the region. The 1947 Pan American Sanitary Conference articulated a regional understanding of health as a human right. Building off the 1946 WHO Constitution, PAHO sought: “to make a reality of the right of citizens to the preservation of health, the treatment of illness, rehabilitation, and to other economic subsidies in time of major want or inability” (Pan American Sanitary Conference, 1947). Alongside other regional normative human rights developments put forth by the OAS, the Hemisphere quickly developed a rights-based
imperative for public health.\(^2\) This grounding forms the basis for past and present PAHO human rights activity.

However, most regional bodies reflect the value sets and objectives of their Member States and the Regional Office for the Americas is no exception. In this regard, the incorporation of human rights into regional health governance was influenced by the promulgation of human rights as a cultural norm throughout the Western Hemisphere (Meier, 2009). Despite the linguistic, cultural and institutional diversity of the region, nations of the Americas have commonly prioritized health rights and developed explicit legal and implementation measures to guarantee these rights nationally (PAHO, n.d.-c). Interestingly, the ideals of social medicine, which include a focus on the social determinants of health, found an early purchase in the region. Influencing healthcare delivery models across the Americas, social medicine values shaped industrial, housing, and economic reforms (Allende, 2006). PAHO encouraged these developments, urging regional governments to address social inequalities and examine health from the perspective of development (\textit{Pan American Sanitary Conference}, 1947). Most importantly for the purposes of this study, the Bureau capitalized on this momentum. Emphasizing the clear links between social medicine, inequality and the human right to health in policymaking, a distinct American rights-based narrative began to emerge.

Regional dynamics played a marked role in the rapidity with which regional governments accessed health related human rights. As an example, Argentina amended its constitution the year following the establishment of the Universal Declaration of

\(^2\) See: The 1978 American Convention on Human Rights and 1988 Protocol of San Salvador, which included specific protections under economic, social and cultural rights for “the right to health”
Human Rights to include social obligations on the right to health (Von Bogdandy, MacGregor, & Antoniazzi, 2010). Other states in Latin America and the Caribbean followed suit and the right to health is now formally enshrined in the constitutions of a majority of PAHO member states (Leary, 1994). Advancing human rights priorities nationally, states in the Americas increasingly began to evaluate PAHO governance as an opportunity to reflect these rights-based social values at a regional level.

Throughout the course of the 20th century, PAHO regional leadership was firm: in the Americas, health is regarded as a right. This recognition and the influence of rights developments in national contexts drove discussion on how to incorporate human rights standards and instruments to the Bureau’s technical projects. Writing in a 1973 Special Issue of *World Health*, PAHO’s Director opened the issue by arguing:

“We regard [health] as a goal for each person and as a means to achieve collective well-being. This enormous conceptual evolution—a reflection of scientific achievements and of the work of men, women, institutions, and governments—gives due priority to our plans, whose ultimate aim is making health a right and duty of all, not a privilege of some” (Horwitz, n.d.)

However, despite taking a clear stance on health and human rights, these words would prove largely empty. PAHO took little interest in the 1978 Declaration of Alma-Ata and regional leadership failed to articulate regional public health objectives in a manner congruent with human rights (Meier, 2009).

However, the emergence of the HIV/AIDS crisis in the 1980s would change this perspective and usher in a new era of PAHO human rights leadership. Motivated by the emergence of Jonathan Mann as a WHO visionary merging public health practice with
the operationalization of individual rights, PAHO adopted a rights-based approach to the crisis in partnership with the WHO Secretariat, PAHO country offices and civil society organizations (Connor, 1989). These efforts would make up the bedrock for future rights-based practice. Technical units within PAHO accessed human rights law to reform national health systems, especially around issues of mental health (Meier & Ayala, 2014). In this way, human rights were incorporated “horizontally,” with technical unit practice motivating regional leadership action. Convening a diverse set of stakeholders to influence Member State public health practice, PAHO began to champion rights-based advocacy (Levav, Restrepo, & de Macedo, 1994). Interfacing with the Inter-American Commission on Human Rights, the Bureau paired legal capacity with technical expertise to propose rights-based reforms in mental health policy, indigenous rights, child health, violence against women, and access to medicines. In a manner decidedly different than both the WHO Secretariat and other Regional Offices, PAHO carved out its own path to mainstream human rights principles throughout the organization.

**III. Mainstreaming Human Rights into PAHO Policies and Programs**

In mainstreaming health-related rights in the Americas, the Bureau would (a) encourage technical collaboration, (b) capacitate Member States through trainings, (c) integrate with regional human rights system on public health issues, and (d) advance rights-based developments regionally, including through PAHO’s governing bodies. The study’s key informant for this case study was Javier Vasquez, Human Rights Advisor to PAHO’s Legal Counsel.

*A) Promoting human rights through collaboration with technical units*
Developing in tandem, WHO and PASB both assembled human rights teams in the late 1990s with a stated goal of working together to advanced rights-based approaches to global and regional health governance (Bureau & Organization, 2001). Within PAHO, the human rights advisor was housed within the PASB Legal Department and worked under the legal counsel and in collaboration with other Departments and technical units to quietly mainstream human rights (Vásquez, 2004). Concretizing the importance of human rights in this way, a fixed position allowed the Bureau to mobilize resources and support the efforts of the health and human rights advisor in liaising with the WHO Secretariat and working independently across Member States.

A key feature of PAHO’s human rights mainstreaming efforts has a high degree of collaboration between the human rights team and the Bureau’s technical units. Through partnerships with academic institutions, the human rights team has organized a series of internal trainings for Regional Office staff. Introducing all staff to the linkages between health and human rights, these trainings include guest lectures by the UN Special Rapporteur on the right to health and online training modules (PAHO, n.d.-a). As a result of these capacitating efforts, Bureau technical staff have been introduced to the practical value of human rights mainstreaming and learn to operationalize rights-based approaches within their substantives foci. In particular, PAHO human rights staff emphasize the potential for human rights to provide a framework to measure success and clarify responsibility. Viewed in terms of “relationship-building,” the human rights team

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3 i.e. the Washington College of Law at American University, the Centers for Law and Public’s Health at Georgetown and Johns Hopkins University, and the University of Albany’s Institute for Health and Human Rights.
critically examines technical team needs and builds credibility by framing collaboration in terms of those needs.

Technical units also collaborate with the human rights team to publish and disseminate documents addressing the intersection of health and human rights. One technical unit is selected annually to apply a rights-based approach to their program of work. Together, these reports form a series of 13 PASB technical documents that present over 10 years of “human rights themes,” paving the path for corresponding human rights resolutions in the Bureau’s Directing Council. Specifically, resolutions have addressed the mentally ill, elders, persons with disabilities, maternal mortality and morbidity, gender equality and violence against women, HIV/AIDS, indigenous peoples, and adolescent and child health (Meier & Ayala, 2014). Several highlights from this process are summarized in Table 3 below. Note that the table is not exhaustive.

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Technical Input(s)</th>
<th>Normative Output</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>Analyses of rights-based policies on primary prevention and mental health promotion</td>
<td>Created a political basis for Member States to address human rights in mental health, culminating in a 2009 Directing Council Resolution calling for strengthened rights-based legal frameworks for people with mental disorders.</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>Development of: <em>Promotion of Sexual Health</em> (2000), the first document to address barriers to sexual rights, and 2008 analysis on sexual health rights in the Millennium Development Goals</td>
<td>In 2013, the human rights team presented a set of recommendations for Member States guiding critical analyses of the links between discrimination and access to care.</td>
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These human rights inputs and resulting outputs at the political and national level served to steadily build support from technical units. Alongside gender and equity, the diffusion of human rights norms through this “horizontal” approach provided the premise for normative advancements that would otherwise be politically unfeasible. For instance, PAHO is leading the world’s global health agencies in rights-based approaches to LGBT health—a controversial topic throughout much of the world. In 2013, the Directing Council approved resolution CD52.R6 entitled *Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons*. Rooted in the same strategy used to advance human rights within previous technical foci of the Bureau (refer to previous table).

In this way, the resolution is rooted in the technical work of a variety of units, including health and human rights documents on gender, patient safety, and the social determinants of health. Specifically, LGBT health and human rights issues had been discussed in a Central American sub-regional report entitled *The Right of Young People to Health and Gender Identities*. The human rights team collaborated with the United States (the PAHO Member State advancing the resolution) to refer to the preexisting
work of technical units on the area as an entry point to a broader resolution on LGBT health. Despite operating in a region where LGBT rights are far from universally acknowledged, the strategy provides strong evidence for the importance of collaboration with technical units in advancing even politically difficult rights-based policies. Importantly, the resolution is likely to serve as a future starting point for strengthening the concept of gender, human rights and sexual orientation in regional health practice.

**B) Bolstering member state human rights capacity**

PAHO has taken an active interest in building capacity among Member State governments for health and human rights. Through close coordination with the Bureau’s country offices, the human rights team and technical units disseminate guidance on applying international human rights instruments, conduct technical trainings for government officials, and, when requested, advise different government sectors on how to integrate human rights standards nationally (Meier & Ayala, 2014). Trainings are grounded in Jonathan Mann’s tripartite framework and promote a uniform understanding of human rights, even as the trainings are adapted to suit national needs (PAHO, n.d.-b). PAHO is also structured trainings in consultation with other UN agencies, civil society organizations, and Inter-American organs. Several highlights from this process are summarized in the table below. Note that the table is not exhaustive.

| **Table 4: PAHO capacity building in the Americas** |
|-----------------|-----------------|--------------------------------------------------|
| **Thematic Area** | **Participants** | **Training Summary** |
| Mental Health    | PAHO Member State government stakeholders, e.g. Paraguay. | Following an Inter-American Commission on Human Rights suit settled with Paraguay on the rights of mental health patients, the Bureau organized human rights training workshops to discuss national level reform. Concurrently, |
PAHO offered human rights training for public health officials.

