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Indicators and the international protection of health-related human rights. A study of the World Health Organization's practices during the COVID-19 pandemic

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“Un pouvoir symbolique est un pouvoir qui suppose la reconnaissance, c’est-à-dire la méconnaissance de la violence qui s’exerce à travers lui.”

Pierre Bourdieu

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Glossary of abbreviations

2020 Concept – WHO Concept for Fair Access and Equitable Allocation of COVID-19 Health Products

2020 Guidance – Indicators to Monitor Health-care Capacity and Utilization for Decision-making on COVID-19

2022 SPRP M&E – COVID-19 Strategic Preparedness and Response Plan 2022: Global Monitoring and Evaluation Framework

3RT – Response, Readiness and Requirements Tracker

AAAQ – Availability, Accessibility, Acceptability and Quality

ACHPR – African Charter on Human and Peoples' Rights ("Banjul Charter")

ACHR – American Convention on Human Rights "Pact of San José, Costa Rica"

CEDAW – Convention on the Elimination of All Forms of Discrimination against Women

CESCR – Committee on Economic, Social and Cultural Rights

CMW – Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families

CoVDP – COVID-19 Vaccine Delivery Partnership

COVID-19 – coronavirus disease 2019

CRC – Convention on the Rights of the Child

CRPD – Convention on the Rights of Persons with Disabilities

D-G – Director-General

DIHR – Danish Institute for Human Rights

EARS – Early AI-supported Response with Social Listening

EB – Executive Board

ECHR – European Convention for the Protection of Human Rights and Fundamental Freedoms

ECtHR – European Court of Human Rights

FAO – Food and Agriculture Organization

FRA – European Union Agency for Fundamental Rights

GCAT – Global COVID-19 Access Tracker

HDI – Human Development Index

HRC – United Nations Human Rights Committee

HRMI – Human Rights Measurement Initiative

IACmHR – Inter-American Commission on Human Rights

IACtHR – Inter-American Court of Human Rights

ICCPR – International Covenant on Civil and Political Rights

ICESCR – International Covenant on Economic, Social and Cultural Rights

ICJ – International Court of Justice

ICU – intensive care unit

IDEA – Institute for Democracy and Electoral Assistance

IHR – International Health Regulations

ILO – International Labor Organization

ISB – International Sanitary Bureau

KNCHR – Kenya National Commission on Human Rights

KPI – Key Performance Indicators

LNHO – League of Nations Health Organization

LON – League of Nations

M&E Africa – Monitoring and evaluation framework for the COVID-19 response in the WHO African Region

NHRAP – National Human Rights Action Plan

OHCHR – Office of the High Commissioner for Human Rights

OIHP – International Office of Public Hygiene

PHEIC – Public Health Emergency of International Concern

SDGs – Sustainable Development Goals

SERF– Social and Economic Rights Fulfilment

SPHS – Strengthening Population Health Surveillance: A Tool for Selecting Indicators to Signal and Monitor the Wider Effects of the COVID-19 Pandemic

SPRP – COVID-19 Strategic Preparedness and Response Plan

TIP – Trafficking in Persons

UDHR – Universal Declaration of Human Rights

UHC – Universal Health Coverage

UN – United Nations

UNDAF – United Nations Development Assistance Framework Guidance

UNDP – United Nations Development Programme

UNESCEO – United Nations Educational, Scientific and Cultural Organization

UNFPA – United Nations Population Fund

UNICEF – United Nations Children's Fund

UNOCHA – United Nations Office for the Coordination of Humanitarian Affairs

UPR – Universal Periodic Review

VCLT – Vienna Convention on the Law of Treaties

WHA – World Health Assembly

WHO – World Health Organization

WHO African Region – World Health Organization Regional Office for Africa

WHO Western Pacific – World Health Organization Regional Office for the Western Pacific

WTO – World Trade Organization

Chapter I

Introduction

The COVID-19 pandemic has claimed more than seven million lives worldwide since it emerged in late 2019.[1] Initially confined to a local public health emergency, it rapidly evolved into a crisis of global health and global health governance,[2] demonstrating the limited capacity of existing structures to ensure an effective response. Despite the existence of regulatory frameworks and coordination mechanisms, state responses remained fragmented and inconsistent, frequently driven by local rather than global considerations.[3] Consequently, the situation revealed that the ability of the global health governance system to protect human lives in an interdependent world, marked by competing political, economic and social interests, ultimately depends on the effectiveness of its institutional architecture.

