

# A LONG AND WINDING ROAD: THE EVOLUTION OF APPLYING HUMAN RIGHTS FRAMEWORKS TO HEALTH

ALICIA ELY YAMIN,\* AND ANDRÉS CONSTANTIN\*\*

## ABSTRACT

*Over twenty years after it began to take shape, the “health and human rights field” is a misnomer; it is not one field, but many. The application of human rights frameworks to health has been a critical part of the expansion of human rights to social and economic policies and in demonstrating the porousness and arbitrariness of divides between the public and private spheres. The interaction between health and human rights fields has advanced the re-interpretation of legal norms in light of gendered and other experiences and encouraged the establishment of institutional frameworks and procedures at national and international levels. Despite extraordinary successes, however, the utility of human rights faces new challenges: gaining and maintaining normative and social legitimacy, meaningfully disrupting economic inequalities that ravage global health, and navigating the complex move from constitutional and other legal norms to effective enjoyment in practice.*

I. INTRODUCTION . . . . .	193
II. THE 1990s: NEW OPENINGS FOR LINKING HEALTH AND HUMAN RIGHTS . . . . .	196
A. <i>The Beginning of a “Health and Human Rights” Movement</i> . . . . .	197

---

\* Visiting Professor of Law, Georgetown University Law Center, and Adjunct Lecturer on Law and Global Health, Harvard T.H. Chan School of Public Health. Yamin also directs the Health and Human Rights Initiative at the O’Neill Institute for National and Global Health Law at Georgetown, and is a Global Fellow at the Centre on Law and Social Transformation. Professor Yamin currently serves as a Commissioner on the Lancet-O’Neill Institute Commission on Global Health and the Law and as a Panelist on the Independent Accountability Panel for the UN Secretary General’s Global Strategy for Women’s, Children’s, and Adolescents’ Health. Previously, she has served on numerous UN expert groups, steering committees and task forces, as well as the Oversight Committee of Kenya’s Constitutional Implementation Commission’s work on the right to health, and as an Independent Expert to the Colombian Constitutional Court on the Implementation of its 2008 T-760/08 decision calling for restructuring the health system. She regularly leads judicial colloquia and strategic litigation courses for practitioners, advises on specific cases, submits amicus curiae petitions and participates in expert consultations relating to the application of international and constitutional law to health issues. © 2018, Alicia Yamin and Andrés Constantin.

\*\* Abogado (JD equivalent), Universidad Torcuato Di Tella, Buenos Aires, Argentina; LL.M. Candidate in Global Health Law, Global Health Law Scholar, Georgetown University Law Center.

	B.	<i>Shifts in Public Health, HIV, and Evidence of the Power of Rights Paradigms</i> . . . . .	203
	C.	<i>Regulation of Private Actors: The Case of Tobacco Control</i> . . . . .	204
	D.	<i>Seeding Norms and Setting Standards</i> . . . . .	205
	E.	<i>Regional Systems Used to Advance New Understandings of Rights</i> . . . . .	206
	F.	<i>How Do We Measure Progress While Considering Resource Availability?</i> . . . . .	208
	G.	<i>Backlash Against Advances in Sexual and Reproductive Health and Rights</i> . . . . .	210
III.		2000-2010: BUILDING HUMAN RIGHTS INSTITUTIONS AND PROCEDURES AT GLOBAL AND NATIONAL LEVELS . . . . .	211
	A.	<i>Constructing the Institutional Architecture of International Human Rights</i> . . . . .	211
	B.	<i>Health Systems Defined as Core Social Institutions</i> . . . . .	213
	C.	<i>Human Rights-Based Approaches to Development and Health Defined</i> . . . . .	214
	D.	<i>Reflections on MDGs: Re-linking Human Rights and Development</i> . . . . .	215
	E.	<i>The Quest for Indicators: Measuring “Effective Enjoyment” of Health and Other Economic and Social Rights</i> . . . . .	216
	F.	<i>Using Treaty Law to Contain Global Health Threats</i> . . . . .	219
	G.	<i>Health Rights as Real Rights: the Role of Legal Enforcement</i> . . . . .	220
	H.	<i>Fragmentation of Norms at the International Level</i> . . . . .	224
III.		2010-2017: OPERATIONALIZATION OF HUMAN RIGHTS-BASED APPROACHES AMIDST GLOBAL SHIFTS . . . . .	224
	A.	<i>Tobacco Control Becomes a Human Rights Issue</i> . . . . .	225
	B.	<i>Challenges of Air Pollution, Mining, and Other Health Hazards</i> . . . . .	226
	C.	<i>MDGs to SDGs: Case Study of Reproductive, Maternal, Newborn, and Child Health</i> . . . . .	227
	D.	<i>Operationalizing Health Rights-Based Approaches to Health</i> . . . . .	229
	E.	<i>Perils Inherent in Converting Human Rights Standards and Principles into Operational Tools</i> . . . . .	230
	F.	<i>Achieving Universal Health Coverage and the Right to Health</i> . . . . .	230
	G.	<i>Metrics and Their Reflection On Human Rights</i> . . . . .	232
	H.	<i>Neoliberalism, Privatization, and the Commercialization of Health</i> . . . . .	234
	I.	<i>Conservative Agendas Gaining Ground</i> . . . . .	235

J. *Legitimacy Questions Relating to the Human Rights Regime* . . . . . 236  
 V. CONCLUSION . . . . . 237

“Our post-war institutions were built for an international world, but now we live in a global world” – *former UN Secretary General Kofi Annan, 1999*<sup>1</sup>

I. INTRODUCTION

The *Escuela de Mecánica de la Armada* (ESMA), the former naval school that served as the largest clandestine torture center during the Argentine dictatorship (1976-1983),<sup>2</sup> is striking for the suffocating intimacy of the horrors that took place there. While women were having babies wrenched from their wombs to be delivered to military families in the attic, and electrodes were being carefully attached to nipples and genitals in the basement, Rear Admiral Rubén Jacinto Chamorro, the director of the ESMA for most of those years, was living with his family in attached quarters and entertaining guests.<sup>3</sup> The ESMA, now a “piece of evidence” in ongoing trials, stands as a sickening symbol in the middle of Buenos Aires of the hell into which the country descended.<sup>4</sup> In turn, the brutality of the military dictatorship in Argentina where an estimated 30,000 people were “disappeared,”<sup>5</sup> as well as across the Southern Cone and elsewhere in the world, lent urgency to the discourse and framework of international human rights. Indeed, in the ESMA itself, the walls that were plastered by the military to hide an elevator and descriptions that had been given to the Inter-American Commission of Human Rights (IACHR) by escaped detainees are telling, as masks tend to be, not so much for what they hide, but for what they reveal.<sup>6</sup> That is, the debate was about the facts—whether the

---

1. KOFI A. ANNAN, WE THE PEOPLES: THE ROLE OF THE UNITED NATIONS IN THE 21ST CENTURY 11 (2000), [http://www.un.org/en/events/pastevents/pdfs/We\\_The\\_Peoples.pdf](http://www.un.org/en/events/pastevents/pdfs/We_The_Peoples.pdf).

2. *El Plan Sistemático de represión ilegal*, ESPACIO MEMORIA Y DERECHOS HUMANOS [EX ESMA], <http://www.espaciomemoria.ar/dictadura.php> (last visited Feb. 20, 2018).

3. See NAT’L COMM’N ON THE DISAPPEARANCE OF PERSONS, NUNCA MÁS REPORT (2d ed. 2006) [hereinafter NUNCA MÁS REPORT]; see also Inter-Am. Comm’n H.R., *Report on the Situation of Human Rights in Argentina*, Doc. 19 corr. 1, OEA/Ser.L/V/II.49, ch. III(D) (Apr. 11, 1980).

4. See NUNCA MÁS REPORT, *supra* note 3; see also ESPACIO MEMORIA Y DERECHOS HUMANOS [EX ESMA], *supra* note 2.

5. See Ernesto Sabato, *Prologue*, in NUNCA MÁS REPORT, *supra* note 3. The authors acknowledge that the number of disappeared people during this period is highly contested in Argentina.

6. See Inter-Am. Comm’n H.R., *Report on the Situation of Human Rights in Argentina*, *supra* note 3.

alleged actions occurred as described. It was clear that, if they had, they would have constituted torture by public officials that contravened international and national law.<sup>7</sup> It was also clear that supranational institutions, such as the IACHR, were essential spaces and forums for people's voices when their governments became predatory and that even the military dictatorship cared about the "overlapping consensus" that condemned Argentina.<sup>8</sup> This Article is largely the story of how the struggles in human rights have evolved since the days of the Argentine junta and how the "health and human rights field" fits into that complicated narrative.

It is, on the one hand, a promising tale about the expansion of understandings of rights and equality, both formal and substantive, which has everything to do with patterns of health and well-being, as well as the spaces in which rights are exercised and violated. That is, the populations actively claiming to be subjects of rights have grown to include, *e.g.*, persons with disabilities, gender-non-conforming persons, and other marginalized groups. And the way we have come to understand both violations and equal enjoyment of rights—including those related to health—has evolved significantly. Actions in the private sphere, such as intimate partner violence (IPV), and in institutions, including health care settings, are understood to lie within the domain of rights and state responsibility. Further, some questions relating to the access to entitlements, including health care, have begun to be regularly addressed in rights terms, and are increasingly enforced in courts across various regions.

The tremendous development, however, of economic, social, and cultural (ESC, or "economic and social") rights, including the right to health itself, have not yet delivered on robustly egalitarian policies. Some scholars have even argued that it has fostered an anemic "sufficientarianism," which sanitizes the economic oppression embedded in the neoliberal global order.<sup>9</sup> Thus, this is also a cautionary tale. The aspiration of universal standard-setting evolved into, on the one hand, the proliferation of human rights-based approaches to health (HRBAs) that are often untethered from the subversive potential of rights, and, on the other, soft law interpretations that have grown increasingly fragmented and inconsistent. The well-founded desire to measure progressive realization of economic and social rights, including health, may

---

7. *Id.*

8. See JACK DONNELLY, UNIVERSAL HUMAN RIGHTS IN THEORY AND PRACTICE 40 (2003).

9. Lukas Meyer, *Sufficientarianism Both International and Intergenerational?*, in ABSOLUTE POVERTY AND GLOBAL JUSTICE: EMPIRICAL DATA, MORAL THEORIES, INITIATIVES 133 (Elke Mack et al. eds., 2009).

well end up reductively defining the meaning of rights and even displacing attention from broader struggles over structural obstacles.

Where we choose to begin a narrative determines the way we perceive the unfolding story. In recounting this evolution, we have chosen to break developments down into three periods. We begin this narrative in the early 1990s with the reconfiguration of the global architecture due to the thawing of the Cold War, which had divided 1) civil and political rights and 2) economic, social, and cultural rights, with civil and political rights clearly dominating the international subsystem as the only “real rights.”<sup>10</sup> An explosion of human rights standards and institutional spaces was creating a renaissance in human rights, while, at the same time, the HIV/AIDS pandemic was challenging not only conventional public health responses, but also fundamental principles of human rights such as non-discrimination.<sup>11</sup>

As to the 1990s, we focus on the conceptual connections being drawn between the fields and in particular on what Jonathan Mann et al. termed the “inextricable linkage” between health and human rights.<sup>12</sup> Our analysis of the second period, 2001-2010, focuses on the normative development of the right to health, in both international law and domestic constitutional frameworks, together with the development of institutions, procedures, and techniques to advance health rights. At the same time, the world of global development adopted a significantly more technocratic approach in the 2000s, evidenced by the Millennium Development Goals (MDGs).<sup>13</sup> Finally, considering the period 2010-2017, we take stock of the transition from the MDGs to the Sustainable Development Goals (SDGs), with implications for human rights and health. We also note the increasing attempts to “operationalize” or implement health rights in practice, from policy guidance to national legal mobilization regarding health as a rights issue.

We conclude that over twenty years after the “health and human rights field” began to take shape, its name is a misnomer; it is not one field but many. This cluster of related work has achieved some extraordinary successes—from global standard-setting to national policies and legal judgments to successful social mobilization. The field now faces

---

10. See HENRY J. STEINER, PHILIP ALSTON & RYAN GOODMAN, *INTERNATIONAL HUMAN RIGHTS IN CONTEXT: LAW, POLITICS, MORALS* 237-38 (3d ed. 2008).

11. See Jonathan M. Mann & Daniel Tarantola, *Responding to HIV/AIDS: A Historical Perspective*, 2 *HEALTH & HUM. RTS.* 5, 5-8 (1995).

12. See Jonathan M. Mann et al., *Health and Human Rights*, 1 *HEALTH & HUM. RTS.* 7, 7-23 (1994).

13. See THE MDGs, CAPABILITIES AND HUMAN RIGHTS: THE POWER OF NUMBERS TO SHAPE AGENDAS (Sakiko Fukuda-Parr & Alicia Ely Yamin eds., 2015).

new challenges, however: legitimacy with respect to a precariously constructed international normative scaffolding, economic inequalities, eroding faith in internationalism over decades, and the complexities of moving from constitutional and other legal norms in countries to effective enjoyment in practice. Finally, the dramatic shifts in the world order and the rise of conservative nationalist populism, which became overwhelmingly evident in 2016, challenge efforts to apply human rights frameworks in new ways.<sup>14</sup>

## II. THE 1990s: NEW OPENINGS FOR LINKING HEALTH AND HUMAN RIGHTS

In the wake of de-colonization in the 1950s and 1960s and the undeniable brutality of the military and other authoritarian regimes that were ravaging much of Latin America (among other regions), human rights became a leading model of emancipation in the 1970s.<sup>15</sup> Yet human rights work (at least in the West) in the 1970s and 80s focused largely on civil and political rights—negative rights protecting freedom of individuals primarily from infringement by governments—in the so-called “public sphere,” a product of the binary construction of the traditional liberal state and the Cold War.<sup>16</sup> The power that human rights were meant to regulate was largely envisioned as abuses stemming from state tyranny.<sup>17</sup> These were violations by police and armed forces, violations of the right to bodily integrity, to political participation, and to due process of law—as exemplified by the Argentine junta example above. International human rights law and practice had yet to evolve to address many other issues crucial to health, ranging from domestic violence in the so-called “private sphere” to affirmative access to entitlements from the state, including public health preconditions and health care.<sup>18</sup> These other issues required a different understanding of what exercises of power prevented people from living lives of dignity and flourishing and of how and when that power was exercised and might be regulated.<sup>19</sup>

---

14. See Philip Alston, *The Populist Challenge to Human Rights*, 9 J. HUM. RTS. PRAC. 1, 1-15 (2017); see also EDWARD LUCE, *THE RETREAT OF WESTERN LIBERALISM* (2018).

15. See Ellen L. Lutz & Kathryn Sikkink, *International Human Rights Law and Practice in Latin America*, 54 INT'L ORG. 633, 644-59 (2000).

16. See STEINER, ALSTON & GOODMAN, *supra* note 10, at 237-38.

17. *Id.*

18. See Hilary Charlesworth, Christine Chinkin & Shelley Wright, *Feminist Approaches to International Law*, 85 AM. J. INT'L L. 613, 613-45 (1991).

19. See ALICIA ELY YAMIN, *POWER, SUFFERING AND THE STRUGGLE FOR DIGNITY: HUMAN RIGHTS FRAMEWORKS FOR HEALTH AND WHY THEY MATTER* 25-72 (2016); see also PAUL FARMER, *PATHOLOGIES OF POWER, HEALTH, HUMAN RIGHTS AND THE NEW WAR ON THE POOR* (2003).