<table>
<thead>
<tr>
<th>Adolescent Health</th>
<th>Collaborative effort with WHO, UNICEF, the University of Southern California, and Save the Children for local country stakeholders</th>
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<tbody>
<tr>
<td></td>
<td>Training takes the form of daylong exercises that develop local strategies on building understanding of the right to health. Following, participants develop plans to apply the right, which the Bureau includes in monitoring national progress.</td>
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</table>

<table>
<thead>
<tr>
<th>Tobacco</th>
<th>PAHO Member State health officials.</th>
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<tbody>
<tr>
<td></td>
<td>The human rights team and tobacco control program carry out joint country workshops across PAHO Member States that train health authorities on rights-based approaches to reduce tobacco consumption. Follow up and technical support is provided to governments drafting tobacco control legislation.</td>
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</table>

In addition to national, sub-regional and local workshops and trainings, PAHO Member States are encouraged to realize specific provisions of the right to health in the 2008-2017 Health Agenda for the Americas developed by the OAS. Most Regional Offices of WHO are only authorized to work with health ministries, however the Health Agenda authorizes the Bureau to adopt an intersectoral approach to health cooperation. Incorporating these provisions as a framework for the 2008-2012 PAHO Strategic Plan and current 2014-2019 PAHO Strategic plan, human rights are seen as providing “a unifying conceptual and legal framework for these strategies, as well as measures by which to evaluate success and clarify accountability and responsibilities” (PAHO, n.d.-d).
C) Integration & relationship with the Inter-American Human Rights System

The Inter-American Commission on Human Rights (IACHR) is an autonomous organ of the organization of OAS and serves alongside the Inter-American Court of Human Rights (“the Court”) as one of the primary institutions within the Inter-American Human Rights System (IAHRS). The Bureau’s human rights team interacts with IACHR in several ways: informal dialogue, formal testimony, and providing written opinions on public health issues of concern to IAHRS. Serving as a bridge between PAHO’s public health and human rights expertise, the Bureau’s legal office (which houses the human rights team) is able to leverage this position to advance health and human rights regionally (Meier & Ayala, 2014).

A strong working relationship between the Inter-American Commission and PAHO began around issues of mental health. In 1990, the two organizations co-sponsored a regional conference on psychiatric care that led to the Declaration of Caracas—an important milestone in rights-based mental health reform. This initial instance of collaboration led to opportunities to provide technical testimony, facilitate formal visits, and jointly write technical opinions (Meier & Ayala, 2014). Since then, the IACHR has solidified mechanisms for requesting PASB guidance and actively solicits Bureau technical opinions on public health issues, including: infant malnutrition, disability, mental health, in vitro fertilization, Chagas disease, health technologies and medication, health services, and HIV/AIDS. Emerging as a symbiotic relationship between PASB and the Inter-American Human Rights System, the Bureau leverages this increasingly formalized connection to develop rights-based public health obligations in
regional human rights agreements.

**D) Advancing human rights regionally through PAHO governance**

The Bureau’s efforts to mainstream human rights in the region began with increased collaboration with technical units and continued through the provision of training to Member States and interfacing with the Inter-American Human Rights System. Adding to this, PAHO Member States have also sought to codify a legislative basis for regional human rights activities through the PAHO Directing Council—the legislating organ of the Bureau. In particular, the Directing Council adopted the 2010 Resolution on Health and Human Rights, a legislative roadmap guiding the Bureau’s response to the region’s increasing demand for technical cooperation on human rights issues (PAHO, n.d.-c). Introduced by Argentina and endorsed by North American states, the Directing Council unanimously adopted the resolution.

Reflecting on more than 10 years of effort in mainstreaming human rights in policies and programs, the Resolution on Health and Human Rights urged:

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

Since 2010, the Resolution has facilitated a noticeable expansion in the realm of rights-promoting activities in which the Bureau may engage. For one, PAHO has
expanded its relationship with academic institutions, the private sector, civil society and social actors. Additionally, new legislative and administrative protocols have been developed to disseminate international human rights instruments across the region. This creates a new platform to facilitate technical collaboration between the Bureau and a variety of branches of Member State governments—including the judiciary. In Peru, this increased mandate set the stage for PAHO support of a new protocol on therapeutic abortions. The 2010 Resolution broadened the human right team’s ability to consult, capacitate and build partnerships across Peru’s government—including with both the health authority and congress. Similarly, the mandate catalyzed increased activity on mental law reform in Argentina.

Success of these emerging governance structures, however, also rests on the willingness of regional leadership to ensure human rights is present in governing body documents and practice. Particularly through agenda setting processes, PAHO Regional Directors have by and large consistently ensured human rights remains a primary area of Bureau engagement (Meier & Ayala, 2014). Additionally, the Regional Director empowers the Secretariat and Bureau teams to interact with non-traditional actors in advancing rights-based practice such as collaboration with the UN Special Rapporteur on the Right to Health. Similarly, PAHO leadership plays a crucial role in supporting implementation of the 2010 Resolution. While a variety of mandates may be present, leadership is needed to ensure successful transitions from legislative mandate to organizational practice.
Finally, human rights mandates such as those enshrined in the 2010 Resolution owe their existence to Member State champions who use political capital to promote norms. Most recently, the leadership of the United States, as aforementioned, was crucial in the adoption of the 2012 Resolution on LGBT Health. Accessing institutional mechanisms to set the agenda, the United States both introduced the resolution and requested that PAHO create both a thematic report and a draft resolution. The success of the LGBT Resolution can be traced to three complementary processes: the presence of a Member State willing to advance a new rights-based agenda, previous PAHO technical work on the subject, and the leadership of the Regional Director who decided to go forward with the topic despite regional political sensitivities, especially in the Caribbean.
## Table 5: Institutional determinants of human rights within AFRO

<table>
<thead>
<tr>
<th>Determinant</th>
<th>Key findings</th>
</tr>
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| **A. Human rights leadership** | • Senior leadership has in recent years been more willing to engage issues in human rights language, especially women’s health and universal coverage. That said, rhetoric is usually expressed in terms of equity or gender—not human rights.  
• AFRO RD leadership was critical to establishing the *Health and Human Rights Resolution*.  
• Commitment to human rights remains vague at best and the February 2015 appointment of RD Dr. Moeti has yet to show results in this area. |
| **B. State support**         | • AFRO Member States have questioned whether human rights should be considered a “core function” of AFRO’s work.  
• There has yet to be a clear Member State champion willing to advocate more heavily for rights-based norms regionally.                                                                                                                                                      |
| **C. Human rights expertise** | • AFRO’s GER team does not currently have a human rights focal point nor is there legal support for human rights activities.  
• Brazzaville Regional Office staff do not receive human rights capacity building.  
• Efforts at partnering with CSOs and non-state actors to boost human rights competency have been denied.                                                                                                                                                   |
| **D. Technical unit commitment** | • Most technical units within AFRO do not articulate their programs of work in human rights terms.  
• Women’s Health and Gender technical unit is a notable exception having contributed to sub-regional human rights workshops and forwarding documentation that uses rights-based language  
• There have been no efforts to harmonize technical unit efforts.                                                                                                                                  |
| **E. Staff perception**      | • AFRO employees are seen to lack understanding of the links between health and human rights.                                                                                                                                                                                                                                               |

The Africa Regional Office (AFRO) of WHO was established in 1951 intending to unite both colonial powers and African states in a joint effort to improve health outcomes across Sub-Saharan Africa. Brazzaville, the present day capital of the Republic of the Congo and then French colony (not to be confused with its larger neighbor Congo-Kinshasa), was selected as the headquarters of the office. On July 23, 1952 WHO Director General Dr. Brock Chisholm and the French Secretary of State for Foreign Affairs Mr. Maurice Schumman signed the office into existence (Samba, 2004). Building on the legacy of the work of the International Office of Public Hygiene and the League of Nations Health Organization in Africa, global powers intended to create the first truly pan-African health organization.

AFRO was born into a complex environment for international health diplomacy. From the beginning of European colonialism on the continent, health projects in Africa were directed at diseases primarily affecting Europeans. Health was used as a means of facilitating imperial rule and health infrastructure catered predominantly to European patients. However, after the establishment of AFRO and post-war international scrutiny on the morality of European colonialism, African colonial governments began also serving their peoples (Cooper, 2002). This shifted colonial powers’ imperative to justifying imperial rule in the name of a “civilizing mission.” Accordingly, colonial authorities in partnership with WHO began vaccinating local peoples against diseases like yellow fever (Cooper, 2002). Rhetoric would continue to shift until Western
European colonial powers reframed health discourse in terms of “development,” rather than “civilization” (Cooper, 2002).

From the end of colonial rule in the late 1950s to the late 20th century, AFRO expanded its mandate. Focusing on eradicating infectious diseases, improving nutrition, and developing the health infrastructure of newly independent African states (Cornia & Mwabu, 1997). The Regional Office and other active international health organizations also facilitated continued health links between colonial powers and their former colonies. The AFRO region would continue to expand its membership to eventually include the 46 Sub-Saharan states of the African continent with the exception of Somalia and inclusion of Algeria (see appendix C). South Sudan became WHO’s newest and youngest member state after its independence from Sudan in July 2011. The addition of these member states would herald the beginning of an expansion in AFRO’s mandate alongside a marked transition in regional leadership.