The World Health Organization (WHO), as the specialised agency of the United Nations (UN), entrusted with directing and coordinating international health work, was in the centre of the crisis. Although having a constitutional mandate[4] to play a leading role in this domain, the Organisation's capacity to act was constrained by different factors. Its guidance, often disputed or only partially implemented, depended largely on the willingness of states to cooperate. Additionally, structural weaknesses (such as financial dependence on voluntary contributions, susceptibility to political pressure, and competition from other actors in global health governance) further weakened its ability to act effectively.[5] Unable to ensure equitable access to essential health products or to compel compliance with the 2005 International Health Regulations (IHR),[6] the WHO increasingly relied on the instruments available within its

[1] *Estimated cumulative excess deaths during COVID-19, World*, available at https://ourworldindata.org/grapher/excess-deaths-cumulative-economist-single-entity

[2] For the definition of 'global health governance' see Section 2 of Chapter II.

[3] L. O. Gostin, R. Habibi and B. M. Meier, 'Has Global Health Law Risen to Meet the COVID-19 Challenge? Revisiting the International Health Regulations to Prepare for Future Threats', (2020) 48(2) *Journal of Law, Medicine & Ethics* 376, at 379-80.

[4] See Section 3 of Chapter II.

[5] L. Jones and S. Hameiri, 'Explaining the failure of global health governance during COVID-19', (2022) 98(6) *International Affairs* 2057, at 2067, 2070.

[6] 2005 International Health Regulations, 2509 UNTS 79, amended by WHA, *Implementation of the International Health Regulations (2005)*, WHA67.13 (2014), and further amended by WHA*, Strengthening preparedness for and response to public health emergencies through targeted amendments to the International Health Regulations (2005)*, WHA77.17 (2024).

institutional reach: data, expertise, and indicators in order to influence the course and coordination of the global pandemic response.

Within this normative and factual framework, indicators served as tools through which the WHO performed its constitutional functions as an actor in global health governance, including directing and coordinating international health work,[7] providing technical assistance,[8] establishing and promoting international standards,[9] collecting and disseminating epidemiological and statistical data,[10] developing and promoting health-related research,[11] advising on health policy,[12] and assisting in the strengthening of national health systems.[13] Indicators offered a means of operationalising abstract commitments such as the right to health, translating them into criteria that could guide action and resource allocation in response to the pandemic. Their use by the WHO reflects a broader shift in the current approach to global governance: from the normative language of law to the technical language of data. Yet this shift also raises a fundamental question: what are the implications of the use of indicators for the protection of human rights?

The hypothesis and aim of study

The hypothesis of this dissertation is that indicators developed and applied within the WHO's institutional practice influence the understanding of human rights related to individual's health[14] not only as interpretive instruments that clarify the content of legal obligations, but also as operational tools that shape how these obligations are implemented and monitored in practice. Consequently, the use of indicators may have substantive implications

[7] Art. 2(a) of the WHO Constitution.
[8] Art. 2(d) of the WHO Constitution.
[9] Art. 2(k) of the WHO Constitution.
[10] Art. 2(f) of the WHO Constitution.
[11] Art. 2(n) of the WHO Constitution.
[12] Art. 2(q) of the WHO Constitution.
[13] Art. 2(c) of the WHO Constitution.
[14] The human rights dimension of health transcends any single entitlement, shaping and intersecting with a range of other rights, including the rights to life, privacy, and non-discrimination. For this reason, this study adopts the term *health-related human rights* in order to capture the broader constellation of legal obligations that bear upon the protection of health. Nevertheless, the right to health is often singled out as a common denominator, serving as a conceptual and normative reference point for the broader category of health-related human rights. See Chapter III.

for the actual enjoyment of health-related human rights by individuals, exposing normative and epistemic implications of governance through measurement.