There was a radical shift, however, in the human rights institutional architecture and field that followed the collapse of the Berlin Wall at the end of the 1980s and early 1990s. When human rights was no longer perceived as an arena for the heated political battles of the Cold War, it was possible to once again—as had occurred in the Universal Declaration of Human Rights at the end of World War II—re-envision rights as interlocking building blocks to construct a life of dignity.<sup>20</sup> The preamble of the Vienna Declaration plainly stated: “All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis.”<sup>21</sup>

The Vienna conference was also important because it made possible the two path-breaking conferences that followed in the mid-1990s, the International Conference on Population and Development (ICPD or Cairo) in 1994<sup>22</sup> and the Fourth World Conference on Women (Beijing) in 1995.<sup>23</sup> These subsequent conferences and the efforts to construct international norms that they triggered were critical to the construction of linkages between human rights and health, in women’s health and beyond. At the same time, the advent of effective treatments for HIV/AIDS and the mobilization of social movements and use of courts to establish the rights of people living with HIV/AIDS set precedents for the field.

#### A. *The Beginning of a “Health and Human Rights” Movement*

During the early and mid-1990s the nascent “health and human rights” movement was also being formally constructed as a theoretical field, with a pivotal role played by Jonathan Mann, founding director of Harvard University’s François-Xavier Bagnoud Center for Health and Human Rights.<sup>24</sup> In a seminal 1994 article, Jonathan Mann and colleagues characterized three linkages between health and human

---

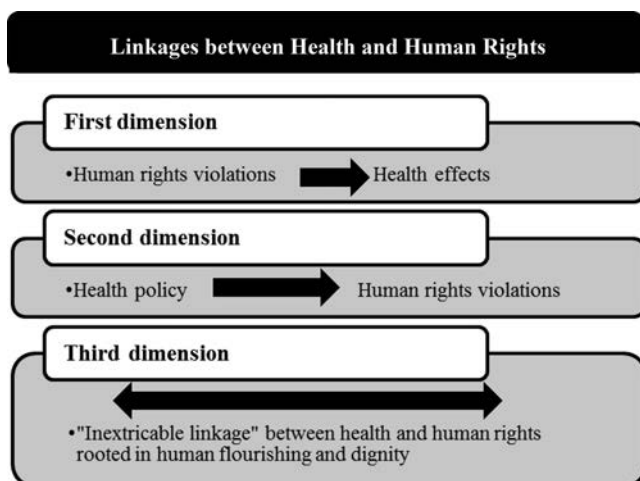
20. See STEINER, ALSTON & GOODMAN, *supra* note 10, at 137-42.

21. See World Conference on Human Rights, *Vienna Declaration and Programme of Action*, ¶ 5, U.N. Doc. A/CONF.157/23 (June 25, 1993).

22. See International Conference on Population and Development, *Report of the International Conference on Population and Development*, U.N. Doc. A/CONF.171/13 (Sept. 5-13, 1994) [hereinafter Cairo].

23. See Fourth World Conference on Women, *Beijing Declaration and Platform of Action*, U.N. Doc. A/CONF.177/20 (Oct. 17, 1995) [hereinafter Beijing].

24. See Lawrence O. Gostin, *A Tribute to Jonathan Mann: Health and Human Rights in the AIDS Pandemic*, 26 J. L. MED. & ETHICS 256, 256-58 (1998).



Source: Jonathan Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS. 7 (1994).

rights.<sup>25</sup> The first dimension relates to the health consequences arising as a result of human rights violations. Especially, in their discussion, civil rights violations such as torture. The second dimension concerned the influence of health policies, programs, and practices on human rights—again, at its outset, with a focus in particular on civil rights. The third and final dimension entailed the recognition of health and human rights as complementary dimensions of, and potentially complementary approaches to, understanding human dignity and wellbeing.<sup>26</sup>

The first dimension is well illustrated by the ESMA case, as rape, torture, and murder by agents of the state quite evidently directly impacted the victims' health. Although those human rights violations were conducted by traditional security officers, the applicability of the state's obligation to prevent and sanction torture has, as we shall see, subsequently been extended to include, *e.g.*, health care workers as agents of the state, as well as the prevention, punishment, and eradication of torture committed by private actors in the home or in other institutions, including intimate partner violence.<sup>27</sup>

25. Mann et al., *supra* note 12.

26. *Id.* at 19-22; see also YAMIN, *supra* note 19, at 36-37.

27. See Juan E. Méndez (Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment), *Rep. of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013) [hereinafter Méndez]; see also Inter-Am. Comm'n. H.R., *Patients at the Federico Mora Hospital*,



Expanding understanding of the arenas in which power is exercised to the private sphere has been a long struggle in human rights law and practice and is still continually contested.<sup>28</sup> Yet it was and remains critical to making the application of human rights relevant to health, and this evolution demonstrates the link between norm creation and making visible the political decisions and human agency behind the suffering of women and children, among others. Take the example of the ESMA again: the delivery of babies by doctors working for the military was at the time understood to be a clear violation of rights, including freedom from cruel, inhuman, and degrading treatment. By contrast, that women delivering in regular health care facilities could also experience degrading treatment and abuse due to systemic violence had yet to be conceptualized as a violation of human rights norms and therefore remained largely invisible.<sup>29</sup> Similarly, while political dissidents imprisoned in psychiatric hospitals were clearly understood to be victims of human rights violations during the Cold War, it was not until the 1990s that the conditions and treatment of patients with intellectual and psychiatric disabilities began to be recognized as an issue of human rights *per se*.<sup>30</sup>

These shifts required new understandings of rights, equality, and the responsibilities of the state. In a narrowly circumscribed liberal paradigm of rights, inherited from constitutions and political thinking dating back to the eighteenth and nineteenth centuries, the assumption is that individuals are “free” insofar as the state does not force them to act against their will or interfere with their personal decisions.<sup>31</sup> Thus,

---

*Guatemala (Precautionary Measure 370/12)* (Nov. 20, 2012) (concerning patients of the Federico Mora Hospital who were subjected to physical, psychological and sexual violence by other inmates, guards and hospital staff); *I.V. v. Bolivia, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 329, ¶ 185* (Nov. 30, 2016) (concerning a woman who was subjected to sterilization without her informed consent in a public hospital in Bolivia); U.N. Comm. against Torture, *Conclusions and Recommendations, Chile*, ¶ 7(m), U.N. Doc. CAT/C/CR/32/5 (May 14, 2004); U.N. Human Rights Comm., General Comment No. 28: Article 3 (The Equality of Rights between Men and Women), ¶ 11, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (Mar. 29, 2000); Carlos Herrera Vacaflo, *Obstetric Violence: A New Framework for Identifying Challenges to Maternal Healthcare in Argentina*, 24 REPRODUCTIVE HEALTH MATTERS 65, 65-73 (2016).

28. See STEINER, ALSTON & GOODMAN, *supra* note 10, at 218-24.

29. See Méndez, *supra* note 27, ¶ 46.

30. See, e.g., MENTAL DISABILITY RIGHTS INTERNATIONAL, HUMAN RIGHTS AND MENTAL HEALTH URUGUAY 30-48 (June 1995).

31. See, e.g., JOHN LOCKE, TWO TREATISES OF GOVERNMENT (Peter Laslett ed., 1988); JOHN STUART MILL, ON LIBERTY AND OTHER WRITINGS (Stefan Collini ed., 1989); JUAN BAUTISTA ALBERDI, BASES Y PUNTOS DE PARTIDA PARA LA ORGANIZACIÓN POLÍTICA DE LA REPÚBLICA ARGENTINA (1998).

rights were understood as shields from state agents, such as in the example of the ESMA. The underlying idea in such a view—*i.e.*, that the private sphere was a realm to be governed by personal morality and behavior, rather than the government—had to be adapted if rights could be deployed to protect women and children, who suffer most violations of their rights within the home.<sup>32</sup> The United Nations (U.N.) Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), promulgated in 1979, and the Convention on the Rights of the Child, promulgated a decade later, transcended these artificial divides and called for states to take responsibility for changing social practices that affect women and children.<sup>33</sup> Yet it was not until the early 1990s, and Vienna, that these new understandings took hold in international law and in a proliferation of national legislation.

It was undoubtedly Jonathan Mann's work as the first director of the WHO's Global Programme on AIDS and experience with the raging HIV/AIDS pandemic that influenced his profound concern with this second dimension of the connection between health and human rights: health policies can cause violations of human rights.<sup>34</sup> Mann argued that health policies were so likely to be inadvertently discriminatory that all "health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise."<sup>35</sup> The history of HIV/AIDS is replete with such discrimination, and the advent and spread of effective anti-retroviral therapy did not put an end to the need to assess laws and policies for their discriminatory effects on the basis of race, gender identity, sexual orientation, caste, ethnicity, and the like in addition to HIV status.<sup>36</sup> A 2015 case from the High Court of Kenya on the constitutionality of the "Uhuru's HIV List" illustrates why this concern remains relevant today.<sup>37</sup> In that case, the Court found that the implementation of a directive issued by the President Uhuru Kenyatta to all County Commissioners to collect data on all school-going children living with HIV/AIDS violated their

---

32. See YAMIN, *supra* note 19, at 43.

33. Convention on the Elimination of All Forms of Discrimination Against Women art. 5, Dec. 18, 1979, 1249 U.N.T.S. 13; Convention on the Rights of the Child, Nov. 20, 1989, 1577 U.N.T.S. 3.

34. See Gostin, *supra* note 24, at 257.

35. Mann et al., *supra* note 12, at 16.

36. See Lara Stemple, *Health and Human Rights in Today's Fight against HIV/AIDS*, 22 AIDS 113, 113-21 (2008).

37. Kenya Legal and Ethical Network on HIV & AIDS v. Cabinet Secretary Ministry of Health and Others (2016) (H.C.K.) (Kenya).

rights to privacy and the best interests of the child.<sup>38</sup> Thus, Mann et al.'s insight continues to be extraordinarily important for applying human rights frameworks to health, in HIV and beyond. That is, public health policies are especially apt to be rife with abuses because they are so often justified under the pretext of safeguarding some overarching purpose, which is made to appear of heightened necessity when coupled with a generalized fear such as containing the spread of a deadly infectious disease or the dangers posed by those with mental illness.<sup>39</sup>

But it was the third dimension of the connection between health and human rights (what Mann et al. called the “inextricable linkage” between health and human rights) that had the most profound implications because it captured the notion that having agency over one’s life—dignity—is intrinsically connected to health.<sup>40</sup> That agency requires freedom from abuse and decisional autonomy in the private sphere, as well as access to endowments in the public sphere. It also requires both civil and political rights and economic and social rights. During the 1990s, that “inextricable linkage” between health and human rights was perhaps best illustrated in women’s health and sexual and reproductive health and rights because transformative paradigm shifts were occurring not only in human rights, but also in public health related to these areas. It was clear to women’s health activists that patterns of reproductive health were the artifact of relations of power that restricted or enabled autonomy and access to endowments—based on gender, but also in conjunction with class, ethnicity, and other axes of identity.<sup>41</sup>

The Programme of Action adopted at ICPD was the result of years of activism of women’s groups from around the world.<sup>42</sup> The ICPD Programme reflected a dramatic shift in public health from targeted policies based on demographic imperatives to policies based on reproductive *rights*. Carmel Shalev, formerly of the Committee on the

---

38. *Id.* ¶ 112(b).

39. See, e.g., *West Africa: Respect Rights in Ebola Response*, HUMAN RIGHTS WATCH (Sept. 15, 2014), <https://www.hrw.org/news/2014/09/15/west-africa-respect-rights-ebola-response> (addressing the threat to human rights posed by quarantines implemented during the Ebola epidemic).

40. Mann et al., *supra* note 12, at 19.

41. See Lynn P. Freedman, *Human Rights and the Politics of Risk and Blame: Lessons from the International Reproductive Health Movement*, 52 J. AM. MED. WOMEN’S ASS’N 165, 165-68 (1997); see also Alicia Ely Yamin, *Transformative Combinations: Women’s Health and Human Rights*, 52 J. AM. MED. WOMEN’S ASS’N 169, 169-73 (1997).

42. See Cairo, *supra* note 22.

Elimination of Discrimination against Women (CEDAW Committee),<sup>43</sup> argued that ICPD was so important because it “posited the human rights of women—especially their rights to personal reproductive autonomy and to collective gender equality—as a primary principle in the development of reproductive health and population programs.”<sup>44</sup> Further, issues that had previously been treated separately, such as family planning, sexually transmitted infections, and maternal health, were now joined together under the issue of *reproductive health*.<sup>45</sup> And reproductive health was defined broadly, echoing the definition of health in the World Health Organization (WHO) Constitution: “a state of complete physical, mental and social well-being . . . in all matters related to the reproductive system” which “implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”<sup>46</sup>

The Fourth World Conference on Women, held in Beijing, China, in 1995, enabled the sexual and reproductive health and rights movement to continue mobilizing around an expanded platform for women’s health and human rights. The Beijing Platform for Action positioned women’s health within a broader socio-political context of women’s empowerment that transcended public and private life, including poverty, sexuality, gender equality, employment, and political participation and decision-making.<sup>47</sup> The notion of gender equality as a precursor to health rights was radical, stirring controversy “around the concept of gender itself, interpreted by religious conservatives as a code for the disruption of cherished certainties about human relations.”<sup>48</sup> Despite this, however, the outcome Platform for Action reiterated the new paradigm of the ICPD: “[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health.”<sup>49</sup>

---

43. The CEDAW Committee is the body of independent experts that monitors implementation of the Convention on the Elimination of All Forms of Discrimination against Women and consists of 23 experts on women’s rights from around the world. See CEDAW COMMITTEE, 30 YEARS WORKING FOR WOMEN’S RIGHTS 15 (2012), <http://www.soon-young.com/wp-content/uploads/2014/09/CEDAWCommemorativePublication.pdf>.

44. Carmel Shalev, *Rights to Sexual and Reproductive Health: The ICPD and the Convention on the Elimination of All Forms of Discrimination against Women*, 4 HEALTH & HUM. RTS. 38, 40 (2000).

45. See Cairo, *supra* note 22, ¶ 7.2; see also Alicia Ely Yamin, *From Ideals to Tools: Applying Human Rights to Maternal Health*, 10 PLOS MED. 1, 1-4 (2013).

46. See Cairo, *supra* note 22, ¶ 7.2.

47. See Beijing, *supra* note 23, ¶¶ 13-38.

48. See Naila Kabeer, *Tracking the Gender Politics of the Millennium Development Goals: Struggles for Interpretive Power in the International Development Agenda*, 36 THIRD WORLD Q. 377, 380-81 (2015).

49. See Beijing, *supra* note 23, ¶ 96.

B. *Shifts in Public Health, HIV, and Evidence of the Power of Rights Paradigms*

Major paradigm shifts were occurring in public health as well as rights during the 1990s. A year after Beijing, at the 1996 World AIDS Conference in Vancouver, Canada, combination therapy using protease inhibitors (now known as antiretroviral therapy or ART) was introduced for the first time.<sup>50</sup> Thus, it was beginning to be understood that HIV need not be an automatic death sentence. Calls were immediately made to governments and pharmaceutical companies to work together to make ART affordable and available to all, a struggle that would continue into the next decades.<sup>51</sup> The prevailing view in the global health field at the time was that ART was not cost-effective or possible in low-resource settings.<sup>52</sup> Yet, a critical mass of researchers, providers, and most importantly activists and patients, rallied around a central premise that states had the power—and obligation—to do something, *i.e.*, provide ART that could mean the difference between life and death for millions.<sup>53</sup> From South Africa to Brazil and India to Argentina, international human rights norms and constitutional frameworks enabled activists to appropriate their human dignity and, as Lisa Forman has written, empowered them “to make claims for health benefits backed with the force of law.”<sup>54</sup> In 1996, Brazil became the first country from the South to provide universal access to ART after activists, non-governmental organizations (NGOs), central and regional governments, and development agencies came together and framed the demand for access to ART as a human right.<sup>55</sup>

50. See Oren J. Cohen & Anthony S. Fauci, *HIV/AIDS in 1998—Gaining the Upper Hand?*, 280 J.A.M.A. 1, 87 (1998) (referring to the IX International Conference on AIDS, *One World, One Hope*, Vancouver (July 7-12, 1996)).