With the appointment of Dr. Ebrahim Malick Samba of Gambia to the post of Regional Director in the late 1990s, AFRO would begin to approach new program areas, including an initial foray into human rights topics. As a clinician and public health expert, he led a pan-West African effort to combat onchocercias (river blindness) earning international acclaim (Samba, 2004). Entering on a platform of improving relations with Geneva, attracting more donor funding and reforming bureaucratic efficiency, Dr. Samba spent 10 years at the helm and steered AFRO through a period marred by turbulence from conflict in the Republic of the Congo. In the words of former Regional Director Dr. Samba, “each time there was a crisis, staff movement was severely limited. WHO/AFRO
staff and members of their families could neither go to the city center, nor could they send their children to school. Just as frustrating was the fact that during these periods of turbulence, staff members billed to undertake duty travel could not gain access to the airport” (Samba, 2004). In 1997, the Regional Office was closed, staff evacuated, and operations temporarily moved to Harare, Zimbabwe.

From a temporary home in Harare, Dr. Samba advanced the Regional Office’s first foray into human rights. In 1995, the Department of Women’s Health and Development (WHM) and its two technical units Women’s Health and Gender (WHM) and Social Aspects of Family and Reproductive Health (SFR) advanced the Women’s Health Strategy for the Africa Region. The strategy was the first to include a gender perspective and life cycle approach, which included strategies to assert the right to health of women, especially through the eradication of harmful traditional practices and gender-based violence (Samba, 2004). These ideas were also incorporated into the 1996-2015 *Regional Plan of Action to Eliminate Female Genital Mutilation in Africa* (WHO, 1997).

Transitioning to the leadership of Regional Director Dr. Luis Sambo (2005 – 2015), AFRO restructured its bureaucracy, bolstered WHO country presences across the region, and focused on strengthening health delivery systems—especially in the realm of universal health coverage (Sambo, 2014a). Working specifically to address health-related Millennium Development Goals (MDGs), AFRO sponsored the 2008 Ouagadougou and Algiers declarations to improve access to and the quality of health services (Sambo, 2014a). Currently, AFRO is structured around five key areas of engagement:
communicable diseases; non-communicable diseases; promoting health through the life course; health systems; and preparedness, surveillance and response.

II. Health and Human Rights in the African Region

Human rights as a legal concept arrived in Africa relatively late (Ibhawoh, 2000). As in other WHO regions, many African political actors claim that, despite the universality of human rights and their principles, different cultural norms within Africa must be taken into account, leading to what some have termed ‘soft’ relativism (Hinz, 2006). Despite this reluctance, Africa is home to a variety of legal instruments and institutions seeking to advance human rights. Many of these structures owe their existence to the United Nations system, developments in other areas of international law, and ascendancy of the African Union. The African Region is also home to several competing ecosystems of regional organizations, many of which have their own human rights tribunals and regional systems. Scholars note that while human rights is often not explicitly at the core of regional agendas, it has begun to play an important role in their legal framework and implementation (Ruppel, 2009).

For instance, in East Africa, the Common Market for Eastern and Southern Africa, Southern Africa Development Community, and Eastern African Community are noted for the extent to which they have integrated human rights into organizational structures (Ruppel, 2009). Similarly, regional economic communities in West Africa have also built normative regimes around African human rights instruments. In particular, the Economic Community of West African States’ Court of Justice is recognized for jurisprudential activity around several human rights obligations, including the right to
health (Nwauche, 2009). Yet, despite the many human rights commitments made by African governments and guaranteed under global, regional and national legal instruments, many promises remain unfulfilled (Murray, 2004).

Most significantly, human rights in the African Region have undergone a transformation. Following the post-colonial struggle for independence from European and American political and corporate colonialism in the late 20th century, fledgling African states accessed civil and political rights. Since then, the region has shifted to more heavily emphasize the right to development and related social, economic and cultural rights (Gawanas, 2009). This transition mirrored the changeover in regional governance organizations from the Organization of African Unity (OAU), founded in 1963 with the aim of eliminating colonialism in Africa, to its successor, the African Union (AU) (Keetharuth, 2009). With a broader mandate, the AU mainstreams human rights into all its programs, building on OAU’s human-rights charters. Framing rights issues as essential to development, the AU has focused human rights in the region through several legal instruments.4

There is still a noted and persistent gap between the rhetoric of African governments, who claim to protect and respect human rights and the daily realities across the continent where human rights violations remain the norm. According to the WHO Global Health Observatory, only seven countries in the Africa region have succeeded in

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allocating 15% of their total national budgets to the health sector as per targets set in Abuja, Nigeria (Organization, 2013). This underwhelming mobilization of resources translates into other key challenges. For instance, the vast majority of people in the Africa Region are unable to access essential health services due to high costs, ineffectual public health infrastructure, and inadequate consideration of gender-responsive health systems (Sambo, 2014a). Despite the worst health outcomes of any WHO region, Africa’s average total expenditure on health as a percentage of GDP is one of the lowest in the world (Mosissa, 2014). Further, although universal coverage is a stated regional priority, only a handful of Member States have advanced these policies nationally (Sambo, 2014b).

Therefore, despite the wide ratification of human rights treaties across WHO/AFRO Member States, many governments have failed to meaningfully guarantee these rights to their citizens (Hafner-Burton & Tsutsui, 2007). For the human right to health, the challenge is exacerbated when national legislation and institutional mechanisms are not harmonized with international commitments. Gutting their potentially transformative components, human rights are instead left to linger in the dreamscape of empty rhetoric. Within the region, there are currently 31 national human rights institutions operating as commissions, ombudspersons or institutions (Peter, 2009). Although established by the State, these bodies in theory are able to act independently to protect rights and promote cultural norms around the protection of human rights. Often more flexible than national court systems, several countries in the Africa region have achieved noted successes (Peter, 2009). Improving enforcement, then, is of critical importance for ensuring that African peoples receive the rights to which they are entitled.
Efforts to enshrine the right to health nationally must also include raising the profile of the right more generally. Scholars have noted that discussions about the right to health tend to be the exclusive domain of policymakers and legal experts (Lakin, 2001). This results in a lack of awareness among citizens and even health workers of the components of the right, which curtails possibilities to advance the right more informally across the region. Experts point to the need to increase efforts to capacitate health systems on this front to avoid the potential for rights violations (Backman et al., 2008).

Further, the significant and sudden increase in clinical trial sites across Africa is another area of concern from a human rights perspective (De Cock, Mbori-Ngacha, & Marum, 2002). Inadequate informed consent, exploitation and bioethics competencies are primary concerns that must be addressed. While the challenge is common to many settings in the Global South, the African Region has particularly poor regulatory infrastructures and a lack of independent oversight processes (Kirigia, Wambebe, & Baba-Moussa, 2005).

While the situation regionally is far from ideal, cause for optimism does exist. The right to health and other rights are gaining credence as a formidable tool to protect the interests of African peoples. Most notably in South Africa in 2001, when a coalition of AIDS-related organizations, citizens, and other civil society actors formed the Treatment Action Campaign and sued the South African government with the right to health forming the legal basis of the lawsuit (Annas, 2003). The South African government sought to limit the provision of generic versions of nevirapine (an anti-
retroviral therapy), caving to the demands of 39 multinational pharmaceutical companies. The Treatment Action Campaign alleged that restricting the availability of the drug violated the right to health of HIV-positive pregnant women and their children, as guaranteed in the South African constitution. Making references to several regional and international binding human rights documents, the campaign was successful (Forman, 2008). This represents an enormous victory in a region marked by few and provides ground for optimism that inaction on the right to health will not go unchallenged (Torres, 2002).

The human right to health in the Africa Region has a strong normative and legal basis. However, Member States are not often held to account for their failures to fully or even partially realize this legal obligation. Despite the fact that human rights organs at the regional level such as the African Union Commission are armed with remedial powers, efforts are hindered by a lack of systemic accountability. Addressing structural accountability deficits in the health sector and at other broader levels of the government must first be addressed if the full realization of the right to health is to become an African reality (Mosissa, 2014). Regional and international organizations have an essential role to play in disseminating these norms despite considerable obstacles.

III. Mainstreaming Human Rights into AFRO Policies and Programs:

Responding to a call from the WHO Secretariat, WHO’s Regional Office for Africa has cautiously attempted to mainstream rights across the organization. Within AFRO, a human rights officer has traditionally coordinated mainstreaming activities, however the position is currently vacant at the time of writing. The previous human rights
A focal point was reassigned to work in the Regional Director’s Office on an unrelated portfolio. Following the appointment of Dr. Matshidiso Moeti as the new WHO/AFRO Regional Director in February 2015, the bureau is undergoing restructuring and reorganizing wherein “human rights appears to be a priority.” While it is too soon to know definitively in what form these efforts will coalesce, the office is collaborating with WHO/GER to draft a new job description for a new human rights focal point. During this transition period, Dr. Davison Munodawafa has assumed human rights responsibilities and was the key informant for this case study.