This hypothesis arises from the observation that there is a continuous need to clarify the substantive content of health-related human rights, as factual circumstances often necessitate the adoption of concrete, context-specific measures aimed at their realisation. In the contemporary landscape of global governance, characterised by a multiplicity of actors with overlapping mandates, the WHO occupies a distinctive position as both a technical and normative institution. Within this complex scenery, indicators have been described as tools with considerable potential to render abstract legal standards measurable and to facilitate their translation into concrete performance expectations. At the same time, their use is not free from risks. The reliance on indicators inevitably entails processes of simplification and prioritisation, which may affect the way legal commitments are understood and pursued. This tension became particularly visible during the COVID-19 pandemic, when the WHO employed indicators not only to monitor national responses but also to guide global allocation of health resources and coordination efforts. The pandemic thus provided a context in which the practical consequences of governance through measurement could be observed. These developments suggest that indicators may indeed influence both the interpretation and implementation of health-related human rights, thereby justifying the hypothesis advanced in this dissertation.

The overall aim of the dissertation is to verify the hypothesis presented above. The available evidence indicates that indicators, as employed within the WHO's frameworks, have progressively evolved from instruments of technical measurement into tools that shape how health-related human rights are understood, implemented and monitored. Their increasing integration into WHO's instruments, also during the COVID-19 pandemic, suggests that indicators are components of a broader process through which legal and institutional meanings are constructed. Accordingly, the dissertation proceeds on the assumption that through the use of indicators the Organisation has sought to translate the broad principles of health-related human rights (most notably the right to health) into observable standards capable of guiding national and international responses. At the same time, by exploring epistemic risks revealed (particularly the tendencies toward reductionism and the promotion of specific cognitive or policy agendas), the study aims to clarify the legal relevance of indicators and to assess their potential to contribute to the protection of health-related human rights.

Research methods

The research employed a dogmatic-legal method combined with institutional, contextual and historical analysis, supplemented by critical legal analysis. Such configuration of research methods reflects the multidimensional character of the hypothesis.

The dogmatic-legal method provides the foundation for the analysis of the international legal framework relevant to health-related human rights, particularly the right to health. This allowed for the examination of legal norms and their relationship to the institutional practices of the WHO. It further serves to verify whether the use of indicators clarifies or modifies the substantive content of human rights obligations.

The institutional and contextual analysis situates this doctrinal inquiry within the human rights practice. It examines how international bodies, including the WHO, employ indicators in different kind of documents to guide decision-making, resource allocation, and the evaluation of states' performance. This approach is particularly relevant for assessing the hypothesis that indicators function as operational tools shaping how legal norms are implemented in practice. The analysis draws on WHO sources (such as monitoring frameworks, evaluation reports, and pandemic response strategies) supplemented by materials from the Office of the High Commissioner for Human Rights (OHCHR) and the Danish Institute for Human Rights (DIHR), and relevant jurisprudence of international adjudicating bodies.

The historical method is employed as a supplementary one, particularly in Chapters II and III, to trace the evolution of global health governance and to contextualise the emergence of indicators as instruments of institutional practice. It allows to reconstruct the development of the WHO's role in health regulation and to explain how indicators acquired their dual function as technical and legal instruments and why their use has become embedded in the institutional practices of the WHO.

Given that the hypothesis also concerns the epistemic dimension of indicators (namely their capacity to define what counts as valid knowledge) the research incorporates a critical legal perspective informed by the insights of the critical legal studies[15] movement. This

[15] Critical legal approach "explore[s] the manner in which legal doctrine and legal education and the practices of legal institutions work to buttress and support a pervasive system of oppressive, inegalitarian relations. Critical theory works to develop radical alternatives, and to explore and debate the role of law in the creation of social,

approach recognises that the production and use of indicators are not neutral technical processes but reflect specific epistemological assumptions and power relations.

The combination of these methods allows the dissertation to address the research problem comprehensively.

Structure of the dissertation

The analysis is divided into six chapters. Chapter II lays the groundwork by situating the WHO within the broader context of global health governance. It explains how the Organisation's constitutional mandate and its evolution have shaped its role as both a producer of knowledge and a standard-setting institution. At the same time, the chapter highlights that as an organisation without coercive powers and dependent on the consent and cooperation of its member states, the WHO has limited capacity to ensure compliance with its guidance. In the light of the foregoing, its influence derives primarily from the credibility of its technical expertise and the persuasiveness of its evidence-based assessments. This reliance on technical activities created the conditions under which indicators would later emerge as key instruments of governance within the WHO. Thus, it analyses the dual foundations of the Organisation's authority – legal and epistemic.