51. See LARS KALLINGS & CRAIG MCCLURE, 20 YEARS OF THE INTERNATIONAL AIDS SOCIETY: HIV PROFESSIONALS WORKING TOGETHER TO FIGHT AIDS 27 (Rodney Kort & Regina Aragon eds., 2008).

52. See, e.g., David Wilkinson, Katherine Floyd & Charles F. Gilks, *Antiretroviral Drugs as a Public Health Intervention for Pregnant HIV-Infected Women in Rural South Africa: An Issue of Cost-Effectiveness and Capacity*, 12 AIDS 1675, 1675-1682 (1998); see also Kenneth A. Freedberg et al., *The Cost-Effectiveness of Preventing AIDS-Related Opportunistic Infections*, 279 J. AM. MED. ASS'N 130, 130-36 (1998).

53. See, e.g., Lisa Forman, *What Contributions Have Human Rights Approaches Made to Reducing AIDS-Related Vulnerability in Sub-Saharan Africa? Exploring the Case Study of Access to Antiretrovirals*, 20 GLOBAL HEALTH PROMOTION (SUPPL. 1) 57, 57-63 (2013).

54. *Id.* at 61.

55. See João Biehl, *Pharmaceuticalization: AIDS Treatment and Global Health Politics*, 80 ANTHROPOLOGICAL Q. 1083, 1083-1126 (2007).

Interestingly, in 1997, United Nations Guidelines on the Use and Availability of Emergency Obstetric Care were also launched, in effect acknowledging the similar life or death effect for women with severe obstetric complications having access to emergency obstetric care—or not.<sup>56</sup> However, the story of how maternal mortality became an accepted human rights issue was dramatically different from HIV/AIDS. While human rights-based approaches to HIV/AIDS largely focused on access to medication for a deadly infectious disease and not on HIV/AIDS as a social phenomenon, efforts to address maternal mortality did not just focus on access to emergency obstetric care. Rather, these efforts were always linked to sexual and reproductive health and rights and broader social determinants, which made implementation and policy far more complex—and contested, as we shall see.<sup>57</sup>

C. *Regulation of Private Actors: The Case of Tobacco Control*

By the end of the 1990s, the tobacco epidemic was a leading cause of premature death and one of the main public health problems worldwide.<sup>58</sup> In the face of this, it was clear that the time to change the rules of the game had come. Introduced by Dr. Ruth Roemer and Dr. Judith Mackay, the idea of using international treaty law as a public health approach to the tobacco control began to gain strength during the 1990s.<sup>59</sup> In October 1994, at the Ninth World Conference on Tobacco or Health in Paris, Mackay introduced a resolution she and Roemer had drafted, calling on national governments, ministers of health, and the World Health Organization (WHO) to “immediately initiate action to prepare and achieve an International Convention on Tobacco Control to be adopted by the United Nations.”<sup>60</sup> The fruits of this effort would take years, but it set a precedent for the regulation of powerful

---

56. UNICEF, WHO & UNFPA, GUIDELINES FOR MONITORING THE AVAILABILITY AND USE OF OBSTETRIC SERVICES (2d ed. 1997).

57. See Gita Sen & Veloshnee Govender, *Sexual and Reproductive Health in Changing Health Systems*, 10 GLOBAL PUB. HEALTH 228, 228-42 (2015); see also Gita Sen et al., *Sexual and Reproductive Health and Rights for the Next Decades: What's Been Achieved? What Lies Ahead?*, 10 GLOBAL PUB. HEALTH (SPECIAL ISSUE) 2 (2015).

58. World Health Org. [WHO], Res. WHA 52.18, *Towards a WHO Framework Convention on Tobacco Control*, U.N. Doc. A/52/VR/9 (May 24, 1999).

59. Judith Mackay, *The Making of a Convention on Tobacco Control*, 81 BULL. WORLD HEALTH ORG. 551, 551 (2003); see also Ruth Roemer, Allyn Taylor & Jean Larivière, *Origins of the WHO Framework Convention on Tobacco Control*, 95 AM. J. PUB. HEALTH 936, 936-38 (2005).

60. Mackay, *supra* note 59, at 551.

commercial interests outside of the health sector that affected health and the right to health.<sup>61</sup>

D. *Seeding Norms and Setting Standards*

During the late 1990s and early 2000s, the human rights community feverishly worked to institutionalize the morally persuasive, but non-binding declarations from the U.N. conferences of the 1990s into international law through “general comments”<sup>62</sup> and “concluding observations.”<sup>63</sup> At the same time, scholars and advocates increasingly argued that these interpretations should be understood as “authoritative interpretations” of the provisions of the treaties.<sup>64</sup> Together with the development of international institutions and procedures related to economic and social rights, including health, this process of slowly building the accumulated corpus of related norms was critical to enshrining the right to health into increasingly binding international law.<sup>65</sup> As detailed below, the 1999 General Recommendation on Women and Health and the 2000 General Comment exemplify this practice.<sup>66</sup>

In another example of this trend, the U.N. Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care were also transformed into the U.N. Convention

---

61. JANET CHUNG-HALL ET AL., IMPACT OF THE WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL ON THE IMPLEMENTATION AND EFFECTIVENESS OF TOBACCO CONTROL MEASURES: A GLOBAL EVIDENCE REVIEW (June 29, 2016), <http://www.who.int/fctc/cop/WHO-FCTC-ITC-Global-Evidence-Review.pdf>.

62. General Comments or General Recommendations are authoritative interpretations of the provisions contained in a Covenant or treaty and issued by the Committee which monitors implementation of that legal instrument. Although not legally binding upon states, they serve as subsidiary means for the determination of the content of a right. See Kerstin Mechlem, *Treaty Bodies and the Interpretation of Human Rights*, 42 VAND. J. TRANS. L. 905, 926-30 (2009).

63. Following the review of a State Party’s periodic report to the respective treaty monitoring bodies on the implementation of their treaty obligations, the treaty body in question issues a “concluding observation” on its assessment of the State’s progress and deficits in the implementation of the human rights treaties and gives recommendations for an improved realization. The concluding observations are not binding under international law. See *id.* at 922-24.

64. See STEINER, ALSTON & GOODMAN, *supra* note 10, at 305-20, 731-37.

65. U.N. Comm. on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR, No. 14]; Comm. on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health), U.N. Doc. A/54/38/Rev.1 (1999) [hereinafter CEDAW, No. 24].

66. See CESCR, No. 14, *supra* note 65; CEDAW, No. 24, *supra* note 65.

on the Rights of Persons with Disabilities (CRPD).<sup>67</sup> Indeed, the rapid and inclusive process through which the landmark CRPD was negotiated, adopted, and entered into force also illustrates the opening in international arenas for accepting new realms of rights as well as rights-holders. Among other things, it defined disability as “an evolving concept, [which] results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”<sup>68</sup>

E. *Regional Systems Used to Advance New Understandings of Rights*

At regional levels, new norms were also being rapidly developed. For instance, the Council of Europe adopted the European Social Charter that guarantees fundamental social and economic rights, including the right to health, and places special emphasis on the protection of vulnerable groups.<sup>69</sup> In the Americas, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (the Protocol of San Salvador), which had been adopted in 1988, entered into force in 1999.<sup>70</sup> The Protocol of San Salvador not only set out norms relating to health and a healthy environment, with clear influences in the approach to health from Latin American social medicine movements, but also permitted individual petitions in the case of violations of certain ESC rights relating to health, such as education.<sup>71</sup> The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention of Belém do Pará), which was adopted in 1994 and entered into force in 1995, was equally important in advancing the conceptualization of health as a product of gender structures as much as biological factors.<sup>72</sup> For example, one in three women worldwide have experienced either physical and/or sexual violence affecting their physical, mental, sexual, and reproductive health, which is not due to biological conditions but rather

---

67. Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.

68. *Id.* pmb., recital 6.

69. European Social Charter (revised), May 3, 1996, E.T.S. 163.

70. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, “Protocol of San Salvador,” Nov. 17, 1988, O.A.S.T.S. No. 69 [hereinafter Protocol of San Salvador].

71. *Id.* arts. 10, 11, 19.6.

72. Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women, “Convention of Belém do Pará,” June 9, 1994, 33 I.L.M. 1534.



to human actions.<sup>73</sup> This understanding of health, and in turn of rights relating to health, demanded different approaches and responsibilities of governments and other duty-bearers. Laws, policies, and institutions beyond the health sector needed to be involved, and social norms had to be changed.

As norms were being seeded based upon this kind of new understanding of health, advocacy groups were actively deploying these new norms for documentation, fact-finding, and supranational litigation. For example, the Center for Reproductive Rights (CRR, or at the time, Center for Reproductive Law and Policy) filed some of the boldest supranational litigation relating to health rights during the 1990s, on topics ranging from forced sterilization to rape by a medical practitioner to abortion.<sup>74</sup> Many cases in the 1990s were brought arguing the futility of exhausting domestic remedies because sexual and reproductive rights issues had yet to be recognized as actionable in domestic legal systems or because they were not susceptible to reasoned public debate due to ideological or religious grounds such as in the case of abortion.<sup>75</sup>

Thus, international law and supranational (regional and international) spaces came to be used in sexual and reproductive health and rights and other arenas affecting health, not just to demonstrate overlapping consensus to shame governments as had happened in the ESMA and similar cases. On the contrary, these cases were used to frame rights long-enshrined in international law, such as bodily integrity and non-discrimination, through a gendered lens (as well as other axes of identity).<sup>76</sup> Accordingly, advocates were able to create new legal standards that previously had stood firmly within the realm of private morality in many countries—such as abortion-related information and same-sex marriage—and were therefore subject to a state’s margin of appreciation.<sup>77</sup> For instance, the decision of the Human Rights

---

73. WHO Media Centre, *Violence Against Women Fact Sheet*, WORLD HEALTH ORG. (Nov. 2017), <http://www.who.int/mediacentre/factsheets/fs239/en/>.

74. *See, e.g., M.M. v. Peru*, Case 12.041, Inter-Am. Comm’n H.R., Report No. 69/14, OEA/Ser.L./V/II.151 (2014); *Mestanza Chavez v. Peru*, Case 12.191, Inter-Am. Comm’n H.R., Report No. 66/00, OEA/Ser.L./V/II.111 (2003); *A, B and C v. Ireland*, App. No. 25579/05, Eur. Ct. H.R. (2008); *Hercz (R.H.) v. Norway*, App. No. 17004/90, Eur. Comm’n H.R. (1992); *Boso v. Italy*, App. No. 50490/99, Eur. Ct. H.R. (2002).

75. *See, e.g., M.M. v. Peru*, ¶¶ 1-2; *Mestanza Chavez v. Peru*, ¶¶ 15-18.

76. *See, e.g., M.M. v. Peru*, ¶¶ 1-2; *Mestanza Chavez v. Peru*, ¶¶ 1, 10, 15-18.

77. *See, e.g., Hercz (R.H.) v. Norway; Ahmad v. United Kingdom*, Eur. Comm’n H.R., 4 E.H.R.R. 126 (1981); *Bruggemann v. Federal Republic of Germany*, App. No. 6959/75, Eur. Comm’n H.R., 3 E.H.R.R. 244 (1981); *Church of Scientology v. Sweden*, 16 Eur. Comm’n. H.R. 68 (1979); 5 Paton

Committee in *Toonen v. Australia* led to a change in law that decriminalized same-sex relationships.<sup>78</sup> Although the struggle to use international forums to try to build normative consensus rather than use existing normative frameworks is an ongoing struggle, the move to interpret international law in new ways that reflect understanding of the law's differential effects on diverse people has proven critical to the application of human rights frameworks to health in sexual and reproductive health and rights but also far beyond.<sup>79</sup>

F. *How Do We Measure Progress While Considering Resource Availability?*

Once the normative basis for understanding health and other ESC rights *as rights* was possible, it became clear that promoting and protecting those rights required some way to measure progress as well as violations. That is, for example, even though the estimates of the number of people “disappeared” under the military dictatorship in Argentina varies widely (from 9,000 to 30,000 in the official Truth Commission report<sup>80</sup>) that extreme variation does not change the fact of a gross violation of human rights. Yet ESC rights, including health, are famously subject to “progressive realization” in accordance with “maximum available resources.”<sup>81</sup> Thus, it would be absurd to simply compare the life expectancy in Norway (82.1 years) with that in Sierra Leone (51.4 years)<sup>82</sup> and declare that Sierra Leone was violating health rights. Advocates began to turn to the social sciences for methods of measurement that would enable the tracing of causal relationships in policies and laws and programs, as well as cross-national/regional comparisons that could take into account “maximum available resources.”<sup>83</sup>

---

(W.P.) v. United Kingdom, App. No. 8416/78, Eur. Comm'n H.R., 3 E.H.R.R. 408 (1980); Airey v. Ireland, 2 E.H.R.R. 305 (1979); Case “relating to certain aspects of the laws on the use of language in education in Belgium” v. Belgium (Belgian Linguistic Case), App. No. 1474/62, 1 E.H.R.R. 252 (1968); Open Door Counselling and Dublin Well Woman v. Ireland, 264 Eur. Ct. H.R. (ser. A) (1992).

78. See *Toonen v. Australia*, Human Rights Comm., Comm. No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994).

79. See REBECCA J. COOK, WOMEN'S HEALTH AND HUMAN RIGHTS 45-48 (1994); see also Rebecca J. Cook, *Gender, Health and Human Rights*, 1 HEALTH & HUM. RTS. 350, 359-63 (1995).

80. NUNCA MÁS REPORT, *supra* note 3, at 2.

81. International Covenant on Economic, Social and Cultural Rights art. 2(1), Jan. 3, 1976, 993 U.N.T.S. 3 [hereinafter ICESCR].

82. *Life Expectancy at Birth, Total (Years)*, WORLD BANK, <http://data.worldbank.org/indicator/SP.DYN.LE00.IN> (last visited Dec. 26, 2017).

83. See, e.g., AnnJanette Rosga & Margaret L. Satterthwaite, *The Trust in Indicators: Measuring Human Rights*, 27 BERKELEY J. INT'L L. 253, 270 (2009); see also ICESCR, *supra* note 81, art. 2.

Within the health and human rights field, Sofia Gruskin and others argued for different programmatic measures to assess progress and, indeed, contended that rights, such as non-discrimination, education, information, and privacy “can help focus programmatic attention and promote health-related interventions.”<sup>84</sup> By contrast, Audrey Chapman argued that the “progressive realization” of economic, social, and cultural rights according to states’ “maximum available resources” did not obviate the need for a violations approach, akin to what civil and political rights advocates used:

The monitoring of human rights is not an academic exercise; it is intended to ameliorate human suffering resulting from violations of international human rights standards. It follows that identifying violations in order to end and rectify abuses deserves a higher priority than promoting progressive realization.<sup>85</sup>

Chapman proposed three categories of economic, social and cultural violations to measure: those resulting from government actions (*i.e.*, policy or legislation), patterns of discrimination, and the failure of the state to adhere to the minimum core obligation for meeting economic, social, and cultural rights (*e.g.*, failure to ensure essential levels of protection for rights, such as emergency health care, primary education, freedom from starvation).<sup>86</sup> These minimum core obligations had been defined by the Committee on Economic, Social and Cultural Rights in General Comment No. 3 in 1990 with the idea of imposing obligations on states to mitigate the erosion of dignity caused by extreme poverty and lack of economic and social rights and included “essential primary health care services,” among other things.<sup>87</sup>

The debate about how to measure progress would take on increasing importance over the following decades, with implications not only for

---

84. Sofia Gruskin, Dina Bogecho & Laura Ferguson, ‘Rights-Based Approaches’ to Health Policies and Programs: Articulations, Ambiguities, and Assessment, 31 J. PUB. HEALTH POL’Y 129, 130 (2010); see also Sofia Gruskin, *Rights-Based Approaches to Health: Something for Everyone*, 9 HEALTH & HUM. RTS. 5 (2006).