Within a complicated regional setting, AFRO has made modest attempts at integrating human rights into the Regional Office although there appears to be a willingness to quicken this process. Thus far, mainstreaming efforts have been characterized by a) a desire to replicate rights-based normative structures from other regions, b) the organization of an increasing number of capacitating activities in-country, c) the framing of some areas of work in rights-based terms, and d) contending with varied regional and Regional Office level dynamics.

**A) Normative developments in advancing human rights in the African Region**

In November 2012, the Regional Committee for Africa met in Luanda, Angola during its sixty-second session. During the prior year’s Regional Committee, member states and AFRO expressed a mutual desire for a regional human rights strategy. Seeking to strengthen its mandate to promote the right to health and fulfill WHO mainstreaming obligations, the Regional Secretariat wanted a new regional guiding human rights framework. Looking to landmark normative developments from other WHO regions such
as the *2010 PAHO Health and Human Rights Resolution*, AFRO leadership under advisement from WHO/GER drafted a report entitled “*Health and Human Rights: Current Situation and Way Forward in the Africa Region*” and an accompanying draft resolution of the same name. Before Ministers of Health, Member State delegations, representatives of the African Union Commission, other United Nations agencies, and nongovernmental organizations, regional leadership presented AFRO’s first foray into a human rights resolution.

The resolution begins by aligning itself with the most important international normative developments for the right to health. Opening with references to the 1946 Constitution of the WHO and principles of the *1978 Alma Ata Declaration on Primary Health Care*, the resolution situates itself as part of a continuum of previous WHO human rights developments. Widely considered a policy failure, referencing Alma-Ata within the AFRO resolution is evidence of what scholars term the enduring “spirit” of the declaration (Meier, 2009). Regionally, the resolution links itself to several African human rights declarations; including the *2008 Ouagadougou Declaration on Primary Health Care* and *African Charter on Human and Peoples Rights* (Banjul Charter), which both importantly reaffirm health as a fundamental human right. In fact, the Banjul Charter imposes an obligation on States to “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick” (Umozurike, 1983).

Honing in on the WHO/AFRO, the resolution references the Regional Office’s Strategic Directions for WHO in the African Region (2010-2015), which references the
integrated gender, equity and human rights mainstreaming process required of all WHO regions. As outlined in the resolution’s accompanying report, all but six of AFRO’s Member States have enshrined the right to health in their constitution.\(^5\) Calling on states to fulfill the obligations enshrined in their constitutions, the resolution concludes by recognizing that the principles of progressive realization obligate states to use the maximum available resources towards progressively achieving the full realization of their citizens’ right to health.

Taking inspiration from Jonathan Mann’s tripartite framework, the resolution also urges regional Member States to tackle several of the key challenges to human rights outlined in Part II of this case study. In particular, the resolution addresses: implementation and enforcement on a national level; countering discrimination and protecting the right to health of vulnerable groups; ensure and work towards universal health coverage; adopt new bioethics standards; strengthen the technical capacities of ministries of health to work with human rights bodies and the Regional Office; and broaden awareness about the right to health (Africano, 2012).

Concurrently, the resolution establishes new obligations for the Regional Director and Regional Office leadership. Specifically, the Regional Director is requested to: promote a human rights-based approach in health development; support Member States in rights-based health policies, capacities and expertise; develop human rights monitoring tools; and report on the implementation of the resolution at the 2015 Sixty-fifth session of the Regional Committee and thereafter (Africano, 2012). These reforms have been seen as bringing AFRO in line with WHO’s Program of Work (which stipulates GER

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\(^5\) Outstanding member states: Botswana, Cameroon, Chad, Ghana, Liberia, Mauritius
mainstreaming) and creating an entry point for advancing a broader regional understanding of human rights.

According to AFRO human rights focal points, the most significant element of the resolution is the new obligation imposed on the Regional Office to report on human rights activity. The need for a formalized method of reporting is clear, as substantive references to human rights activities are often absent in AFRO documentation, proceedings, and other outputs. AFRO’s first report on the implementation of the 2012 Health and Human Rights resolution is due in several months at the 2015 Regional Committee meeting. However, at the time of writing no progress had yet been made on that report.

**B) Subnational human rights capacity building efforts**

The main avenue through which AFRO has sought to build regional human rights awareness in Member States is through sub-regional workshops. Cognizant that “human rights” as an idea is politically sensitive within a region that understands rights as oppositional to state sovereignty, workshops stress the integrated (gender, equity and human rights) approach of WHO/GER (Okere, 1984). Gender and equity are viewed as both less contentious and more easily understood in a public health. These two themes function as a gateway to discussions on human rights. Generally, workshops operate on a standard program. GER issues are discussed uniformly and rarely adapted to local or sub

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6 For instance, in the Report of the Sixty-Fourth Regional Committee in 2014, the singular reference to “human rights” is to a discussion by Member States: “[Member States] also questioned if areas such as gender, equity and human rights mainstreaming, ageing and health, and social determinants of health could be considered as a mandate shared with other organizations. They emphasized the need for WHO to focus more on its core function” (régional de l’Afrique, 2014)
regional contexts, despite the often sub-regional setting of the workshops. Lacking the
resources to organize trainings independently, AFRO frequently partners with other UN
agencies and non-governmental donors. While this has led to several partnerships, it also
affects workshop content—much of which becomes dictated by donor and partner agency
funding priorities.

Several recent workshops have brought human rights issues to the fore:

1. **Mainstreaming Gender, Human Rights and Family Planning into Health Programs (May 17 – 22, 2010). Accra, Ghana.**
   a. The workshop sought to strengthen sub-regional capacity to mainstream GER into family planning programs. The relationship between gender and human rights concepts and their health implications were discussed. While the workshop focused more strongly on the concept of gender than human rights, a diverse set of stakeholders were present and health and human rights was discussed with an African example.
   b. 23 participants from Gambia, Ghana, Liberia, Nigeria and Sierra Leone. Ethiopia was also invited on a special request.
   c. AFRO facilitators: Gender and Women’s Health (GWH) and Social Determinants of Health (SDH).

2. **Human Rights-Based Approach to maternal, newborn and child health, including related sexual and reproductive health issues (November 18-20, 2013). Lilongwe, Malawi.**
   a. The objective of the training was to build capacity in the realm of assessing legal and policy environments in order to integrate human rights into laws, policies and programs related to maternal, sexual and reproductive health and newborn and child health.
   b. Human rights tools introduced included WHO’s sexual and reproductive health and human rights: a tool for examining laws, regulations and policies.
   c. The workshop was organized as a partnership between several international agencies (WHO, UNFPA, and the Partnership for Maternal, Newborn and Child Health) came together under the leadership of the Office of the High Commissioner on Human Rights.
   d. Participants included governments, national human rights institutions, UN Country Teams, and civil society actors from Tanzania, Malawi, Uganda and South Africa. National level law, policy and implementation assessments were to be conducted following the workshop in all four countries.
e. AFRO participants: two members from AFRO/GER.

   a. The objective of the training was to assist WHO program managers staff with mainstreaming gender, equity and rights as an integrated approach.
   b. First time the WHO human rights focal point had directly liaised with other UN agencies as partners on a workshop (UNFPA, UNICEF)

C) Framing gender in rights-based terms

While mainstreaming human rights and health is widely understood to entail linking all programs of work to rights, AFRO only expresses some technical areas in human rights terms. As mentioned previously, gender was the first area of work in AFRO to be described in rights-based language at the end of the 20th century. Accordingly, in 2009, the Regional Office established a multidisciplinary Commission on Women’s Health in the Africa Region in response to a resolution adopted by the WHO Regional Committee for Africa at its 58th Session in Yaoundé, Cameroon in 2008 (AFRO, 2008). Consisting of 16 experts under the leadership of President Ellen Johnson of Liberia, the commission recommends appropriate action across health sectors to improve the health of women. Of interest to this study is the language used to frame these issues.

In the opening forward of the 2012 Report on the Commission on Women’s Health in the Africa Region, Regional Director Luis Sambo articulates “that the role of women in society goes far beyond childbearing, which also makes the fundamental point that women have—first and foremost—a right to good health” (AFRO, 2012). The report details the human rights instruments that guarantee women’s rights and the status of their
ratification in the African Region. Couching the goals of the Commission in this rights-based language is significant.

Continuing this trajectory, the 2013 AFRO Agenda for Accelerating Universal Access to Sexual and Reproductive Health encourages government sectors, NGOs, health professionals, legal experts and human rights groups to work together to champion SRH issues (AFRO, 2013). Ending with a call to action, AFRO calls on African countries to “[create] a dynamic environment for strong support for rights-based sexual and reproductive health initiatives and involvement of not only ministries of health, but also ministries of finance, … and human rights groups” (AFRO, 2013).