Chapter III examines the international legal protection of health-related human rights, with a particular emphasis on the right to health as prescribed in the International Covenant on Economic, Social and Cultural Rights (ICESCR)[16] and interpreted through the jurisprudence and general comment of the Committee on Economic, Social and Cultural Rights (CESCR). The chapter positions the right to health within the broader context of international human rights law, showing how it has evolved over time. It emphasises that the right to health, despite being universally recognised, has remained conceptually ambiguous, requiring translation into tangible state performance. It analyses how the Availability, Accessibility, Acceptability and Quality (AAAQ) framework clarifies the content of the right to health into operational dimensions that lend themselves to measurement. The analysis points at showing that this

economic and political relations that will advance human emancipation." P. Fitzpatrick and A. Hunt, 'Critical Legal Studies: Introduction', (1987) 14(1) *Journal of Law and Society* 1, at 1-2.

[16] 1966 International Covenant on Economic, Social and Cultural Rights, 993 UNTS 3.

framework is the necessary first step to clarifying the dimensions of the right to health. Indicators, in turn, serve to operationalise this framework by linking each dimension with concrete operational practices. The chapter thus highlights the normative and operational dimensions of the right to health, showing that the demand for indicators arises from the very nature of international human rights obligations.

Chapter IV examines the concept of indicators in international human rights law and clarifies their function within legal and institutional practice. It examines indicators as both legal and methodological instruments that bridge the gap between legal obligations and processes of assessment and evaluation. The chapter discusses the differences between structural, process and outcome indicators, explaining how each reflects a different aspect of state performance under human rights law. Additionally, based on the framework established by the OHCHR it examines how indicators impact the interpretation of rights and the understanding of compliance and accountability. In doing so, the chapter defines the analytical foundations necessary for assessing their use within the practice of the WHO.

Chapter V analyses indicators as instruments of global governance that reshape how authority and accountability operate in international law. The analysis highlights that the appeal of indicators lies in their capacity to present complex phenomena in a seemingly objective and neutral form, what facilities consensus and legitimises intervention. Yet it also considers the implications of this process: the privileging of data-rich over data-poor contexts, and the reinforcement of specific policy models under the guise of technical neutrality. The discussion situates these dynamics in the context of the WHO, where the lack of coercive power makes indicators more appealing as a means of exercising influence through expertise and analyses how indicators generate both normative (by structuring legal expectations) and epistemic effects (by defining the way that compliance is assessed).

Chapter VI applies these insights to the WHO's practices during the COVID-19 pandemic. It examines five illustrative institutional documents, ranging from methodological frameworks to resource-allocation instruments, in which indicators played a significant role in shaping the Organisation's response to the crisis. Through analysis of these materials, the chapter shows how indicators informed the monitoring of national health systems, guided pandemic preparedness assessments, and influenced the distribution of global health resources, while at the same time revealing how the WHO operationalised key dimensions of the right to health in practice. The analysis confirms that the use of indicators strengthened the operational

articulation of health-related human rights but also contributed to epistemic tensions linked to the quantification of human rights.

The concluding chapter brings together the findings of the study and reflects on their broader implications for international law. It confirms the hypothesis that indicators developed and applied within the WHO's institutional practice influence both the interpretation and implementation of health-related human rights. It shows how indicators, far from being neutral technical tools, participate in defining what constitutes compliance or progress in global health law. The dissertation concludes by examining the opportunities and risks inherent in this mode of governance and by reflecting on the significance of indicators for the protection and realisation of human rights.

Chapter II

Steering global health: the role of the WHO in global health governance

Infections do not have nationality and do not respect geopolitical borders or governmental authority.[17] Driven by travel, trade, tourism, and globalization, global health risks resulting from a disease epidemic in a remote location can quickly spread across borders to endanger populations in far-off regions.[18] This epidemiological reality necessitates coordinated international responses to safeguard health of individuals. Among the actors engaged in such collective endeavour, the WHO, acting within multifaceted and polycentric[19] socio-political-legal context, plays a leading role.[20] However, this dissertation argues that the effectiveness of the WHO's efforts in this context increasingly depends on its capacity to offer transparent and empirically grounded guidance. Within this context, indicators have emerged not merely as technical measurement instruments, but as strategic tools through which the WHO seeks to govern health-related issues globally.