85. Audrey R. Chapman, A “Violations Approach” to Monitoring the International Covenant on Economic, Social and Cultural Rights, HUM. RTS. DIALOGUE (Sept. 5, 1997), [https://www.carnegiecouncil.org/publications/archive/dialogue/1\\_10/articles/580.html](https://www.carnegiecouncil.org/publications/archive/dialogue/1_10/articles/580.html).

86. *Id.*

87. U.N. Comm. on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties’ Obligations (Art. 2, Para. 1, of the Covenant), ¶ 10, U.N. Doc. E/1991/23 (Dec. 14, 1990).

assessing the respect, protection, and fulfillment of health-related rights, but also for conceptualizing the rights themselves.

G. *Backlash Against Advances in Sexual and Reproductive Health and Rights*

In the years that immediately followed Cairo and Beijing, governments struggled to interpret the aspirational norms set at those conferences into budgets, policies, and programs in women's health.<sup>88</sup> Similar efforts were underway in other fields, such as education and social development, in which the U.N. Conferences of the 1990s had laid out transformational, cross-cutting agendas which required significant social restructuring.<sup>89</sup> The tools to operationalize these aspirational documents did not yet exist, nor did the necessary interdisciplinary and inter-sectional dialogues.<sup>90</sup> It would be more than a decade before more systematic efforts were undertaken to translate normative language into the "immanent regularity of practices," as Pierre Bourdieu calls them, in health systems and beyond on the ground.<sup>91</sup>

Moreover, in addition to other factors, such as waning foreign aid and institutional restructuring in global health, the inability to translate broad emancipatory visions into practice led to a far narrower focus in the Millennium Development Goals (MDGs) in 2001, which were "quantitative in orientation and . . . more pragmatic than idealistic."<sup>92</sup> Despite the appearance of some commonalities with human rights commitments, the adoption of the MDGs as a blueprint for global development created divisions between the development and human

---

88. See Alicia Ely Yamin & Vanessa M. Boulanger, *From Transforming Power to Counting Numbers: The Evolution of Sexual and Reproductive Health and Rights in Development; and Where We Want to Go from Here* (The New Sch. & Harvard Sch. Pub. Health, Working Paper Series, 2013).

89. See, e.g., Sakiko Fukuda-Parr, Alicia Ely Yamin & Joshua Greenstein, *The Power of Numbers: A Critical Review of MDG Targets for Human Development and Human Rights*, 15 J. HUM. DEV. & CAPABILITIES 105, 105-17 (2014).

90. See Alicia Ely Yamin, *Learning to Dance: Bringing the Fields of Human Rights and Public Health Together to Promote Women's Well-Being*, in LEARNING TO DANCE: CASE STUDIES ON ADVANCING WOMEN'S REPRODUCTIVE HEALTH AND WELL-BEING FROM THE PERSPECTIVES OF PUBLIC HEALTH AND HUMAN RIGHTS 1, 1-36 (Alicia Ely Yamin ed., 2005).

91. PIERRE BOURDIEU, *OUTLINE OF A THEORY OF PRACTICE* 78 (1977).

92. Philip Alston (Special Adviser to the United Nations High Commissioner for Human Rights on the Millennium Development Goals), *A Human Rights Perspective on the Millennium Development Goals*, at 12 (2004) (paper prepared as a contribution to the work of the Millennium Project Task Force on Poverty and Economic Development).

rights fields.<sup>93</sup> This was especially the case in sexual and reproductive health and rights, which went from the expansive and cross-cutting approaches of the 1990s conferences that required multi-sectorial action and power shifts, to a single goal regarding the reduction of maternal mortality.<sup>94</sup> In turn, this global goal was rapidly used in practice as “an ineffective marker for monitoring progress at the national level and . . . too narrow for guiding policies, omitting critical aspects of sexual and reproductive health and rights.”<sup>95</sup> The inherent reductionism of going from sexual and reproductive health and rights to maternal mortality reduction led to vertical, targeted programs and the marginalization of important human development and human rights concerns, including those related to laws and policies regarding abortion and sexual education.<sup>96</sup>

### III. 2000-2010: BUILDING HUMAN RIGHTS INSTITUTIONS AND PROCEDURES AT GLOBAL AND NATIONAL LEVELS

The 1990s had largely been about building connections between the health/development fields and the human rights field conceptually, as well as seeding norms. In the first decade of the millennium, while these norms continued to be developed, greater attention was placed on creating institutions and procedures to clarify and begin to implement them. It also became clear that there was not a single “health and human rights framework” or approach but many different domains of work, sometimes reinforcing each other and other times revealing dissonances in understanding and practices.

#### A. *Constructing the Institutional Architecture of International Human Rights*

In 1999 and 2000, the CEDAW Committee and the CESCR, the treaty bodies that oversee the implementation of CEDAW and the ICESCR, respectively, issued relevant interpretations related to women and health and the right to health.<sup>97</sup> These arguably “authoritative interpretations” by independent experts opened new prospects for the

---

93. See Philip Alston, *Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen Through the Lens of the Millennium Development Goals*, 27 HUM. RTS. Q. 755, 799 (2005).

94. G.A. Res. A/RES/55/2, United Nations Millennium Declaration (Sept. 18, 2000).

95. Alicia Ely Yamin & Vanessa M. Boulanger, *Why Global Goals and Indicators Matter: The Experience of Sexual and Reproductive Health and Rights in the Millennium Development Goals*, J. HUM. DEV. & CAPABILITIES 1, 9 (2014).

96. See Yamin & Boulanger, *supra* note 88.

97. CESCR, No. 14, *supra* note 65; CEDAW, No. 24, *supra* note 65.

understanding of what the right to health required in terms of states' obligations. For example, the CESCR noted that "the right to health contains both freedoms and entitlements"<sup>98</sup> and spelled out obligations to *respect* by refraining from direct infringements; the obligation to *protect* from third parties' violations; and the obligation to progressively *fulfill* through legislative and other means.<sup>99</sup>

In addition, in what proved to be influential for advocates and scholars, the CESCR explained that the right to health contained four inter-related and essential elements: availability, accessibility, acceptability, and adequate quality.<sup>100</sup> Accessibility comprised four dimensions: non-discrimination; physical accessibility; economic accessibility (affordability); and information accessibility.<sup>101</sup> The CEDAW Committee echoed these criteria and clarified them in the case of women, including for example, stating that "[a]cceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives."<sup>102</sup> These standards, in turn, helped advocates, for example in Peru, where the involuntary sterilization of over a quarter of a million overwhelmingly indigenous women had just come to light and was a topic of major advocacy in the women's rights movement in that country.<sup>103</sup>

But international law is not constructed of free-floating norms. Just as the Office of the High Commissioner of Human Rights (OHCHR) had been established after *Vienna* to implement this new vision of rights as interdependent and universal,<sup>104</sup> in the early 2000s as the U.N. was also creating institutions and procedures. These institutions and procedures, including the 2001 establishment of the Office of the Special Rapporteur on the Right to the Highest Attainable Standard of Health, were needed to support the elucidation and eventual enforcement of norms related to health and other economic and social rights.<sup>105</sup> In

98. CESCR, No. 14, *supra* note 65, ¶ 8.

99. *See id.* ¶ 33.

100. *See id.* ¶ 12.

101. *See id.*

102. CEDAW, No. 24, *supra* note 65, ¶ 22.

103. *See generally* Sophie Davies, *Peruvian Activists Fight for Forcibly Sterilized Women*, REUTERS (Dec. 14, 2016), <http://www.reuters.com/article/us-peru-women-sterilisation-idUSKBN1430JQ>.

104. G.A. Res. 48/141 (Dec. 20, 1993).

105. *See, e.g.*, U.N. Commission on Human Rights Res. 2002/31, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. E/2002/23-E/CN.4/2002/200 (Apr. 22, 2002). *See also* Marc Limon & Hilary Power, *History of the United Nations Special Procedures Mechanism: Origins, Evolution and Reform*, UNIVERSAL RIGHTS GROUP (Sept. 2014),

turn, the Special Rapporteur explicated aspects of the right to health that were critical to translate normative aspirations into policy-relevant guidelines for non-lawyers and for people working in health systems at the national level.<sup>106</sup>

B. *Health Systems Defined as Core Social Institutions*

One of the most fundamental advances during this decade was a reconceptualization of health systems and their role in promoting and protecting not just the right to health but also to democratic governance. The first Special Rapporteur on the Right to Health, Paul Hunt, contributed significantly to advancing a new understanding of health systems as inherently social structures that are not merely delivery apparatuses for good and services, but are also core social institutions that reflect, encode, and embed patterns of inequality and discrimination.<sup>107</sup> This was a critical opening for the human rights field working in this area, as it opened possibilities for operationalizing health rights to a far greater extent. As Lynn Freedman wrote in 2005:

If poverty is fundamentally relational, then it is important to understand the social norms and institutions that structure those relationships. Human Rights activists have long understood the political arms of the state—prisons, judicial systems, and police forces—to have the power to exclude, abuse and silence. But rarely are social and economic rights and the social institutions on which they depend approached with the same understanding. This must change. Health systems are part of the very fabric of social and civic life.<sup>108</sup>

The ways in which health systems challenge or reinforce the “pathologies of power”<sup>109</sup> in the overall society can be understood through analyses at every level. At a macro-level, how much solidarity and equity

---

[http://www.universal-rights.org/wp-content/uploads/2015/02/URG\\_HUNSP\\_28.01.2015\\_spread.pdf](http://www.universal-rights.org/wp-content/uploads/2015/02/URG_HUNSP_28.01.2015_spread.pdf).

106. See Paul Hunt (Special Rapporteur of the Commission of Human Rights), *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, ¶¶ 28, 29, U.N. Doc. A/59/422 (Oct. 8, 2004); see also Paul Hunt, *Interpreting the International Right to Health in a Human Rights-Based Approach to Health*, 18 HEALTH & HUM. RTS. 109 (2016).

107. See Lynn P. Freedman, *Achieving the MDGs: Health Systems as Core Social Institutions*, 48 DEV. 19, 20 (2005); see also Alicia Ely Yamin & Ole Frithjof Norheim, *Taking Equality Seriously: Applying Human Rights Frameworks to Priority Setting in Health*, 36 HUM. RTS. Q. 296 (2014).

108. Freedman, *supra* note 107, at 21.

109. See FARMER, *supra* note 19.

is there in financing? At a “meso-level,” who in a given society can access health care and preconditions for health? At a micro-level, how are patients treated by providers in facilities?<sup>110</sup>

This reconceptualization of health systems as social institutions was also essential in eroding the rigid dichotomy in public health between progressive impulses to advance social determinants of health and approaches centering on access to care.<sup>111</sup> If health systems are understood as part of democratic governance, as Freedman notes, “health claims, legitimate claims of entitlement to the services and other conditions necessary to promote health,” can be seen as “assets of [social] citizens in a democratic society.”<sup>112</sup>

### C. *Human Rights-Based Approaches to Development and Health Defined*

Freedman co-led a task force, together with Ronald Waldman, also from Columbia University, on MDG 4 and 5, which noted the importance of human rights to the attainment of the MDGs, especially in relation to child and maternal health.<sup>113</sup> This effort to link human rights and development was notable but not unique. Indeed, in 2003, the U.N. set out the elements of a human rights-based approach to development, in contradistinction to the vertical and technocratic approach adopted in the MDGs.<sup>114</sup> That statement called for “a common understanding of [the human rights-based] approach and its implications for development programming,” including human rights principles such as: universality and inalienability; indivisibility; inter-dependence and interrelatedness; non-discrimination and equality; participation and inclusion; accountability and the rule of law.<sup>115</sup>

110. See YAMIN, *supra* note 19, at 121.

111. WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (2008) (defining “social determinants of health” as the conditions in which people are born, grow, live, work, and age).

112. Freedman, *supra* note 107, at 19, 21. We take Freedman’s use of “citizenship” to refer to social citizenship—members of a community or society—and not the exclusionary notion of legal citizenship.

113. See generally Lynn Freedman et al., *Millennium Project: Interim Report of Task Force 4 on Child Health and Maternal Health* (Apr. 19, 2004).

114. See U.N. Secretary-General, *UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming*, annex B (May 2003) [hereinafter *U.N. Common Understanding*].

115. *Id.* at 91; see also *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies*, HRBA PORTAL, <http://hrbaportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies> (last visited Jan. 28, 2018) (setting out the principles).



Nonetheless, the meaning of those principles was itself contested: what was required for genuine, non-tokenistic participation? What does accountability require of different actors in the health system and beyond? These questions, which are critical to answer if human rights-based approaches are to be meaningful in health systems and people's lives continue to puzzle human rights-based approaches to this day and complicate attempts to mainstream human rights into development and public health practice.<sup>116</sup>

D. *Reflections on MDGs: Re-linking Human Rights and Development*

As the first decade of the MDG agenda came to a close, there was an assessment of the development paradigm that underlay the MDGs from a human rights perspective. The sense among many scholars and activists in human development and human rights was that the highly reductionist approach of the MDGs narrowed targets and dramatically restricted a transformative development agenda based on rights.<sup>117</sup> For instance, the framing of MDG 4 (on child health) took no account of ongoing efforts to embed human rights principles in the pursuit of child survival.<sup>118</sup> Similarly, MDG 5 sidelined the broader sexual and reproductive health and rights agenda articulated in the ICPD and instead focused on narrow, select interventions.<sup>119</sup> Not only were some priorities neglected, but also the human principles of participation, equality, democratic voice, transparency, and accountability did not count because they could not be counted.<sup>120</sup>

Yet, throughout the first decade of the MDGs, a host of new players in human rights—from service delivery organizations, such as the Cooperative for Assistance and Relief Everywhere (CARE), to major international non-governmental human rights organizations, which had traditionally focused on civil and political rights violations—launched campaigns around health issues in terms of rights.<sup>121</sup> These

---

116. See Alicia Ely Yamin & Rebecca Cantor, *Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights-Based Approaches to Health*, 6 J. HUM. RTS. PRAC. 451 (2014).