**D) Regional dynamics and challenges within the Regional Office**

AFRO suffers from several limitations in health and human rights promotion in the region. For one, the human rights focal point has been unable to establish partnerships with NGO/civil society actors that go beyond workshops. In fact, the team is unable to liaise with these actors. Second, Regional Office personnel do not clearly understand the linkages between human rights and health. Even so, AFRO lacks the resources to organize capacity building sessions at the Regional Office in Brazzaville. These concerns have been allayed in part by focusing on the non human rights components of GER. Additionally, while individual units within AFRO promote human rights in their own work—such as the technical unit on Women’s Health and Gender—there exists no harmonization between the units and the GER team.
Regional Office leadership in AFRO appears to be responsible for many of the human rights advances in the region—such as the 2012 Resolution. Previous Regional Directors have cautiously approached the topic of human rights and often only in the realm of speaking to equity or gender. Speaking at the end of his term as Regional Director, Dr. Luis Gomes Sambo was clear on the links between equity and human rights, especially in the realm of ensuring universal health coverage—a key AFRO priority over the next 15 years, stating:

“In my view, a tight partnership between Member States, WHO and other health development partners is crucial for the achievement of the post-2015 UHC goal of ensuring that all people in the African Region have access to the needed quality health services without exposure to financial hardship. The Universal Declaration of Human Rights adopted and proclaimed by United Nations General Assembly resolution 217 A (III) of 10 December 1948, clearly indicates that everyone has the right to life (Article 3) and a standard of living adequate for the health and well-being of himself and of his family (Article 25). That was over 65 years ago. Despite subsequent commitments at various forums, such as the adoption of the Declaration of Alma-Ata in 1978 following the launch of the Health-for-All movement by the World Health Assembly in 1977, and efforts by national governments and partners, there are still millions of African people suffering and dying prematurely from preventable communicable and non-communicable diseases and injuries… In a nutshell, although individual Member States have a paramount role to play, coordinated global health solidarity will be needed to keep the promise of UHC in order for all Africans to have access to better health and quality of life” (Sambo, 2014a).

Other senior regional leaders have also spoken to human rights, but only in referential terms to other areas of work and not as an explicit goal in itself. For instance, Dr. Tigest Ketsela, Director of Health Promotion, referenced human rights while speaking on prioritizing gendered health issues:

“Women’s well-being, in addition to being a human rights issues, has a direct bearing on child health and development. A child with a mother has
a better chance of surviving… More importantly, a child with an empowered mother not only survives but also thrives and reaches his/her full potential to be a productive citizen. Putting mothers and children first is therefore fundamental to the socio-economic development of any society” (Sambo, 2014a).

Regional leadership appears to understand human rights and the right to health as relating to some health issues more than others (e.g. maternal health) and not necessarily related to all health issues. While the 2012 Resolution defines a more inclusive vision of health and human rights, it has yet to translate into programmatic action. The February 2015 appointment of a new Regional Director presents an opportunity for a new perspective on human rights within AFRO. In the opening address following her nomination, incoming Regional Director Dr. Moeti mentioned the need to further enhance equity and human rights in pursuit of universal health care, stating “I commit myself and colleagues to build on what we have created so far and I am confident that we will ride on the positive things happening in the region” (WHO, 2015). However, it remains to be seen if Dr. Moeti will move human rights beyond a focus on gender and equity.
### Table 6: Institutional determinants of human rights within SEARO

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<tr>
<th>Determinant</th>
<th>Key findings</th>
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</table>
| **A. Human rights leadership**  | • RD prioritizes the objectives of regional Member States. In SEARO, this translates to a focus on equity over human rights.  
• Director’s Office is supportive of human rights when the mandate comes from WHO HQ, but rights are not prioritized.  
• While RD rhetoric supports the right to health, funding priorities limit its advancement. |
| **B. State support**            | • Most regional Ministries of Health are not interested in engaging human rights, rendering progress “almost impossible”  
• Historically negative attitudes towards human rights makes gender and equity easier “entry points” with Member States. |
| **C. Human rights expertise**   | • Even “very good” technical staff require more capacity building to understand how to apply human rights.  
• SEARO is entirely reliant on JPOs from the Global North to serve as human rights focal points. There are no plans for a handoff when the current JPO’s term ends in June 2015. |
| **D. Technical unit commitment** | • Some technical units (HIV/AIDS, Emergency Management, NCDs) have been receptive to incorporating human rights into their work.  
• GRE focal points in SEARO Country Offices are overworked, although rights-based capacity building efforts take place yearly. |
| **E. Staff perception**         | • SEARO employees are seen to question the efficacy of human rights in their work and reference the ‘Asian values defense’  
• Staff have been known to claim that human rights is not the mandate of WHO and is instead the purview of other UN agencies. |
I. Origins of the South-East Asia Office of the World Health Organization

Prior to the Second World War, the term “Southeast Asia” was rarely used as a geographic designation and was often substituted by the term “Far East” to denote the region between India and China (Christie, 2000). However, the term came to the fore as a convenient designation within a post-colonial context for the states lying at this geopolitical nexus. The countries typically thought to inhabit this space include Brunei, Burma, Thailand, Laos, Cambodia, Vietnam, Malaysia, Singapore and Indonesia. Some international organizations also consider the Philippines South-East Asia.

The first decade of WHO operations (1948 – 1957) coincided with a dynamic

<table>
<thead>
<tr>
<th>SEARO Member State</th>
<th>Became Party to WHO Constitution</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>May 19, 1972</td>
</tr>
<tr>
<td>Bhutan</td>
<td>March 8, 1982</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>May 19, 1973</td>
</tr>
<tr>
<td>India</td>
<td>January 12, 1948</td>
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<td>Indonesia</td>
<td>May 10, 1950</td>
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<tr>
<td>Maldives</td>
<td>November 5, 1965</td>
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<tr>
<td>Myanmar</td>
<td>July 1, 1948</td>
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<tr>
<td>Nepal</td>
<td>September 2, 1953</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>July 7, 1948</td>
</tr>
<tr>
<td>Thailand</td>
<td>September 26, 1947</td>
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<tr>
<td>Timor-Leste</td>
<td>September 27, 2002</td>
</tr>
</tbody>
</table>
stretch of human history. Following on the heels of the Second World War, countries in South-East Asia sought to throw off the colonial yoke and begin new trajectories as independent states. India won her independence in 1947 followed closely by Burma (Myanmar) and Ceylon (Sri Lanka) in 1948. The Democratic People’s Republic of Korea (commonly referred to as “North Korea” and in this study as DPRK) came into existence following the withdrawal of Soviet troops in 1948 and the Republic of Indonesia emerged in 1949.

Seeking to participate more fully in the creation of new global governance structures, these newly ascendant states and others would make up the foundation of what would become the WHO South-East Region Office (SEARO). As previously discussed, the First World Health Assembly designated a Committee in 1948 to consider the delineation of regional structures. Unusually, newly acceding Member States in South-East Asia could request transfer from one region to another. A combination of no uniform method of designation and political animosities between states largely account for the patchwork appearance of SER (see Appendix C). For instance, Indonesia, originally designated as part of the Western Pacific Region, transferred immediately to SEARO. Nevertheless, beginning in 1947 with Siam (now Thailand), countries across South-East Asia would continue to join WHO and jumpstart a new undertaking in regional health diplomacy. As the first of six WHO regional office, WHO/SEARO comprised seven independent Member States by the end of the agency’s first decade (WHO, 1999b).

The first session of the WHO Regional Committee for South-East Asia was held in 1948 at the office of the Indian Minister of Health beginning an important annual
organizational exercise in agenda setting. Initial SER Member States and European
powers with continued colonial holdings in South-East Asia (representatives of French
India, Portuguese India, and the British Maldives Islands) designated New Delhi as the
location of the Regional Office. Additionally, the Regional Committee launched South
East Asia’s first program of action to control the spread of major communicable diseases
and support regional health infrastructure development (WHO, 1999b). These themes
would form the bedrock of SEARO activity in the region for the decades to follow.

By the mid 1950s, SEARO became the first WHO regional office to designate
WHO Representatives to Member States. These representatives served to liaise between
the WHO and member state ministries of health. This development spurred the beginning
of long-term WHO/SEARO investment in country-level field projects and related
program staff. Resulting bureaucratic structures remain in place at present day. Despite
ever normative developments in human rights on the international stage, in the initial
decades of its existence, SEARO maintained a singular focus on expanding health
services, bolstering health planning, and reducing the burdens of communicable disease
among member state populations.

For the human right to health, the mid 1970s marked the emergence of new ideas
of ‘social relevance’ and ‘social justice’ within global health and reflected in a new moral
conscience on health and development (SEARO, 2015). These ideals culminated in a new
global understanding of primary care at the 1978 International Conference on Primary
Health Care at Alma-Ata, incorporating a political dimension to primary health care. As a
foundational moment in the development of the human right to health, member states
pledged to secure health for all (WHO, 1999b). These ideals, however, had been foreshadowed at the 1937 Intergovernmental Conference of Far-Eastern Countries on Rural Hygiene in Badung, Indonesia almost 40 years before Alma-Ata. Engaging regional actors, the Conference underscores the normative components of the right to health and advocated the inclusion of women, cross-sector approaches to health care and a focus on guaranteeing access. In fact, SEARO regional leadership has long emphasized ideals of health equity:

“Despite normative developments in human rights on the international scale, SEARO maintained its focus on expanding health services, bolstering health planning, and reducing regional burdens of communicable disease” – Dr V.T. Heart Gunaratne, Regional Director of SEARO from 1968 to 1981 (WHO, 1999b).

Moving on from the widely acknowledged failure of the Declaration of Alma-Ata to codify a universal rights-based path for the agency, other WHO regions successfully capitalized on the spirit of this vision to advance human rights and health (Meier & Ayala, 2014; Salim, 1988). Conversely, Member States within SEAR eschewed the explicit recognition of human rights, opting to implicitly advance substantive components of the right to health through collaboration and a focus on social equity. For instance, at the Thirty-first session of the Regional Committee for South-East Asia in 1978, Member States endorsed a collectivist framework to prioritize regional health disparities. The South-East Asian Charter for Health Development continues to guide regional health priorities (SEARO, 2015; WHO, 1978, 1999b). This regional preference was reinforced through other actions of the Regional Committee, such as encouraging a “social equity and justice” regional focus to fulfill the mandate of WHO’s Health For All strategy (WHO, 1999b). Rarely, however, was the human right to health explicitly recognized in a
II. Health and human rights in the South-East Asia Region.

With certain exceptions, SEARO Member States only earnestly began to engage with human rights issues in the early 1990s as the Cold War drew to a close and oppressive regimes became more heavily scrutinized by the international community (Ciorciari, 2012). Perhaps most glaringly, the imprisonment of democratic leader Aung San Suu Kyi in Myanmar following the results of the 1990 national election, 1991 Santa Cruz massacre of 200 protesters in Timor Leste by Indonesian troops, and 1992 “Black May” military crackdowns in Thailand sparked international condemnation (Cardenas, 2002). Coupled with increased pressure from the United States and other Western allies, Asian governments\(^7\) met in 1993 to issue the Bangkok Declaration, affirming their commitment to human rights and beginning a conversation on “the need to explore the possibilities of establishing regional arrangements for the promotion and protection of human rights in Asia” (Bangkok Declaration, 1993).

However, the Bangkok Declaration would also formalize the concept of “Asian values” and launch a debate globally on cultural relativism and human rights—or the idea that rights-based norms should be contextual and not universal. Reformulating the foundation of human rights, the Bangkok Declaration notes that “while human rights are universal in nature, they must be considered in the context of a dynamic and evolving

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\(^7\) Participating states included Bahrain, Bangladesh, Bhutan, Brunei Darussalam, China, Cyprus, Democratic People’s Republic of Korea, Fiji, India, Indonesia, Iran, Iraq, Japan, Kiribati, Kuwait, Lao People’s Democratic Republic, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Oman, Pakistan, Papua New Guinea, Philippines, Republic of Korea, Samoa, Singapore, Solomon Islands, Sri Lanka, Syria, Thailand, United Arab Emirates, and Vietnam.
process of international norm-setting, bearing in mind the significance of national and regional particularities and various historical, cultural and religious backgrounds” (Bangkok Declaration, 1993). This normative development lent credence to regional SEAR governments who maintained that a universal concept of human rights is a reflection of Western culture and values and cannot be superimposed on Asian traditions (Durbach, Renshaw, & Byrnes, 2009).

Led by Malaysian Prime Minister Mahathir Mohamad and Singaporean leader Lee kuan Yew, proponents of Asian values claimed that Asian societies emphasize the rights of the community over those of the individual, drawing from Confucian philosophy and social norms (Le, 2011). Scholars note that while the Asian values debate often descended into political talking points, it did reflect a genuine normative contestation and political concerns of import to South-East Asian governments (Ciorciari, 2012). For one, regional governments feared the use of human rights as a tool of Western political prerogative and a pretext for intervention in the region (Le, 2011). As noted previously, for many nations in South-East Asia, recent experiences with colonial rule and European intervention created political sensitivities on the topic. Further, most regional governments feared that human rights discourse was often coupled with accompanying demands for democratization. Pushing back, Asian governments stressed the collective good and economic, social and cultural rights such as entitlements to health and decent standards of living. Indeed, the Bangkok Declaration’s sole reference to a “universal and inalienable right” was the collective “right to development” (Ciorciari, 2012).

Shifting the focus from civil and political freedoms served the interests of
regional governmental and justified the dominant role of South-East Asian governments in managing the state (Mauzy, 1995). This focus is most strongly evident in one of the region’s most significant normative outputs, the 1988 Declaration on Health Development in the South-East Asia Region in the 21st Century adopted at the Fifteenth Meeting of SEAR Minister of Health in Bangkok, Thailand. Evident of a regional reluctance to articulate human rights as such, the declaration states that SEARO Member States “take note of the social goal of ‘health for all’ and… affirm unwavering commitment to ensure access to health care to all… through collective leadership … and Regional solidarity” (WHO, 1999a). Importantly, even recent developments in regional human rights promotion struggle with the legacy of Asian values. For instance, it took sixteen years and several rounds of debate for the Association of South-East Asian Nations (ASEAN) to establish the ASEAN Intergovernmental Commission on Human Rights (IACHR) (Ciorciari, 2012). These regional political dynamics have and do hamper attempts by WHO/SEARO to effectively integrate human rights into their work and provide grounds for the sidelining of human rights.

As a note, it must be recognized that attempts to discuss human rights within the many and diverse national contexts within South-East Asia is an exercise beyond the scope of this study. However, the discourse would be remiss if it did not mention that India, a prominent member of SEARO, played an enthusiastic and early role in drafting both the Universal Declaration and the two International Covenants (Reus-Smit, 2001). Human rights in India have their own basis in ancient Bahmani and Vijayanagar tradition. Rights-based discussions have long been part of national dialogue in India (Das & Mohanty, 2007). Therefore, it is important to note that the country is excepted from much
of the discourse above pertaining to the development of human rights in the region.

III. Mainstreaming human rights into SEARO policies and programs:

Responding to the reintroduction of human rights as a basis of global health government by the WHO Secretariat, SEARO’s efforts to mainstream human rights are largely composed of reactions to directives from Geneva. Under the Department of Family Health, Gender and Life Course (FGL), rights-based initiatives are organized by the WHO/SEARO Gender, Equity, & Human Rights technical unit (see SEARO organizational structure). The unit is composed of two people: a coordinator and Benedicte Briot, a health and human rights technical advisor. Ms. Briot was the key informant for this case study.

In mainstreaming health-related rights in the South-East Asia Region, SEARO a) leverages its relationship with the WHO Secretariat for direction, b) finds region-specific entry points to discuss human rights, c) seeks to capacitate Member States and elements of the regional office in health and human rights through trainings and workshops, d) develops internal and external alliances to promote human rights in policies and programs.

A. Relationship with the WHO Secretariat & global Gender, Equity and Human Rights team

Of critical importance to SEARO’s human rights mandate is the regional unit’s relationship with the recently formed (2012) Gender, Equity and Human Rights team at the WHO Secretariat in Geneva (not to be confused by the name of the SEARO technical
unit of the same name). At the regional level, SEARO paralleled this rebranding of “health and human rights” in its organizational structure and expanded the mandate of the regional human rights advisor to include two additional focal points: gender and equity. The global GER team liaises directly with the regional human rights advisor and responds to requests for support.

SEARO is also heavily reliant on the provision of Junior Professional Officers (JPO) by donor countries such as Finland and Belgium. JPO is a designation within the UN system that denotes a young professional financially supported by their respective government (all of which are in located in the Global North). Finland provided SEARO’s first health and human rights focused JPO in 2007, sponsoring an additional Finnish JPO in 2008 after the first had vacated the position. Following the end of Finnish sponsorship in 2010 and then a yearlong vacancy of the position at SEARO, Belgium took over sponsorship under the erroneous assumption that Vietnam—a priority aid recipient for the Belgium government—was a SEARO Member State. Regardless, Belgian support has continued and Benedicte Briot is the third human rights focused JPO to work in SEARO. Of immediate concern is the looming termination of her contract in June 2015. To date, there are no immediate plans to hand off human rights responsibilities within the office. Members states have yet to pledge money to fund a fixed term position. Additionally, the Coordinator of SEARO/GER is also the acting Regional Advisor for Nursing and Midwifery and already overburdened with responsibility. In this regard, the future of human rights in SEARO is unclear.

SEARO is heavily reliant on direction, support and guidance from the WHO
Secretariat and the staffing of JPOs in the realm of human rights. This may be partly attributed to a lack of regional leadership in advancing rights-based reform and a lukewarm feeling among Member States on the subject of human rights initiatives. Despite staff transitions at the WHO Secretariat creating several gaps in support at the regional level, new Secretariat leadership in GER has revitalized mainstreaming efforts leading to an improved working relationship with SEARO. In this context, Member States in SEARO have been more likely to respond to top down initiatives on human rights that carry the weight of the WHO Director General.

**B. Region-specific entry points to human rights**

As noted previously, the South-East Asia Region has a complex history with human rights. The windfall between historic comprehensions of regional rights-based norms and contemporary efforts to promote universal rights create tension that hampers SEARO’s effectiveness in this realm. One of the primary challenges facing the regional office is a lack of interest from Member State health ministries who interpret SEARO’s human rights leadership as closely tied to civil and political rights. Regional ministries of health are the primary governmental contacts for SEARO. This decided lack of political will hampers the effectiveness of human rights promotion in regional global health governance.

Within SEARO member states, there is a perception that the ratification of human rights is largely a ceremonial exercise. High-level officials seeking to appease donors and the international community sign treaties to which they never intent to commit. Accordingly, critiques from Member States frequently highlight this perception and draw
attention to a perceived lack of practicality in rights-based approaches to health. On this basis alone, many SEARO nations opt out of GER trainings, workshops and capacity building projects. However, each Member State in SEARO understands and relates to human rights from its own unique national context. These perceptions shape ministry and government willingness and engagement with SEARO/GER. For instance, representatives of the Democratic People’s Republic of Korea have claimed in the past that as “all people are equal in [their] society, there is no need to build capacity in GER.” While DPRK is an outlier in many metrics of analysis, other states in the region also struggle with human rights abuses, particularly in violating the rights of minorities and through inequitable provision of humanitarian assistance following natural disasters. To regional governments, engaging SEARO on human rights issues may call further attention to these abuses. With 11 diverse countries ranging from Bhutan to Timor-Leste, the challenge in finding a common method of building broad support for human rights is considerable.