117. See e.g., Alston, *supra* note 92, at 61-62.

118. See Fukuda-Parr, Yamin & Greenstein, *supra* note 89, at 107, 114.

119. See Yamin & Boulanger, *supra* note 88.

120. See Fukuda-Parr, Yamin & Greenstein, *supra* note 89, at 107, 114.

121. See, e.g., *Discrimination, Inequality, and Poverty: A Human Rights Perspective*, HUMAN RIGHTS WATCH (Jan. 11, 2012), <https://www.hrw.org/news/2013/01/11/discrimination-inequality-and-poverty-human-rights-perspective> (recognizing the “growing body of evidence that human rights-based approaches . . . can lead to more sustainable and inclusive development results”); AMNESTY INTERNATIONAL, *BUILDING IRELAND’S FUTURE: A HUMAN RIGHTS HANDBOOK* (2013), <https://www.amnesty.org/>

groups and others, often from the global South, developed and deployed new forms of fact-finding and documentation during this time, for example, linking budgetary expenditures with the realization of economic and social rights.<sup>122</sup> These awareness-raising and advocacy efforts were aimed at operationalizing and “making real” the growing body of normative standards.<sup>123</sup> They focused not only on the right to health, but also on so-called “human rights-based approaches” (HRBAs) to health, which were necessarily multi-sectoral and involved the many different rights, including civil, political, economic, social, and cultural, in order to enable diverse people to live healthy and flourishing lives.<sup>124</sup>

E. *The Quest for Indicators: Measuring “Effective Enjoyment” of Health and Other Economic and Social Rights*

The drive to operationalize human rights-based approaches to health and the right to health was spurred by the recognition that if human rights were to be meaningful in the realm of health, and economic and social rights more broadly, they needed to be translated for the fields that were charged with actually implementing these rights. In health, this was the medical and public health fields, which were particularly resistant to the forms of argument and evidence used in traditional human rights.<sup>125</sup> To some extent, this involved creating typologies that took into account questions of resources and the need to shift structures as well as produce specific outcomes.<sup>126</sup> For example, the OHCHR had developed indicators of structure (legal frameworks),

---

amnesty.org/en/documents/sec01/016/2009/en/ (focusing on the principles of HRBA and how they can be used); CELS ET AL., COMMENTS ON THE OHCHR RECOMMENDED PRINCIPLES AND GUIDELINES ON HUMAN RIGHTS AT INTERNATIONAL BORDERS (2013), [http://www.cels.org.ar/common/documentos/UPDATED%20CELS%20and%20Others%20Comments%20on%20the%20Principles%20and%20Guidelines%20at%20Borders%20\(1\).pdf](http://www.cels.org.ar/common/documentos/UPDATED%20CELS%20and%20Others%20Comments%20on%20the%20Principles%20and%20Guidelines%20at%20Borders%20(1).pdf) (adopting a human rights-based approach to assess the content of the Principles and Guidelines) [hereinafter CELS].

122. See, e.g., CELS, *supra* note 121, at 4.

123. See, e.g., DANIELA FRANCISCA DÍAZ ECHEVERRÍA, MORTALIDAD MATERNA: UNA TAREA INCONCLUSA (2006).

124. See, e.g., Human Rights Council, *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Mortality and Morbidity*, ¶¶ 10-13, U.N. Doc. A/HRC/21/22 (July 2, 2012) [hereinafter HRC Technical Guidance 2012]. See also U.N. *Common Understanding*, *supra* note 114, at 92; *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies*, *supra* note 115 (setting out the principles).

125. See Dainius Pūras, *Human Rights and the Practice of Medicine*, 38 PUB. HEALTH REV. 9 (2017).

126. See Christopher J. L. Murray & Julio Frenk, *Health Metrics and Evaluation: Strengthening the Science*, 371 LANCET 1191-97 (2008).

process (policy efforts) and outcome (*e.g.*, health indicators), which were meant to capture different dimensions of rights.<sup>127</sup> The Center for Economic and Social Rights was also actively developing a framework, which it would call OPERA, which measured Outcomes, Policy Efforts, Resources and Assessment.<sup>128</sup>

But, to some extent, measurement of “rights” required using language that public health people understood, publishing in health journals, and using existing metrics that were acceptable in the field.<sup>129</sup> In an article published in the *Lancet* in 2008, the first Special Rapporteur on the right to health, Paul Hunt, together with Gunilla Backman and colleagues, proposed 72 indicators designed to measure these dimensions to capture “right to health features of health systems.”<sup>130</sup> These features represented a wide range of human rights principles, including non-discrimination, participation, and accountability/monitoring, as well as legal recognition of the right to health, creation of national health plans, access to medicines, health financing, and social determinants of health.<sup>131</sup> Although the publication of these indicators and further work on indicators specifically for the right to health did not garner much traction at the time, the importance of being able to compare countries across time and context and measure progress became increasingly important in the field as efforts to bring the legal norms into public health practice proceeded.<sup>132</sup>

Moreover, indicator development was not just occurring at the international level, illustrating the recursive relationship between these epistemic models at national, regional, and supranational levels.<sup>133</sup> In the Inter-American System, a Working Group was formed to create

127. See U.N. Office of the High Commissioner for Human Rights, *Human Rights Indicators: A Guide to Measurement and Implementation*, U.N. Doc. HR/PUB/12/5 (2012) [hereinafter U.N. Guide to Measurement].

128. CENTER FOR ECONOMIC AND SOCIAL RIGHTS, THE OPERA FRAMEWORK (2012), <http://archive.cesr.org/downloads/the.opera.framework.pdf>. Alicia Ely Yamin was Vice-Chair and then Chair of the Board of Directors of the Center for Economic and Social Rights and involved in the decision to advance this indicator framework.

129. See Murray & Frenk, *supra* note 126, at 1191-97.

130. Gunilla Backman et al., *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047, 2050-53 (2008).

131. *Id.*

132. See Rosga & Satterthwaite, *supra* note 83, at 270; see also LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 60 (3d ed. 2016) (highlighting the relevance of indicators and measurement in demonstrating an intervention’s effectiveness).

133. See, *e.g.*, ORGANIZATION OF AMERICAN STATES WORKING GROUP OF THE PROTOCOL OF SAN SALVADOR, PROGRESS INDICATORS FOR MEASURING RIGHTS UNDER THE PROTOCOL OF SAN SALVADOR, OEA/Ser.D/XXVI.11 (2d ed. 2015).

indicators to measure achievement of economic and social rights under the Protocol of San Salvador, including the right to health.<sup>134</sup> The gap between often promising laws and policies, on the one hand, and dismally unequal outcomes in the region made the effort to measure policy effort (budgets) and outcomes particularly important.

At the national level, in a landmark decision in 2004,<sup>135</sup> the Constitutional Court of Colombia instructed the government to provide details about the rights of internally displaced persons (IDP) as well as the policies that affected them. The Court ruled that the Government had failed to provide sufficient resources and develop the institutional capacity needed to minimally uphold IDP rights and had created an “unconstitutional state of affairs.”<sup>136</sup> Following the ruling, the Government of Colombia established an evaluation apparatus, as well as specific indicators of “effective enjoyment” of internally displaced persons’ health rights, among others.<sup>137</sup>

Similarly, in 2006, in the *Matanza-Riachuelo River Basin* case, a case seeking decontamination of the Riachuelo River, which was affecting people’s health and well-being, the Argentine Supreme Court chose not to mandate a black-letter rule, but rather urged other branches of government to seek a structural solution to a complex policy problem.<sup>138</sup> In order to promote implementation and effective enjoyment of the rights affected, the Argentine Supreme Court designated the ACUMAR (Authority of the Matanza-Riachuelo River Basin) to oversee the Plan of Action for the Matanza-Riachuelo Basin.<sup>139</sup> The Court further instituted deadlines and reporting policies and imposed fines for lack of compliance.<sup>140</sup>

Both the Colombian IDPs case and the *Matanza-Riachuelo* case signaled a new understanding of the role of courts in catalyzing political

134. Organization of American States, *Protocol of San Salvador: Composition and Functioning of the Working Group to Examine the Periodic Reports of the States Parties*, AG/RES. 2582 (XL-O/10) (June 8, 2010).

135. Corte Constitucional [C.C.] [Constitutional Court], enero 22, 2004, Sentencia T-025/04, <http://www.corteconstitucional.gov.co/relatoria/2004/t-025-04.htm> (Colom.).

136. *Id.* at 80-87. Justice Manuel José Cepeda, who authored the opinion, in attempting to erode formalism in judicial opinions—where rights written into laws and policies eluded people in practice—created the innovation of calling for the development of *goce efectivo* indicators (indicators of effective enjoyment).

137. *See generally* U.N. Guide to Measurement, *supra* note 127, at 15.

138. Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 07/08/2008, “Mendoza Beatriz Silvia y Otros c. Estado Nacional y Otros /Daños y Perjuicios,” ¶ 20.V, Fallos (2008-331-1622) (Arg.).

139. *Id.*

140. *Id.*

action through remedies, thereby arguably preserving judicial legitimacy and enhancing democratic deliberation.<sup>141</sup> More generally, this decade reflected growing experimentation with metrics and indicators for measuring health rights, triggered both by the recognized need to move beyond statements of norms in human rights, and the use of quantified metrics in the health and development fields.

F. *Using Treaty Law to Contain Global Health Threats*

At the same time, as measures of state progress were proceeding, so too were efforts to address health threats. It was not until 1998 that the World Health Organization (WHO) seriously embarked on the making of a framework convention for tobacco control.<sup>142</sup> Driven largely by the newly elected WHO Director-General Dr. Gro Harlem Brundtland, tobacco control became a priority, and the Tobacco Free Initiative was established.<sup>143</sup> In that year, litigation brought by the Association of Attorneys General in the United States against the tobacco industry resulted in a Master Settlement Agreement, which made previously confidential industry documents containing evidence of the industry's long history of deceit publicly available.<sup>144</sup> These documents heightened the sense of urgency for a comprehensive global response to the tobacco epidemic, which in turn prompted a trajectory of deliberation, negotiations, and a fight that pitted the industry's interests against public health and the right to health.<sup>145</sup>

In 2003, the World Health Assembly unanimously adopted the WHO Framework Convention on Tobacco Control,<sup>146</sup> the first global public health treaty, which entered into force in 2005.<sup>147</sup> Although the MDGs

141. See Roberto Gargarella, *Dialogic Justice in the Enforcement of Social Rights: Some Initial Arguments*, in LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH? 232, 232-45 (Alicia E. Yamin & Siri Gloppen eds., 2011). See also MARK TUSHNET, *WEAK COURTS, STRONG RIGHTS: JUDICIAL REVIEW AND SOCIAL WELFARE RIGHTS IN COMPARATIVE CONSTITUTIONAL LAW* (2008).

142. Mackay, *supra* note 59, at 551; see also Roemer, Taylor & Larivière, *supra* note 59.

143. WORLD HEALTH ORG., *HISTORY OF THE WORLD HEALTH ORGANIZATION FRAMEWORK CONVENTION ON TOBACCO CONTROL* 5 (2009).

144. National Association of Attorneys General, *Master Settlement Agreement* (Nov. 1998), <http://www.naag.org/assets/redesign/files/msa-tobacco/MSA.pdf>.

145. See Walter J. Jones & Gerard A. Silvestri, *The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later*, 137 CHEST 692, 692-700 (2010).

146. World Health Org. [WHO] Res. WHA 56.1, WHO Framework Convention on Tobacco Control, U.N. Doc. WHA56/2003/REC/1 (May 19-28, 2003).

147. World Health Organization, *Global Tobacco Treaty Enters into Force with 57 Countries Already Committed*, WHO MEDIA CENTRE (Feb. 24, 2005), <http://www.who.int/mediacentre/news/releases/2005/pr09/en/>.

did not include an explicit target for reducing tobacco use, it was later recognized that the prevalence of tobacco users is higher among poorer fractions of the population, thus linking the problems arising from tobacco consumption with the development arena.<sup>148</sup> Indeed, the Economic and Social Council in a resolution adopted in July 2004 recognized “the adverse impact of tobacco consumption on public health, as well as its social, economic and environmental consequences, including for efforts towards poverty alleviation.”<sup>149</sup> But it would not be until the next decade that human rights would be explicitly invoked in the enforcement of provisions of the treaty.

G. *Health Rights as Real Rights: the Role of Legal Enforcement*

These efforts at normative standard-setting, coupled with policy measurement and monitoring, coincided with growing judicial enforcement of health rights in general, especially in middle-income countries.<sup>150</sup> The emergence of health rights litigation globally coincided generally with the advent of effective anti-retroviral medications, which created that “Lazarus effect.”<sup>151</sup> Some of the most well-known cases are from South Africa, where a string of cases relating to HIV/AIDS—from the *Hazel Tau* case<sup>152</sup> to *PMA and Another: In re Ex Parte President of the Republic of South Africa and Others*<sup>153</sup> to the *Treatment Action Campaign*

148. Joy de Beyer, Chris Lovelace & Ayda Yürekli, *Poverty and Tobacco*, 10 TOBACCO CONTROL 210, 210-11 (2001).

149. Economic and Social Council Res. E/2004/62, Tobacco Control (July 23, 2004).

150. See COURTING SOCIAL JUSTICE: JUDICIAL ENFORCEMENT OF SOCIAL AND ECONOMIC RIGHTS IN THE DEVELOPING WORLD 309-14 (Varun Gauri & Daniel Brinks eds., 2008). See also LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH?, *supra* note 141, at 52, 76, 138.

151. *Garcia Alvarez v. Caja Costarricense de Seguro Social*, Judgment 5394, Exp. 5778-V-97 No. 5394-97 (1997) (Costa Rica). In this case, the Sala IV of the Costa Rican Supreme Court reversed itself and granted ARVs as part of the right to health, understood as part of the right to life.

152. *Hazel Tau v. GlaxoSmithKline SA (Pty) Ltd.* (Competition Commission) (S. Afr.) (concerning the excessive pricing of patented ARV medicines in South Africa, which affected individuals infected with HIV/AIDS). The Commission found that the defendants had abused their dominant positions in ARV market, thus charging excessive prices and engaging in exclusionary behavior. *Id.* ¶ 56. Before referral and prosecution, the defendants negotiated a settlement with the Commission in 2003, in which they agreed to grant licenses to generic manufacturers, permit the licensees to export the relevant ARV medicines to sub-Saharan African countries, permit the importation of ARV medicines for distribution in South Africa only, and not require royalties in excess of five percent of the net sales of the relevant ARVs. See *CPTech’s 2003 Reports for the RSA Competition Commission, in Hazel Tau et al. v GSK, Boehringer, et al.*, KNOWLEDGE ECOLOGY INTERNATIONAL, <https://www.keionline.org/competition/2003-hazel-tau-tac> (last visited Jan. 27, 2018).

153. *Pharmaceutical Manufacturers Association of South Africa and Another: In re Ex Parte President of the Republic of South Africa and Others* 2000 (2) SA 674 (CC) (S. Afr.) (concerning PMA’s attempt to

case<sup>154</sup>—demonstrated how social movements, which framed demands for ART in terms of rights, coupled with favorable legal opportunity structures, contributed to the recognition and enforcement of legal claims. But South Africa is far from the only context in which judicial enforcement transformed the issue from one of government largesse into one of claimable rights.<sup>155</sup>

Indeed, a wave of new or reformed constitutions in Latin America and/or newly created constitutional courts or chambers (Brazil, 1988;<sup>156</sup> Costa Rica, 1989;<sup>157</sup> Colombia, 1991;<sup>158</sup> Argentina, 1994<sup>159</sup>) included robust enumerations of social rights and structural modifications that permitted easier access to courts. Social constitutionalism in Latin America and beyond (including South Africa) embedded new understandings of the state that went beyond the traditional liberal state of the nineteenth century.<sup>160</sup> Rights were no longer understood merely as shields from government interference; rather, across these countries, the social contract was understood to include leveling of the background conditions that perpetuated inequalities and deprivation.<sup>161</sup> Structural

---

stop the Medicines and Related Substances Control Amendment Act, which allowed for the substitution of brand-name medicines with generic medicines once a patent had expired, the importation of generic medications and a transparent pricing mechanism). To be effective, the Act required a comprehensive regulatory infrastructure, which was not in place according to the plaintiffs and as a result could highly damage the public in that control over dangerous medicines would be lost before the new infrastructure was in place. *Id.* ¶ 65.

154. *Minister of Health v. Treatment Action Campaign* 2002 (5) SA 703 (S. Afr.) (concerning restrictions on the provision of antiretroviral drugs to HIV positive pregnant women).

155. *See, e.g.*, Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 24/10/2000, “Campodónico de Beviacqua, A.C. c. Ministerio de Salud y Acción Social,” Fallos (2000-323-3229) (Arg.); Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 1/6/2000, “Asociación Benghalensis y Otros c. Ministerio de Salud y Acción Social – Estado Nacional,” Fallos (2000-323-1339) (Arg.); Corte Constitucional [C.C.] [Constitutional Court], junio 7, 1995, Sentencia T-499/95 (Colom.); Corte Suprema de Costa Rica [Supreme Court], Resolución 280-92 (1992); Corte Suprema de Costa Rica [Supreme Court], Resolución 5934-97 (1997); *Sahara House v. Union of India*, Delhi HC, W.P. (C) No. 535 of 1998 (India); *Sankalp Rehabilitation Trust v. Union of India*, SC, W.P. (C) No. 512 of 1999 (India); *Voluntary Health Association of Punjab v. Union of India*, W.P. (C) No. 311 of 2003 (India); *Common Cause v. Union of India*, W.P. (C) No. 61 of 2003 (India).

156. CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] (Braz.).

157. CONSTITUCIÓN POLÍTICA DE COSTA RICA [C.P.] (Costa Rica).

158. CONSTITUCIÓN POLÍTICA DE COLOMBIA [C.P.] (Colom.).

159. CONSTITUCIÓN NACIONAL [CONST. NAC.] (Arg.).

160. *See* Roberto Gargarella, *Latin American Constitutionalism: Social Rights and the “Engine Room” of the Constitution*, 4 NOTRE DAME J. INT’L & COMP. L. 9, 9-18 (2014).

161. *See id.*; *see also* RODRIGO UPRIMNY, CÉSAR A. RODRÍGUEZ GARAVITO & MAURICIO GARCÍA VILLEGAS, ¿JUSTICIA PARA TODOS?: SISTEMA JUDICIAL, DERECHOS SOCIALES Y DEMOCRACIA EN COLOMBIA (2006).

modifications, including perhaps most importantly the introduction of protection writs (*amparos, tutelas*), allowed individuals to claim fundamental rights, creating a new relationship between rights holders and duty bearers.<sup>162</sup> This represented a dramatic shift that helped to belie the claim that economic and social rights and health rights more specifically should be construed as “programmatic aspirations” and not legally enforceable rights.<sup>163</sup>

In Latin America more than any other region, the combination of extremely easy access to courts to resolve health claims (through protection writ mechanisms), paired with the perception of legislatures and executive branches as corrupt, ineffectual, and politicized, led people to seek legal enforcement of ART and later a broad spectrum of health entitlements.<sup>164</sup> Increasingly, however, health and related rights are being enforced by courts around the world, including in even very low-income countries such as Uganda.<sup>165</sup>

Judicialization, however, has not been free of critiques. Indeed, some evidence suggests that individualized litigation (in legal and health systems in which positive judgments do not lead to systemic changes) may not produce pro-poor reforms and, in the worst of cases, may exacerbate underlying inequities.<sup>166</sup> For example, the initial HIV/AIDS litigation tended to directly challenge the power of pharmaceuticals to set prices and claimed access to medications *as a right* which implied access through generics, parallel importation, compulsory licensing, and the like.<sup>167</sup> On the other hand, subsequent litigation has sometimes pursued very expensive on-patent pharmaceuticals.<sup>168</sup> Moreover, it became increasingly evident from numerous scholarly studies that the exponential surge in litigation for all kinds of treatments and conditions required systemic approaches that addressed equity across the health

162. See Gargarella, *supra* note 141, at 242-43.

163. See STEINER, ALSTON & GOODMAN, *supra* note 10, at 245-47.

164. See VICTOR ABRAMOVICH & CHRISTIAN COURTIS, LOS DERECHOS SOCIALES COMO DERECHOS EXIGIBLES 129-68 (2004). See generally THE LATIN AMERICAN CASEBOOK: COURTS, CONSTITUTIONS, AND RIGHTS (Juan F. Gonzalez-Bertomeu & Roberto Gargarella eds., 2016).

165. See, e.g., Ctr. for Health, Human Rights & Dev. v. Attorney Gen. (S.C. Uganda) (Oct. 30, 2015).

166. See Octavio Luiz Motta Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?*, 11 HEALTH & HUM. RTS. 33, 33 (2009); cf. João Biehl, Mariana P. Socal & Joseph J. Amon, *The Judicialization of Health and the Quest for State Accountability: Evidence from 1,262 Lawsuits for Access to Medicines in Southern Brazil*, 18 HEALTH & HUM. RTS. 209, 209-19 (2016).

167. See RODRIGO UPRIMNY & JUANITA DURÁN, EQUIDAD Y PROTECCIÓN JUDICIAL DEL DERECHO A LA SALUD EN COLOMBIA 50-52 (2014).

168. *Id.*



system as a broader social institution, rather than the addition of certain medications to a formulary.<sup>169</sup>

In this regard, the Colombian Constitutional Court has been a pioneer. In 2008, it issued the most sweeping judgment regarding health rights in the world, calling for reform of the health system based on the right to health.<sup>170</sup> In 2015, Colombia adopted a new Statutory Framework Law on Health based explicitly on the state's obligation to respect, protect, and fulfill the right to health.<sup>171</sup> As in the earlier internally displaced persons ruling, the Colombian Court adopted a "dialogical," as opposed to a command-and-control, approach to remedies, which sought to catalyze coordinated action by the political branches of government, rather than set out black-letter rulings or displacing political authority.<sup>172</sup> As noted above, regarding the case of *Matanza-Riachuelo* in Argentina, other courts have followed similar approaches regarding health.<sup>173</sup> By the end of the decade, and increasingly in recent years as the SDGs laid out Universal Health Coverage as a Goal, the question was no longer whether judicial enforcement of health rights was possible, but under what circumstances courts could best promote health equity and broader aspects of justice in health.<sup>174</sup>

169. See Alicia Ely Yamin & Fiona Lander, *Implementing a Circle of Accountability: A Framework for Judiciaries in Enforcing Health-Related Rights*, 14 J. HUM. RTS. 312 (2015); see also THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY (Colleen M. Flood & Aeyal Gross eds., 2014); Alicia Ely Yamin, *Power, Suffering, and Courts: Reflections on Promoting Health Rights through Judicialization*, in LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH?, *supra* note 141, at 333, 333-72.

170. Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08, [https://www.escri-net.org/sites/default/files/Sentencia\\_CC\\_SALUD\\_T-760\\_2008\\_0.pdf](https://www.escri-net.org/sites/default/files/Sentencia_CC_SALUD_T-760_2008_0.pdf) (Colom.).

171. L. 1751, febrero 16, 2015, DIARIO OFICIAL [D.O.] 49427 (Colom.) (regulating the right to health).

172. Corte Constitucional [C.C.] [Constitutional Court], julio 31, 2008, Sentencia T-760/08, [https://www.escri-net.org/sites/default/files/Sentencia\\_CC\\_SALUD\\_T-760\\_2008\\_0.pdf](https://www.escri-net.org/sites/default/files/Sentencia_CC_SALUD_T-760_2008_0.pdf) (Colom.).

173. See Gargarella, *supra* note 141, at 242-43. See generally TUSHNET, *supra* note 141; Alicia E. Yamin, *The Right to Health: The Challenges of Constructing Fair Limits*, in OXFORD HANDBOOK OF COMPARATIVE CONSTITUTIONAL LAW IN LATIN AMERICA (Conrado Hubner Mendez & Roberto Gargarella eds., forthcoming 2018); Ctr. for Law and Soc. Transformation, *Can Litigation Clean Rivers? Assessing the Policy Impact of 'the Mendoza Case' in Argentina*, CMI BRIEF (May 2012), <https://www.cmi.no/publications/4467-can-litigation-clean-rivers>.

174. See Benedict Rumbold et al., *Universal Health Coverage, Priority-Setting, and the Human Right to Health*, 390 LANCET 712, 712-14 (2017); see also Alicia Ely Yamin, *Taking the Right to Health Seriously: Implications for Health Systems, Courts and Achieving Universal Health Coverage*, 39 HUM. RTS. Q. 341 (2017); G.A. Res. 70/1, Transforming Our World: The 2030 Agenda for Sustainable Development, at 16 (Sept. 25, 2015) [hereinafter Sustainable Development Goals] (Target 3.8).

H. *Fragmentation of Norms at the International Level*

At the same time, supranational institutions at regional and global levels were ever more engaged in proliferating norms and standards for countries to follow in relation to health, including sexual and reproductive health.<sup>175</sup> Many of these were not entirely consistent as the number of procedures and institutions addressing some aspects of the same issues exponentially grew.<sup>176</sup> That is, special rapporteurs and independent experts were not always aligned with resolutions from the Human Rights Council or with the conclusions of different Treaty-Monitoring Bodies when it came to interpreting specific treaties.<sup>177</sup> So-called “vernacularization” of rights at the domestic level—which advocates had counted on to, among other things, “bring sexual and reproductive rights home”—as well as other path-breaking interpretations regarding disability and gender began to show weaknesses in this decade, and some scholars raised critical voices.<sup>178</sup> But the full effects of the gap on social legitimacy and especially backlash due to conservative forces trying to undermine the legitimacy of international law and institutions would only be felt in the next decade.

III. 2010-2017: OPERATIONALIZATION OF HUMAN RIGHTS-BASED APPROACHES  
AMIDST GLOBAL SHIFTS

The last period under review has been one of reassessment and reaccommodation. Normative developments have continued apace, expanding into areas previously not construed in terms of rights, but rapid normative creation has been sometimes untethered from social legitimacy, including in more controversial domains of sexual and reproductive health. The idea of universal human rights has become

175. See generally David W. Kennedy, *The International Human Rights Regime: Still Part of the Problem?*, 15 HARV. HUM. RTS. J. 101 (2002).

176. See LAWRENCE O. GOSTIN, *GLOBAL HEALTH LAW* 64, 251-57 (2014). See generally Mindy J. Roseman & Alice M. Miller, *Normalizing Sex and Its Discontents: Establishing Sexual Rights in International Law*, 34 HARV. J. L. & GENDER 313 (2011); Philip Alston, *Conjuring up New Human Rights: A Proposal for Quality Control*, 78 AM. J. INT'L L. 607 (1984).

177. See, e.g., Human Rights Council, *Rights of the Child: Protection of the Rights of the Child in the Implementation of the 2030 Agenda for Sustainable Development*, U.N. Doc. A/HRC/34/L.25 (Mar. 21, 2017); cf. Committee on the Rights of the Child, General Comment No. 20: On the Implementation of the Child During Adolescence, U.N. Doc. CRC/C/GC/20 (Dec. 6, 2016).

178. See MARGARET E. KECK & KATHRYN SIKKINK, *ACTIVISTS BEYOND BORDERS: ADVOCACY NETWORKS IN INTERNATIONAL POLITICS* (1998); *THE POWER OF HUMAN RIGHTS: INTERNATIONAL NORMS AND DOMESTIC CHANGE* (Thomas Risse, Stephen C. Ropp & Kathryn Sikkink eds., 1999); see also Peggy Levitt & Sally Engle Merry, *The Vernacularization of Women's Human Rights*, in *HUMAN RIGHTS FUTURES* (Leslie Vinjamuri, Jack Snyder & Stephen Hopgood eds., 2016).

inverted in some forums to mean the rights that states can universally agree upon—undermining the very legitimacy of a supranational aspirational set of standards.<sup>179</sup> Further, the lasting effects of the 2008 global economic crisis, together with neoliberal political economies, have led to questions over whether the quest for economic, social, and cultural rights, including health rights, is genuinely subversive of power structures that leave vast sectors of humanity in drudgery and misery. Finally, the rapid ascendance of conservative populist nationalism, which coincided with the beginning of the Sustainable Development Era, is cause for profound self-reflection in the human rights community writ large.<sup>180</sup>

#### A. *Tobacco Control Becomes a Human Rights Issue*

By the end of the first decade of the millennium, major tobacco companies began to challenge national health policies in an effort to protect the industry's interests. In 2010, one of the largest transnational tobacco companies, Philip Morris International, launched an arbitration under the 1998 Switzerland-Uruguay bilateral investment treaty (BIT) against Uruguay's tobacco control measures: 1) increasing the size of health warnings to 80% of each package and 2) requiring a "single presentation"—one variant per brand family.<sup>181</sup> On July 8, 2016, the International Centre for Settlement of Investment Disputes (ICSID) released its decision.<sup>182</sup> On the merits, the tribunal ruled in favor of Uruguay with respect to all claims and recognized that regulatory authorities enjoy a "margin of appreciation" when making public policy determinations in contexts involving health rights and the public's health.<sup>183</sup>

At the same time, ten years after its entry into force, the WHO Framework Convention on Tobacco Control (FCTC) was included in the Sustainable Development Goals (SDGs) (Goal 3), revealing a robust international consensus on the matter.<sup>184</sup> Governments agreed to support, raise awareness, and mobilize resources for the FCTC

---

179. See generally Alston, *supra* note 176.

180. See Paul Hunt, *Configuring the UN Human Rights System in the "Era of Implementation": Mainland and Archipelago*, 39 HUM. RTS. Q. 489 (2017).

181. Philip Morris Brands Sarl v. Uruguay, ICSID Case No. ARB/10/7, Award (Jul. 8, 2016), ¶¶ 9-18, [http://icsidfiles.worldbank.org/icsid/ICSIDBLOBS/OnlineAwards/C1000/DC9012\\_En.pdf](http://icsidfiles.worldbank.org/icsid/ICSIDBLOBS/OnlineAwards/C1000/DC9012_En.pdf).

182. *Id.*

183. *Id.* ¶¶ 398-99. See generally Harold H. Koh, *Global Tobacco Control as a Health and Human Rights Imperative*, 57 HARV. INT'L L. J. 433 (2016).

184. See Sustainable Development Goals, *supra* note 174, at 16 (Target 3.A).

implementation and to reduce premature mortality rates from non-communicable diseases by one third.<sup>185</sup>

Meaningful tobacco control, however, still faced a steep uphill battle in practice in countries, given the resources of the industry to capture political agendas. Further, tobacco itself seemed unique in the array of industries that required greater controls on their market discretion because tobacco companies were uniformly decried as nefarious purveyors of a product that led directly to sickness and death.<sup>186</sup> For example, food industries pose more complex issues, despite the evident trends in diabetes and other nutrition-related non-communicable diseases.<sup>187</sup>

### B. Challenges of Air Pollution, Mining, and Other Health Hazards

The right to health under international law includes not just access to care but also public health preconditions; further state obligations are understood to include “protections” from the acts of third parties.<sup>188</sup> Some regional treaties, such as the Protocol of San Salvador, and national constitutions are even more explicit about the right to a healthy environment.<sup>189</sup> The human rights community has attempted to address some environmental issues and their impact on people’s health, from mining and extraction industries in indigenous communities to air pollution and the right to a healthy environment, as evident from the *Matanza-Riachuelo* case in Argentina, discussed above.<sup>190</sup> Other cases have involved air pollution in Delhi<sup>191</sup> and requirements of

185. *See id.* at 16 (Target 3.4).

186. *See* National Association of Attorneys General, *supra* note 144.

187. *See* Luis Galicia, Rubén Grajeda & Daniel López de Romaña, *Nutrition Situation in Latin America and the Caribbean: Current Scenario, Past Trends, and Data Gaps*, 40 REV. PANAM. SALUD PÚBLICA 104 (2016).

188. *See* CESCR, No. 14, *supra* note 65; U.N. Committee on Economic, Social and Cultural Rights, General Comment No. 24, State Obligations Under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities, U.N. Doc. E/C.12/GC/24 (Aug. 10, 2017).

189. *See e.g.*, Protocol of San Salvador, *supra* note 70; Art. 41, CONSTITUCIÓN NACIONAL [CONST. NAC.] (Arg.).