However, contextualizing human rights is not only a topic of concern for member states, but also for elements internal to SEARO. Human rights focal points face challenges in translating the importance of human rights and health even for regional office staff. The links between human rights and health are often not obvious for WHO regional staff, many of whom work in highly technically focused areas such as food safety, disease prevention and human resources for health. Many staff claim that a focus on human rights impedes WHO/SEARO’s technical mandate and is a subject best left to other less UN agencies. While this perception is evident in WHO more generally, SEARO staff fall prey to poor regional human rights leadership and the entrenched
specter of the Asian values defense (Meier, 2010). This deficiency highlights the need for basic capacity building. For instance, linking the right to health beyond healthcare to encompass the social determinants of health and other key programmatic foci for SEARO.

To circumvent the political difficulties of talking about “human rights,” SEARO/GER has sought new entry points to human rights. Focusing more closely on gender and equity and rephrasing “human rights” as the “right to health” are region-specific strategies that have been effective in cultivating broader engagement. Ministries of health in the region are less likely to engage with the more inclusive, less specific language of human rights, and are more comfortable with gender and equity—two areas of work that predate human rights in SEAR. For instance, discussions around women’s health began in 1997 with the creation of the Women, Health and Development technical unit and continued with a regional action plan for the “Safe Motherhood Initiative” (WHO, 1999b).

The Regional Director is able to set agenda and influence strategic prioritization. However, senior leadership in SEARO nearly always prioritizes the objectives of regional member states. Referring to the regional office’s history, this means collective action on technically focused health priorities and little action on health and human rights. Most recently, SEARO and member state priorities have aligned on concerted action towards universal access to health care (SEARO, 2013). With obvious and direct implications for health equity, this focus has in fact created a new entry point to discussing health and human rights. In this way, linking of health and human rights to gender and equity at both
the WHO Secretariat and SEARO level has facilitated, not hindered, human rights discussions in the region. Within SEARO, this emphasis has brought about the tepid support of the Regional Director. Coupled with the inclusion of human rights (GER) as a new metric within annual staff performance reviews, rhetoric supporting human rights has increased in recent years. Unfortunately, funding priorities largely determined by intransigent member states limit the ability of SEARO to move from rhetoric to reality.

**Chart: Recent “human rights” rhetoric in SEARO.**

N.b. I am in the process of putting together a timeline that compares the mentions of the term “human rights” and related concepts in SEARO literature. Under analysis are the Biennial Reports of the Regional Director and also minutes and reports of the last 10 years of RD meetings with WHO counterparts. Based on a preliminary analysis, it is clear that there has been an uptick in human rights rhetoric after the introduction of the three-pronged “GER” mainstreaming approach and also the new focus on universal coverage. While ‘talk is cheap,’ we do know that one of the main areas of concern in SEARO is an entrenched distaste for the term itself.

C. **Efforts to build capacity and raise the profile of human rights regionally.**

Through close partnerships with WHO’s GER team in Geneva, SEARO has advanced several recent initiatives that seek to capacitate member states and promote rights-based approaches to health regionally. Once again, political sensitivities around human rights and the dynamics between New Delhi and member states have limited concrete outputs. Nevertheless, requests from member states have increased over the past several years. Specifically, SEARO/GER organized an inter-country training of trainers (“ToT”) on human rights-based and gender-sensitive approaches to health programs in partnership with UNAIDS for Bangladesh, Indonesia, Myanmar, Thailand and Timor-
Leste in 2013. Additionally, human rights concepts were incorporated into a 2012 regional capacity-building workshop on urban health equity assessments where a health in all policies approach was melded with a rights-based approach. The six remaining countries will be invited in April, 2015. Additionally, regional office staff attended a June 2013 meeting on mainstreaming of GER that emphasized “the need for country offices to recognize and mainstream these concepts and programs into new country cooperation strategies” (SEARO, 2013). Additionally, SEARO’s GER JPO infrequently collaborates with other sections of SEARO to develop trainings that have a small health and human rights component. While the WHO/GER team supports these specialized presentations, there are strict limitations on travel, time and funds. Looking ahead, SEARO/GER was requested by the Maldives to organize a presentation on gender, equity and human rights in health programs in 2015.

Beyond workshops and capacity building exercises, SEARO/GER has several concrete health and human rights outputs. Most recently, the SEARO/GER team is engaged in developing indicators for reporting on health, equity and gender in the South-East Asian context. In the past, the SEARO/GER team has been commissioned to provide health and human rights focused technical briefs for Member States (e.g. a human rights assessment on Maldives). Additionally, the unit has produced a series of reports in collaboration with regional academics (see Table 8).
Table 8: Human rights documents in SEARO

<table>
<thead>
<tr>
<th>Year</th>
<th>SEARO Health and Human Rights Output</th>
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</thead>
<tbody>
<tr>
<td>2012/2013</td>
<td>• Human Rights Assessment on Maldives’ National Policy on Ageing</td>
</tr>
</tbody>
</table>
| 2010/2011  | • Neonatal Health and Human Rights Factsheet for Indonesia  
|           | • Health and Human Rights Factsheet on TRIPS agreement and patient protection for Maldives  
|           | • Report: Right to Health in the Constitutions of Member State of the World Health Organization South-East Asia Region  
|           | • Report: Right to Health through Education: Mental Health and Human Rights |

D. Forging human rights alliances both internally and externally.

Unilateral actions on the part of SEARO/GER to advance human rights are seen as ineffective. Instead, human rights successes in SEARO are relationship-driven. Within the regional office, certain divisions or technical units are more receptive to human rights ideals than others. For instance, the HIV/AIDS technical units across WHO collaborate closely with one another, other UN agencies, and are more closely attuned to global normative developments in human rights (Meier & Onzivu, 2014). In this regard, SEARO’s HIV/AIDS unit is no exception with an intuitive understanding of the interplay between human rights to health and other social goods required for effective public health practice such as principles of nondiscrimination. Other receptive technical units include
those that focus on non-communicable disease. Similarly, the technical unit on social
determinants of health promotes gender analysis and is therefore tied to SEARO/GER.
Finally, the emergency and humanitarian action unit has itself engaged with human rights
after questions about discrimination in service provision following the tsunami in Sri
Lanka.

Other potential human rights allies for SEARO/GER include the GER focal points
placed in each of WHO’s country offices. However, while these focal points receive
directives from SEARO/GER, the scope of the portfolio is large and human rights is
often lost in the milieu. Further, all country level focal points are also maternal and child
health focal points, often approaching the subject from medical training as a nurse or
midwife and not necessarily in rights-based approaches to health. Accordingly, maternal
and child health is often emphasized over equity or human rights. Successful human
rights mainstreaming in each member state is largely dependent on how well these
country focal points advance priorities as they liaise directly with the WHO country
representative and focal point in the ministry of health. While focal points are capacitated
alongside member state representatives at SEARO/GER workshops, frequent staff
turnover necessitates a larger emphasis on training. A regional meeting for focal points
takes place on an annual basis, but turnover often occurs at a faster pace.

SEARO/GER has also found human rights success in collaborating directly with
NGOs, civil society actors, and other UN agencies. For instance, UNAIDS and civil
society actors contributes to the 2013 ToT. Unlike WHO, whose government
relationships revolve around country ministries of health, other UN agencies are not
solely reliant on a single government ministry and may potentially contribute this
flexibility to SEARO/GER programs. However, WHO and SEARO leadership only
support these relationships after explicit approval from national ministries of health,
which severely curtails the involvement of these non-traditional actors in promoting
health and human rights in the region. While this is not technically mandated, it has
become organizational practice. More informally, SEARO/GER often reaches out
directly to human rights focal points in other UN agencies to ascertain support for
SEARO programs. And while the integrated approach of GER has been successful on
some levels, it is also unique within the UN system. This has limited the opportunities for
collaboration with other UN agencies who have not merged these streams.

It should also be noted that SEARO/GER collaborates with two academic
institutions to support the development of GER-focused workshops. In India, a strategic
partnership with the Public Health Foundation seeks to train more people to give
presentations on human rights, gender and equity. This would reduce the burden on
SEARO/GER staff to potentially reach new audiences in the region. In Thailand, SEARO
has sought a partnership with Mahidol University focused more closely on equity. These
academic partnerships serve as waypoints to build support for SEARO’s mainstreaming
mandate and provide continued technical assistance in capacity building projects in the
region.

Lastly, SEARO/GER has been able to engage informally with human rights treaty
bodies and other UN agencies. Using gender as an entry point, many SEARO country
offices include Gender Task Teams (GTT), where all UN agencies working on gender
issues host meetings led by UNFPA and UN-Women. These venues have provided opportunities for SEARO/GER to contribute to reporting mechanisms for human rights treaty bodies, such as the Indian shadow report for the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). As reporting is mandatory for all signatories, the collaboration provided a unique opportunity for SEARO/GER to work with a member state (India), other UN agencies and invited civil society organizations to engage on human rights and advance the right to health in particular.
IV. Discussion:

Summary of key themes:

**Pan-American Health Organization (PAHO):**

PAHO’s unique history and organizational character have set the stage for a trajectory unique among WHO’s regional offices. Human rights increasingly form the framework through which policies and programs to advance disease prevention and health promotion are framed. Throughout the history of the Bureau, supportive secretariat leaders have promoted rights-based approaches to health and provide entrepreneurial technical units with both the legitimacy and resources to pursue these goals. Collaboration between these technical units and human rights advisors has allowed for the horizontal integration of human rights across the organization and into regional normative developments. At pivotal moments, secretariat leaders have been willing to expend political capital to drive gains in human rights. Member States active in codifying the right to health in national constitutions also reflect these values at the regional level and support the right to health in PAHO policy. Regional Office human rights expertise is also high—recognized through both a legal team working to translate human rights law to public health and Bureau-wide human rights capacity building opportunities for staff. These efforts deepen institutional capacity and facilitate relationships with regional human rights bodies such as the Inter-American Human Rights System and other UN system processes. Seemingly energized by developments in the region, health and human
rights advisor Javier Vasquez was clear on what he thought of PAHO’s mainstreaming efforts: “It’s a new way of thinking about global health!”