190. *See supra* Section III.D.

191. Delhi ranks among the world’s most polluted cities. Air pollution is a major risk factor for heart disease, stroke, chronic obstructive pulmonary disease and lung cancer, and increases the risks for acute respiratory infections and exacerbates asthma. According to WHO data an estimated 1.5 million people died from the effects of air pollution in 2012 in India. *See* WHO, *India Takes Steps to Curb Air Pollution*, 94 BULL. WORLD HEALTH ORG. 487 (2016).

prior notification for extraction activities on indigenous lands.<sup>192</sup> These cases have shown both the potential and limitations of approaches based on legal enforcement of rights, whether for majorities or minorities. Rights, for good and ill are inherently legal claims as well as discourses for social mobilization. Yet courts depend upon coordination and cooperation from political organs of government to enforce their judgments, especially in complex areas of social policy such as environment and health.<sup>193</sup> The very reasons individuals and social movements turn to courts, however, are often exasperation with political dysfunction or capture.<sup>194</sup> Thus, making progress through courts is an iterative approach to transformation at best and often remains palliative and “sufficientarian” or worse—a paper victory only.<sup>195</sup>

*C. MDGs to SDGs: Case Study of Reproductive, Maternal, Newborn, and Child Health*

With respect to HIV, the MDG decade was one of exceptional success in many ways. Funding and awareness of HIV dramatically increased.<sup>196</sup> Moreover, new institutions—including UNAIDS and the Global Fund to Fight AIDS, TB, and Malaria—provided leadership and organization to struggles to expand treatment, as well as prevention, in low-resource settings.<sup>197</sup> The story of women’s and children’s health were quite different and, in many ways, more representative of the struggles to link human rights with its full subversive potential with global development agendas.

In 2010, acknowledging inadequate progress and failures of accountability with respect to achieving MDGs 4 and 5, the United Nations

192. See, e.g., Corte Constitucional [C.C.] [Constitutional Court], julio 27, 2016, Sentencia C-389-16 (Colom.).

193. See generally, SOCIAL RIGHTS JUDGMENTS AND THE POLITICS OF COMPLIANCE: MAKING IT STICK (Malcolm Langford, César Rodríguez-Garavito, Julieta Rossi eds., 2017).

194. Oscar Parra, *The Protection of Social Rights*, in THE LATIN AMERICAN CASEBOOK: COURTS, CONSTITUTIONS AND RIGHTS 147, 147-71 (Juan F. Gonzalez-Bertomeu & Roberto Gargarella eds., 2016).

195. See e.g., FUNDACIÓN AMBIENTE Y RECURSOS NATURALES, CENTRO DE ESTUDIOS LEGALES Y SOCIALES, GREENPEACE ARGENTINA, ASOCIACIÓN CIUDADANA POR LOS DERECHOS HUMANOS & VECINOS DE LA BOCA, 9 AÑOS DEL FALLO DE LA CORTE: UNA POLÍTICA DE ESTADO TODAVÍA AUSENTE 3 (July 2017), <https://www.cels.org.ar/web/wp-content/uploads/2017/07/Riachuelo-informe-a-9-a%C3%B1os-del-fallo-de-la-CSJN.pdf>.

196. See Giorgio Cometto et al., *A Global Fund for the Health MDGs?*, 373 LANCET 1500, 1500-02 (2009). See also Nicoli Nattrass, *Millennium Development Goal 6: AIDS and the International Health Agenda* 12-17 (The New Sch. & Harvard Sch. Pub. Health, Working Paper Series, 2013).

197. See Nattrass, *supra* note 196, at 12-17.

Secretary General launched his “Global Strategy for Women’s and Children’s Health,” which led to the creation of a Commission on Information and Accountability (CoIA).<sup>198</sup> CoIA in turn established an independent Expert Review Group (iERG) tasked with enhancing accountability at the global level for reducing maternal mortality.<sup>199</sup> To this end, the iERG called for a global governance framework, a new global financing mechanism for women’s and children’s health, the clarification of context-specific country-priorities in line with MDG 4 and 5, increased attention on and use of human rights frameworks and tools to guide programs and policies, and renewed resources for research and monitoring at national levels.<sup>200</sup>

As the U.N. development apparatus was reacting to the lack of rights provisions in the MDGs, so too were civil society advocates. Beginning around 2010, civil society coalitions and campaigns struggled to expand the understanding of sexual and reproductive health that would be incorporated in the next development framework to encompass broader understandings and requirements for inter-sectoral action, which resulted in, among other things, Target 5.6 being added: “universal access to sexual and reproductive health and reproductive rights *as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.*”<sup>201</sup> More broadly, the Sustainable Development Goal (SDG) framework, in contrast to the MDGs, is universal in that it applies to poor and wealthy countries alike, is “interdependent,” and mentions issues that are critical to rights, such as access to justice (Goal 16), which were all gains in terms of the calls for reforming the MDGs to be more aligned with human rights law.<sup>202</sup>

Further, in September 2015, after the SDGs were adopted, the U.N. Secretary-General launched the updated “Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030” to help further the

198. U.N. Secretary-General, *Global Strategy for Women’s and Children’s Health* (2010), [http://www.who.int/pmnch/topics/maternal/20100914\\_gswch\\_en.pdf?ua=1](http://www.who.int/pmnch/topics/maternal/20100914_gswch_en.pdf?ua=1).

199. independent Expert Review Group (iERG), *Every Woman, Every Child: From Commitments to Action: The First Report of the independent Expert Review Group on Information and Accountability for Women’s and Children’s Health*, at 8 (2012), [http://www.who.int/woman\\_child\\_accountability/iERG/reports/2012/IERG\\_report\\_low\\_resolution.pdf](http://www.who.int/woman_child_accountability/iERG/reports/2012/IERG_report_low_resolution.pdf).

200. *Id.* at 4-5.

201. Sustainable Development Goals, *supra* note 174, Target 5.6 (emphasis added).

202. See Alicia Ely Yamin, *Sexual and Reproductive Health, Rights, and MDG 5: Taking Stock, Looking Forward*, in *THE MILLENNIUM DEVELOPMENT GOALS AND HUMAN RIGHTS: PAST, PRESENT AND FUTURE* 232, 232-54 (Malcolm Langford, Andrew Sumner & Alicia Ely Yamin eds., 2013). See also Yamin & Boulanger, *supra* note 95, at 10.

SDGs Agenda and appointed the Independent Accountability Panel (IAP).<sup>203</sup> With a more robust mandate than that of the iERG, the IAP reports annually on progress and use independent panelists' expertise to ensure the strategies were implemented effectively.<sup>204</sup> In its first report released at the U.N. General Assembly in 2016, the IAP added judicial remedies to the global health accountability framework and explicitly rooted accountability in human rights frameworks, bringing it in line with international law.<sup>205</sup>

#### D. Operationalizing Health Rights-Based Approaches to Health

At the same time as the broader development and health communities were reacting to the lack of accountability for women's and children's health in MDGs, the U.N. Human Rights Council, pushed by a concerted advocacy strategy by various NGOs working with OHCHR, decided to take on defining and clarifying what a human rights-based approach to maternal health could add. This series of resolutions by the Human Rights Council, which increasingly expanded upon an analytical framework connecting human rights approaches to maternal mortality in 2012, led to the U.N. Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity (U.N. Technical Guidance).<sup>206</sup> This U.N. Technical Guidance was the first document endorsed through an inter-governmental process to articulate specific ways in which human rights could be implemented by line ministries, thereby representing a significant advance in terms of providing operational instructions for policy makers and programmers on what had largely been abstract legal concepts.<sup>207</sup> It was then followed by a U.N. Technical Guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce and eliminate preventable mortality and morbidity of children under five

---

203. U.N. Secretary-General, *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)* (2015), <http://who.int/life-course/partners/global-strategy/globalstrategyreport2016-2030-lowres.pdf>. Alicia Ely Yamin is a panelist of the Independent Accountability Panel for the Global Strategy on Women's, Children's and Adolescents' Health (EWEC).

204. See Independent Accountability Panel, *2016: Old Challenges, New Hopes: Accountability for the Global Strategy for Women's, Children's and Adolescents' Health*, at 8-12 (2016), [http://www.iapreport.org/downloads/IAP\\_Report\\_September2016.pdf](http://www.iapreport.org/downloads/IAP_Report_September2016.pdf).

205. *Id.*

206. HRC Technical Guidance 2012, *supra* note 124. Alicia Ely Yamin served as a primary consultant for the U.N. Technical Guidance.

207. *See id.*

years of age.<sup>208</sup>

E. *Perils Inherent in Converting Human Rights Standards and Principles into Operational Tools*

These Technical Guidances, together with follow-up tools created for different constituencies to implement them, were a dramatic step forward in moving human rights frameworks and principles out of the ministries of justice and foreign affairs and into ministries of health and, to lesser degrees, education, planning, and finance. But, at the same time, the inherent challenges arising from the reliance on powerful institutions to change power structures became clear. That is, in order to fulfill their promise to change the systems that perpetuate inequality, human rights-based approaches to health “must adopt a holistic and integrated approach to health systems” and examine “the dominant assumptions underlying the structural determinants of . . . health . . . [including] strategies to address those factors, to reshape the possibility frontier for advancing . . . health.”<sup>209</sup> In other words, they challenge power structures and the status quo. A human rights-based approach therefore changes decision-making processes and the issues and actors included in those processes, as well as outcomes.<sup>210</sup> But asking governments or powerful global institutions to limit their own power voluntarily undermines much of the power of human rights as tools of struggle, reducing them to pleas for beneficence. As the IAP was quick to note (and the iERG had noted before) both governments and global institutions would be required to subject themselves to meaningful independent oversight to achieve meaningful, rights-based accountability, but these recommendations garnered little traction in practice.<sup>211</sup>

F. *Achieving Universal Health Coverage and the Right to Health*

The SDGs, unlike the MDGs, adopted a single goal on health, with a specific target on health systems: SDG Target 3.8, which calls for achievement of Universal Health Coverage (UHC).<sup>212</sup> To some

208. Human Rights Council, *Technical Guidance on the Application of a Human Rights-Based Approach to the Implementation of Policies and Programmes to Reduce and Eliminate Preventable Mortality and Morbidity of Children under 5 Years of Age: Report of the Office of the United Nations High Commissioner for Human Rights*, U.N. Doc. A/HRC/27/31 (June 30, 2014).

209. See, e.g., HRC Technical Guidance 2012, *supra* note 124, ¶¶ 24, 37.

210. See, e.g., *id.* ¶ 24.

211. See Independent Accountability Panel, *supra* note 204, at 8-12.

212. Sustainable Development Goals, *supra* note 174, ¶ 4.



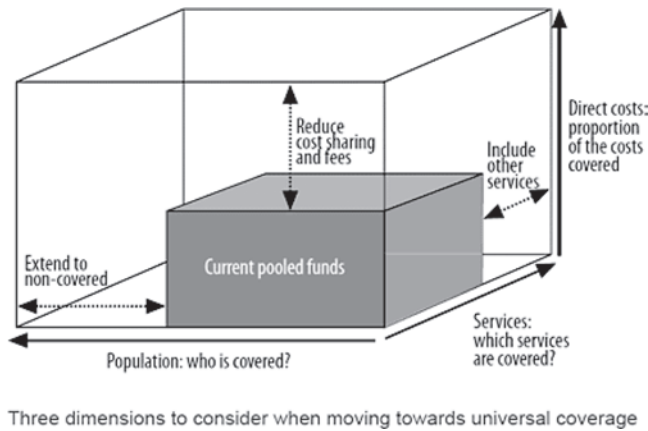


FIGURE 1: World Health Organization, Universal Health Coverage - Three Dimensions.<sup>214</sup>

advocates this may have been a disappointment, as it seemed to undercut progress made on HIV/AIDS through the targeted MDG 6. But it also offered the potential for synergies between development and human rights. Progressively achieving UHC requires not a one-off decision, but a series of choices regarding: 1) expanding priority services; 2) including more people in coverage; and 3) reducing out-of-pocket payments.<sup>213</sup> The progressive realization of the right to health requires grappling with many of these same decisions.

Unlike the MDGs, the universal framework of the SDGs addresses inequalities within rich countries, rather than addressing just poor countries.<sup>215</sup> Moreover, the SDGs are to be understood as interdependent. For example, in the new development agenda, Goal 3 relating to healthy lives should be considered in light of other goals, including Goal 16, which addresses the rule of law and transparent and accountable institutions.<sup>216</sup> Thus, the SDGs and the progressive realization of

213. *Id.* Target 3.8.

214. *Health financing for universal coverage*, WHO, [http://www.who.int/health\\_financing/strategy/dimensions/en/](http://www.who.int/health_financing/strategy/dimensions/en/) (last visited Feb. 20, 2018).

215. See Sustainable Development Goals, *supra* note 174, at 3, 13, 14; see also Dean T. Jamison et al., *Global Health 2035: A World Converging within a Generation*, 382 LANCET 1898 (2013); World Health Org., *Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage* (2014), [http://apps.who.int/iris/bitstream/10665/112671/1/9789241507158\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/112671/1/9789241507158_eng.pdf?ua=1).

216. Sustainable Development Goals, *supra* note 174.

the right to health, which is also universal and interdependent on other rights, have much in common, and there is room for synergistic approaches.

Nevertheless, taking seriously a right to health and a human rights-based approach to health requires understanding health systems as social institutions and, thus, part of democratic governance.<sup>217</sup> Therefore, for example, principles of fair financing, fair and democratically-legitimate priority-setting, effective regulation and oversight, and popular participation in decisions regarding policies and programs that affect people's health are vital to guarantee that efforts to achieve UHC are consistent with principles of human rights.<sup>218</sup> As discussed below, the overwhelming privatization of the development agenda and little appetite for effective oversight or accountability beyond monitoring data suggests that the overlaps in development and human rights may be confined to the rhetorical level.<sup>219</sup>

### G. Metrics and Their Reflection On Human Rights

If the SDGs in some ways represent advances in conceptualizing the cross-sectoral and multi-sectoral nature of development issues, they also reflect an exponential trend toward further quantification of all progress in the world. For example, under Target 5.2.1 related to the achievement of gender equality and empowerment of all women and girls, the indicator used is “[p]roportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age” as a way of including human rights in what gets measured.<sup>220</sup> On the one hand, these indicators represented a significant achievement in including human rights in consideration of what matters in terms of development. At the same time, this surge in the appropriation and reduction of human rights to indicators should give pause as well. As Rosga and Satterthwaite assert:

---

217. See Paul Hunt & Gunilla Backman, *Health Systems and the Right to the Highest Attainable Standard of Health*, 10 HEALTH & HUM. RTS. 81, 81-92 (2008).

218. See KEITH SYRETT, LAW, LEGITIMACY AND THE RATIONING OF HEALTH CARE: A CONTEXTUAL AND COMPARATIVE PERSPECTIVE 75-119 (2007); see also Yamin, *supra* note 169.

219. See Audrey R. Chapman, *Evaluating the Health-Related Targets in the Sustainable Development Goals from a Human Rights Perspective*, 21 INT'L J. HUM. RTS. 1098, 1098-1113 (2017).

220. United Nations Statistics Division, *SDG Indicators* (Nov. 30, 2017), <https://unstats.un.org/sdgs/indicators/database?indicator=5.2.1>.