**Regional Office for Africa (AFRO):**

AFRO operates in a challenging region for global health and contends with resource constraints, poor public health infrastructure and the continued legacy of colonialism. With a strong focus on improving health outcomes, rights-based approaches have yet to reach a tipping point within the office and be fully mainstreamed. While leadership from the Regional Director was important in advancing the landmark 2012 Health and Human Rights Resolution, there are few other examples of when human rights is prioritized for more than its rhetorical value. Despite internal consensus at WHO HQ in Geneva, African Region Member States still openly question whether human rights should be a “core function” of agency’s work. This skepticism may fuel staff apathy on the subject and contribute to poor understandings on the links between health and human rights. In this realm, while AFRO has had some success in rights-based capacity building at the sub-regional level, staff in Brazzaville lack expertise in both human rights law and more foundational understanding of health related rights. At the technical unit level, evidence suggests that women’s health focused teams pursue rights-based approaches in 1) framing health disparities in human rights terms, and 2) supporting a regional coalition whose existence is justified by the right to health. With new a new Regional Director and ongoing process of restructuring, the prioritization of human rights remains to be seen as the Regional Office does not currently have a human rights focal point. But the potential is great. Upon leaving his post after decades in
working in the public service of Africans, former RD Dr. Samba said: “My experience of more than 20 years as a director has taught me that change cannot occur if one has to wait for all the ‘right’ conditions to be in place before embarking on a desired change” (Samba, 2004).

**Regional Office for South-East Asia (SEARO):**

SEARO is one of the only WHO regions to be composed entirely of recipient countries. This contrasts sharply to offices like the Western Pacific, which house a greater diversity of recipient (Philippines) and donor (Australia, Japan, South Korea) countries and the European Region, which may be considered entirely composed of donor countries. Member state reluctance to engage on issues of human rights renders efforts by SEARO/GER to mainstream human rights considerably difficult. Staffing concerns including a reliance on JPOs provided by countries in the Global North and no direct handoff planned for human rights responsibilities after June 2015 add to the difficulty. Regional leadership very rarely prioritizes human rights and even more rarely moves from rhetoric to reality. Regional office personnel lack understanding of how a rights-based approach to health can complement their work and largely reject human rights as incompatible with SEARO’s mandate. While certain technical units have sought to individually advance human rights, this willingness is curtailed by strict limitations on collaboration with civil society. Necessity is the mother of invention and SEARO/GER has sought to advance the spirit of human rights in a manner agreeable to the South Asian palate. Often this means emphasizing gender and equity and reframing contentious terms such as “human rights.” Reflecting on her tenure at SEARO, human rights focal point
Benedicte Briot summarizes, “if health and human rights is too sensitive, then you just talk about the right to health. It’s only wording. You change your jacket; whichever is easier to do your job without losing sight of the end goal. It’s about diplomacy and adaptation.”

<table>
<thead>
<tr>
<th>Regional Office</th>
<th>Yes/No/Maybe</th>
<th>Definition: Positive action taken by executive leadership to wield structural influence in order to promote human rights.</th>
</tr>
</thead>
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<tr>
<td><strong>A. Human rights leadership</strong></td>
<td>PAHO: Yes</td>
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<tr>
<td></td>
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<td></td>
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<table>
<thead>
<tr>
<th>Regional Office</th>
<th>Yes/No/Maybe</th>
<th>Definition: Member state willingness to pursue opportunities to establish human rights within organizations, e.g. advancing rights-based normative legislation in regional organizations.</th>
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</thead>
<tbody>
<tr>
<td><strong>B. State support</strong></td>
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<tr>
<td></td>
<td>AFRO: Maybe</td>
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<td></td>
<td>SEARO: No</td>
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<table>
<thead>
<tr>
<th>Regional Office</th>
<th>Yes/No/Maybe</th>
<th>Definition: Institutional and staff capacity to meaningfully apply rights-based approaches and understand the linkages between health and human rights.</th>
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<tbody>
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<td><strong>C. Human rights expertise</strong></td>
<td>PAHO: Yes</td>
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<td></td>
<td>AFRO: No</td>
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<td></td>
<td>SEARO: No</td>
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<thead>
<tr>
<th>Regional Office</th>
<th>Yes/No/Maybe</th>
<th>Definition: Technical team support for human rights and understanding of the programmatic advantages of human rights law to technical programs.</th>
</tr>
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<tbody>
<tr>
<td><strong>D. Technical unit commitment</strong></td>
<td>PAHO: Yes</td>
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<td></td>
<td>AFRO: Maybe</td>
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<td></td>
<td>SEARO: Maybe</td>
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</table>
**E. Staff perception**

<table>
<thead>
<tr>
<th>Definition: Employee understanding of human rights in relation to the organization’s mission, culture and values.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAHO</td>
</tr>
<tr>
<td>AFRO</td>
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<tr>
<td>SEARO</td>
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**Significance:**

Mapping the causal processes that shape the impact of human rights efforts on public health outcomes is an essential component of the global movement toward health equity. Only human rights provides a framework that guides governments and other organizations in generating conditions in which all peoples can achieve the highest attainable standard of health. In a health governance environment where Regional Offices of WHO are able to provide leadership and disseminate new norms, ensuring the effective mainstreaming of the human right to health is of the utmost priority.

This study confirms and elaborates on the results of Meier & Ayala, 2014 who first made the case that understanding the institutional determinants of human rights in health governance can aid a global implementation effort. This study expands on the four original pathways identified by Meier & Ayala, clarifying the form these variables take by expanding analysis to a comparison of other regional WHO contexts—particularly those where human rights are generally not prioritized. By providing evidence from the other side, many of the results emerging from PAHO’s remarkable human rights success story continue to be affirmed: the absolute necessity of secretariat leadership, initiative of technical staff, and capacity building to build fluency in applying human rights.
The unfortunate reality is that it is often the world’s most resource poor regions that are likely to suffer the greatest violations of the right to health. Telling the story of how some regional organizations are both succeeding and stumbling in addressing this challenge could serve as the impetus for future research in this area. Ultimately, research of this nature could structure institutional roadmaps for reform, positively shifting the way global health governance seeks to respect, protect, and fulfill the right to health.

Limitations:

This study has several limitations that must be understood to contextualize findings. It is based on a small $n$ sample size of only three key informants. While the number of key informants possible (six) was already small, the sample may not be large enough to protect against random bias. This may skew research findings along the personality and idiosyncrasies of individual interviewees, which may not be entirely indicative of the regional office context.

Steps were taken through rigorous document analysis prior to the interview offset this challenge. Further, semi-structured interviews are heavily reliant on the interviewer’s familiarity with context and content. Thus, a lack of personal familiarity with the historical background of each regional office may limit the effectiveness of questions asked. Once again, rigorous preparation, including through ‘pilot interviews,’ may largely mitigate this risk (Merriam, 2009).

Finally, while document analysis presents many benefits such as increased access to resources around the globe, the approach also faces limitations. In the study, certain
regional settings yielded a much larger amount of documents than others. This weights the type of evidence used to judge conclusions from both methods of analysis. Further, data, especially grey literature, is not often developed for the purposes of research and may be incomplete from a research perspective (Merriam, 2009, p. 154). There is an added danger that sources may provide unrepresentative samples or offer information incongruent with findings emerging from data gleaned in interviews (Merriam, 2009). It is for this reason that documentary analysis will primarily inform the first research question, rather than the second.
Appendices:

- **Appendix A**: Standard Key Informant Guide
- **Appendix B**: Map of WHO Regional Offices
- **Appendix C**: List of Acronyms
Appendix A. Standard Key Informant Guide

Regional Human Rights Officer Questions:
1. How has the regional office integrated human rights into policies, programs and practices?
   a. Probe for specific programs and publications
   b. What was your role?

2. How do regional technical staff learn about the role of human rights in regional office programming?
   a. Is there a formal training/capacity building program in human rights?
   b. What was your role?

3. How and in what ways is support from regional office leadership important to your work?

4. In what ways do regional legislative bodies support or hinder human rights promotion within your regional context?

5. Can you describe how member states influence human rights mainstreaming in your regional office?

6. If applicable, what is the relationship between your unit and regional human rights systems and structures? What support, if any, is provided?

7. If applicable, could you describe how relationships with international NGOs and regional civil society organizations affect human rights in your office?

8. In your opinion, how important is technical legal expertise in improving rights-based approaches in your office?

9. Can you describe how the WHO Secretariat has supported your efforts to mainstream human rights? What connections, if any, exist among different sections of WHO?

10. How would you define success for your mandate and what are the chief challenges to achieving that success? What could you do better?
Appendix B. Map of WHO Regional Offices
References