. . . [D]ebates about indicators may provide advocates with new opportunities to use the language of science and objectivity as a powerful tool to hold governments to account. However, because human rights compliance indicators threaten to close space for democratic accountability and purport to turn an exercise of judgment into one of technical measurement, advocates of human rights should to remain vigilant to effects of the elisions at work in the indicators project.<sup>221</sup>

The goal of enabling objective cross-country comparisons appears naturally desirable, reasonable, and neutral. Nonetheless, it is precisely the abstraction from social context—and therefore from complexities such as what legal norms imply in different societies, the meaningfulness of participation, and other process concerns—that can cause these crystallized metrics to sometimes obscure more than they reveal about the power dynamics at play. Rather than better capturing reality, such indicators may well come to *define* a distorted reality.<sup>222</sup> For example, in a study done in Argentina on violence against women, Catalina Smulovitz found that laws and regulations across provinces were defined very differently;<sup>223</sup> therefore, comparing effects could only result in a nominal checklist-type of accountability or understanding of reality in that country. As Smulovitz explains, “[w]e know that heterogeneity is an expected result of federalism. . . . However, from the point of view of the citizens of a common political unit, these variations imply that a common ‘demos’ (the Argentine citizens) enjoy unequal rights and that the protection to which they can aspire is unequal. Since the characteristics of the rights citizens enjoy depend on the district in which they live, it can be argued that at the same time that federalism enables autonomy and innovation, it might conspire against equality under the law.”<sup>224</sup>

In the MDGs, the problem was the narrow spotlight approach of eight goals that overlooked human rights concerns. The impending problem in the SDGs is distinct. The excessive reliance on technocratic

221. Rosga & Satterthwaite, *supra* note 83, at 258.

222. See Alicia Ely Yamin, “Speaking Truth to Power”: A Call for Praxis in Human Rights, OPEN DEMOCRACY (Apr. 18, 2017), <https://www.opendemocracy.net/openglobalrights/alicia-ely-yamin/speaking-truth-to-power-call-for-praxis-in-human-rights>. See also SALLY ENGLE MERRY, THE SEDUCTIONS OF QUANTIFICATION: MEASURING HUMAN RIGHTS, GENDER VIOLENCE, AND SEX TRAFFICKING 5 (2016).

223. Catalina Smulovitz, *Legal Inequality and Federalism: Domestic Violence Laws in the Argentine Provinces*, 57 LATIN AM. POL. & SOC’Y 1, 5-21 (2015).

224. *Id.* at 21.

exercises may well undermine our consciousness of the need to struggle against structural obstacles within countries and in the global neoliberal order.<sup>225</sup> In combination with a plethora of human rights-based approaches set out in formulaic manner by institutions at the global level, there is also a real danger in eliding questions of power and struggle that lie at the heart of realizing human rights. As Sally Engle Merry puts it, “[q]uantification depends on constructing universal categories that make sense across national, class, religious, and regional lines;”<sup>226</sup> “[q]uantification has a great deal to contribute to global knowledge . . . but it is important to resist its seductive claim to truth.”<sup>227</sup> And it is the inherently contextual nature of power struggles, the quality of participation, and the validity of legal processes that give effective enjoyment of rights, including health rights, their meaning.<sup>228</sup>

H. *Neoliberalism, Privatization, and the Commercialization of Health*

The quantification of progress needs to be read in conjunction with the increasingly salient role of the private sector in delivering health goods and services, influencing health directly and indirectly, and financing arrangements that determine the possibilities for achieving health rights. At the dawn of the SDG era, the human rights community faces multiple and simultaneous challenges from old forms of tyranny and resurgent conservative ideologies that refuse to acknowledge all people, in our diversity, as equal subjects of rights.<sup>229</sup> But we also increasingly face as yet unmet challenges of devising ways to counter neoliberalism’s domination of networks and exchange through, *e.g.*, financialization of economies, transnational investment, and inter-country tax issues, coupled with marketization of health systems and entire societies, which converts citizens into consumers.<sup>230</sup> Many of the challenges noted above, such as the regulation of private actors, are derived from the implacable realities of neoliberalism. Indeed, in recent years as income inequality became ever more apparent and

---

225. See Yamin, *supra* note 222.

226. MERRY, *supra* note 222, at 1.

227. *Id.* at 222.

228. See Inga T. Winkler & Margaret L. Satterthwaite, *Leaving No One Behind? Persistent Inequalities in the SDGs*, 21 INT’L J. HUM. RTS. 1073 (2017).

229. See Alston, *supra* note 14; see also Samuel Moyn, *Trump and the Limits of Human Rights*, OPEN GLOBAL RTS. (Nov. 14, 2016), <https://www.openglobalrights.org/trump-and-limits-of-human-rights/>.

230. See generally CIVIL SOCIETY REFLECTION GROUP, SPOTLIGHT ON SUSTAINABLE DEVELOPMENT 2017: RECLAIMING POLICIES FOR THE PUBLIC 49-56 (2017), [https://www.2030spotlight.org/sites/default/files/download/spotlight\\_170626\\_final\\_web.pdf](https://www.2030spotlight.org/sites/default/files/download/spotlight_170626_final_web.pdf).

private actors have assumed ever-greater power to determine the parameters for people's well-being, human rights-based approaches to health and development were justifiably critiqued as having little influence on, or even being a handmaiden to, neoliberalism.<sup>231</sup> Reflecting on this limited influence, some scholars argue that "[t]he tragedy of human rights is that they have occupied the global imagination but have so far contributed little of note, merely nipping at the heels of the neoliberal giant whose path goes unaltered and unresisted."<sup>232</sup> While more diffuse and impersonal than the power exercised by the military rapist or torturer in the ESMA, this form of power is no less effective at degrading dignity.

### I. *Conservative Agendas Gaining Ground*

Despite advances in sexual and reproductive health and rights over the course of the last twenty years, there has not always been a clear implementation of the decisions, nor broad social legitimacy of the norms. Sometimes, implementation of these decisions fails due to lack of capacity of the progressive NGOs; weak links with national actors, social movements, and politicians; changes in funding priorities or focus within the organizations (which is possible given the length of the litigation procedures); or even a conscious decision of the NGO that the work ends with the decision, as the objective is to set a standard.<sup>233</sup> Helfer and Slaughter have noted there are many factors that impact the opportunity of obtaining an effective implementation of an international/regional court decision, including the links to domestic actors, the nature of the violation, and the existence of autonomous domestic institutions committed to the rule of law and to being responsive to the citizens.<sup>234</sup> For example, what made implementation successful in the Human Rights Committee's *Toonen v. Australia* (1994) decision described above, which decriminalized same-sex relationships, was implementation at the national level.<sup>235</sup> This can be contrasted with supranational cases decided against Peru relating to abortion, where

---

231. See Samuel Moyn, *Do Human Rights Cause Inequality?*, CHRON. HIGHER EDUC. (May 26, 2015), <http://www.chronicle.com/article/Do-Human-Rights-Increase/230297/>.

232. *Id.*

233. Alicia Ely Yamin, Neil Datta & Ximena Andion, *Behind the Curtain: The Roles of Transnational Actors in Legal Mobilization Over Sexual and Reproductive Rights*, GEO. J. GENDER & L. (forthcoming 2017).

234. Laurence R. Helfer & Anne-Marie Slaughter, *Towards a Theory of Supranational Adjudication*, 107 YALE L.J. 273, 300-35 (1997).

235. *Toonen v. Australia*, Human Rights Comm., Comm. No. 488/1992, U.N. Doc CCPR/C/50/D/488/1992 (1994).

compliance with judgments on sexual and reproductive health has been anemic, at best.<sup>236</sup>

Moreover, more recently, conservative actors have been especially successful in both adopting and adapting progressive human rights strategies in sexual and reproductive health for their own objectives. These conservative groups have relentlessly used international forums, including the Human Rights Council, to advance issues such as “traditional family” and to counter the invented threat of “gender ideology,” which encompasses abortion, gender equality, sexuality education, and occasionally right to die.<sup>237</sup> The Catholic Church and other conservative actors have long portrayed the “gender ideology” that began in the 1990s in documents such as *ICPD* and *Beijing* as part of a global conspiracy that requires resistance.<sup>238</sup> As we scan the world in 2017 as of this writing, that conservative agenda is gaining substantial ground in undermining the solidity of progressive interpretations of international law that had come to seem irreversible.<sup>239</sup> And these conservative groups are enabled and supported by many of the populist nationalists that have come to power questioning the international legal order for a multitude of self-serving reasons.<sup>240</sup>

### J. *Legitimacy Questions Relating to the Human Rights Regime*

Beyond controversial issues in human rights, such as sexual and reproductive health, there are some troubling fissures in the legitimacy of the international regime of human rights that has been constructed over the last twenty-odd years. For example, in 1994, Argentina underwent a constitutional reform that incorporated a “constitutional bloc” to harmonize its domestic law with international human rights law, as

236. See, e.g., *K.L. v. Peru*, Human Rights Comm., Comm. No. 1153/2003, U.N. Doc. CCPR/C/85/D/1153/2003 (2005).

237. See, e.g., Human Rights Council, *Promoting Human Rights and Fundamental Freedoms through a Better Understanding of Traditional Values of Humankind: Best Practices*, U.N. Doc. A/HRC/RES/21/3 (Oct. 9, 2012); Human Rights Council, *Protection of the Family: Contribution of the Family to the Realization of the Right to an Adequate Standard of Living for Its Members, Particularly through Its Role in Poverty Eradication and Achieving Sustainable Development*, U.N. Doc. A/HRC/RES/29/22 (July 22, 2015).

238. For the best example of how gender-ideology is part of a global conspiracy, see GABRIELE KUBY, *THE GLOBAL SEXUAL REVOLUTION* (rev. ed. 2015).

239. See Alston, *supra* note 14; see also Ingrid Wuerth, *International Law in the Age of Trump: A Post-Human Rights Agenda*, *LAWFARE* (Nov. 14, 2016), <https://www.lawfareblog.com/international-law-age-trump-post-human-rights-agenda>.

240. See Alston, *supra* note 14.

many Latin American countries did.<sup>241</sup> Since then, the recognition of an internal order inextricably linked with the commitments adopted at regional and international levels was fundamental to advancing norms relating to health and economic and social rights and even to regimes regarding abortion under domestic law.<sup>242</sup>

However, the recent jurisprudence of the Argentine Supreme Court in the cases *Muiña*<sup>243</sup> and *Fontevicchia*<sup>244</sup> (especially *Muiña*, which dealt with abuses during the dictatorship) reveal that even those advances regarding classic human rights abuses under the military regime, which had been thought to be settled, remain contested.<sup>245</sup> Indeed, these two cases taken together appear to reopen questions regarding the relationship between international and domestic law and the hierarchy of authority in interpreting provisions where domestic norms mirror international obligations, which were at the center of the discussions before the 1994 reform precisely in light of situations such as the ESMA. The legislature responded quickly to the *Muiña* decision in Argentina to ensure prosecution of crimes against humanity in accordance with international law.<sup>246</sup> Nevertheless, Argentina is far from unique, and debates that seemed to have been settled are suggesting new fissures in the legitimacy of the international regime.

## V. CONCLUSION

The power of a collective memory that concedes its subjectivity and captures perspectives of the powerless as well as the powerful is essential to advancing human rights. In 1998, then-president of Argentina, Carlos Menem, submitted a proposal to tear down the ESMA.<sup>247</sup> Activists and opposition members fought the proposal and were able to preserve the site as a space for collective memory and as a piece of evidence in trials that were re-opened against the dictatorship in 2005

241. See Art. 75.22, CONSTITUCIÓN NACIONAL [CONST. NAC.] (Arg.).

242. See Gargarella, *supra* note 160, at 9-18.

243. Corte Suprema de Justicia de la Nación de Argentina [CSJN] [National Supreme Court of Justice], 05/03/17, “Bignone, Reynaldo Benito Antonio y otro s/ recurso extraordinario,” *Fallos* (2017-340:549) (Arg.).

244. Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 02/14/2017, “Ministerio de Relaciones Exteriores y Culto s/ informe sentencia dictada en el caso ‘Fontevicchia y D’Amico vs. Argentina’ por la Corte Interamericana de Derechos Humanos,” *Fallos* (2017-340:257) (Arg.).

245. Roberto P. Saba, *Corte Suprema y los derechos humanos como ideales sociales. A propósito del caso “Bignone”*, 6 REVISTA DE DERECHO PENAL Y CRIMINOLOGÍA, 68, 68-93 (2017).

246. Law No. 27.362, May 10, 2017, B.O. 11/05/17 (Arg.).

247. Decree 8/98, Jan. 6, 1998, B.O. 09/01/98 (Arg.).

after the Argentine Supreme Court declared the unconstitutionality of laws putting an end to prosecutions.<sup>248</sup> In retracing the history of the “health and human rights” field, we have implicitly argued for the importance of understanding how we got to the place we are in the diverse fields that intersect around health and human rights in order to collectively reflect on the path forward. This is an inexorably subjective and selective account, as all exercises in recounting such histories are bound to be. Yet it leaves us with some conclusions for deliberation.

More than twenty years have passed since the “health and human rights field” began to take shape. If it ever really was one “field,” it is no longer one, but many. The story of the evolution of applying human rights frameworks to health is a story of trial and error, adaptation, evolution, and iterative transformations.

We have implicitly argued that

human rights are, or should fundamentally be, about the regulation of power—as shields from tyranny in the public square and private bedroom; as curbs on public lassitude and private greed that undermine social justice; but also as challenges to the structures of thought that drive patterns of suffering and indignity across the globe. Over the decades, advocacy of human rights in relation to health has extended the bounds of human and governmental agency; re-interpreted norms in light of gendered and other experiences; showed the porousness and arbitrariness of divides between the public and private and between the political and economic realms in conventional conceptions of the liberal state; and created institutional frameworks and procedures at national and international levels.<sup>249</sup>

All of these have played critical roles in our capacity to apply human rights frameworks to health. Throughout this history, the greatest source of human rights energy has come from the diverse people who have been affected by, and collectively struggled against “pathologies of power.”<sup>250</sup> Thus, we suggest that any strategies that lead to the

---

248. See Law No. 23.492 (*Punto Final* law), Dec. 23, 1986, B.O. 24/12/86 (Arg.) (establishing the prescription of the criminal action against the accused of committing crimes during the dictatorship); Law No. 23521 (*Obediencia Debida* law), June 4, 1987, B.O. 08/06/87 (Arg.) (establishing a presumption *iuris et de iure* that crimes committed by members of the Armed Forces during the dictatorship were not punishable for having acted under “due obedience”).

249. See Yamin, *supra* note 222.

250. See FARMER, *supra* note 19.



bureaucratization of human rights-based approaches will invariably dilute that energy and understanding of the importance of applying human rights in health.

Perhaps the greatest lesson of this twisting tale is that human rights and the application of human rights to health can never be divorced from social and historical context. Understanding what drove the abuses that occurred in the ESMA and their lingering impacts in Argentine social and political consciousness is not possible without that historical and social context and the national and global power relations at play. Today, it is in the daunting context that the rise of conservative nationalist populism presents that we must now find our feet and return to the central insight of human rights, which is that we are all “endowed with reason and conscience” and “entitled to a social and international order in which [our] rights and freedoms . . . can be fully realized.”<sup>251</sup>

It is not just that conservative populist nationalism, cynically invoked by plutocrats and autocrats, is used to dismiss the need for fundamental institutions of democratic governance, including independent judiciaries, effective oversight, and regulations that affect health. Or that the very foundations of human rights, from constitutionalism and rules-based orders to democratic deliberation based on objective empirical truths, is at risk. It is also that the world order is a fundamentally neoliberal one that assigns disproportionate and unquestionable qualities to the market as an allocator of goods and destinies. This world order is incompatible with a robustly egalitarian and inclusive human rights perspective. In these times, the human rights community must take care not just to stand against the tyranny of illiberal democracies and the new and resurgent threats that these pose to standards of health and social issues related to health that have been achieved over more than two decades.

---

251. G.A. Res. 217 (III) A, Universal Declaration of Human Rights, arts. 1, 28 (Dec. 10, 1948).