This chapter analyses the evolving institutional and normative foundations of global health governance,[21] with a particular focus on the role of the WHO in this area. Its aim is to present the trajectory of the WHO's development, while tracing how indicators became important to its functioning. It begins by examining the globalisation of health risks and the resulting need for transnational regulatory responses (Section 1). What follows is a discussion on the institutionalisation of global health governance, focussing on the legal and political configurations that have shaped its evolution (Section 2). The chapter then turns to the WHO itself: its historical formation, structure, normative mandate, and the instruments through which it governs health-related issues (Section 3). The analysis highlights how the growing

[17] A. Kay, 'Understandings of Global Health Governance: The Contested Landscape', in A. Kay and O. Williams (eds.), *Global Health Governance* (2009), 27 at 27-8.

[18] 'Global health' refers to "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide." See J. Koplan et al., 'Towards a Common Definition of Global Health', (2009) 373 *Lancet* 1993, at 1993.

[19] See B. Kingsbury and M. Donaldson, 'Global Administrative Law', in R. Wolfrum (ed.), *Max Planck Encyclopedia of Public International Law* (2011), available at www.mpepil.com.

[20] See R. Tabaszewski, 'Prawo człowieka do zdrowia i jego definiowanie w systemie ochrony Światowej Organizacji Zdrowia', in J. Jaskiernia and K. Spryszak (eds.), *Uniwersalne standardy ochrony praw człowieka a funkcjonowanie systemów politycznych w dobie wyzwań globalnych* (2016), 264 at 267.

[21] For the definition of global health governance see Section 2.

complexity of global health challenges has reinforced the WHO's reliance on indicators as tools for the formulation of health standards, situational assessment, and decision-making.

The primary purpose of this chapter is to provide an understanding of the fundamentals of the establishment and functioning of the WHO. As will be demonstrated in the following sections, the WHO's increasing deployment of indicators reflects a deeper structural dynamic in global governance: a shift from legal compulsion towards incentive strategies grounded in evidence-based persuasion. In light of budgetary constraints, geopolitical pressures, or institutional fragmentation, indicators allow the WHO to translate broad normative commitments (such as the right to health)[22] into data, enabling it to navigate this complex and demanding global health landscape. Consequently, this chapter treats indicators as important and useful tools through which global health is governed in the twenty-first century.

1. Global problems related to health

For centuries, practical challenges related to the protection of individual health have appeared throughout the world. Before the eighteenth century, the responsibility for caring for individuals afflicted with illnesses and diseases was predominantly held by private entities such as families, churches, and charitable organizations.[23] Early forms of health care lacked any systematic mechanisms for assessing population health or tools for measuring the spread or severity of diseases. The history of public health demonstrates a gradual growth of responsibility, moving from local initiatives to state intervention, and eventually to international coordination. Repeating epidemics have shown that diseases cannot be reduced to biological phenomena alone but are shaped by broader social and economic conditions. Cholera and typhus in the nineteenth century revealed the link between poverty and vulnerability, while the AIDS crisis underscored how diseases can generate stigma and deepen patterns of exclusion. More recently, COVID-19 has confirmed both the scale of disruption that health emergencies

[22] The definition, scope, and content of the right to health will be discussed in Chapter III. In this study, the term is employed as a conceptual common denominator for a wide range of human rights concerns that arise in connection with health-related matters. While specific issues may implicate distinct rights (such as the right to privacy, the prohibition of discrimination, or the right to information) the right to health offers a unifying framework through which these problems can be examined and assessed in a coherent manner.

[23] Until the eighteenth-century public institutions played a limited role, intervening primarily during outbreaks of epidemics or pandemics, mainly by imposing quarantine measures to curb contagion. D. Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (2005), 17.

can cause and the continuing limitations of health governance.[24] Together, these events illustrate the persistence of health crises as turning points that expose structural inequalities and the recurrent need for effective mechanisms of collective response.

1.1. Early responses to health challenges

Throughout history, communities have consistently recognised a responsibility to safeguard and improve the health conditions of their members. The main concern was cleanliness, with a particular emphasis on major urban areas where population density posed significant challenges.[25] Notably, ancient civilizations in regions such as Egypt, India, Greece, and the Roman Empire demonstrated pioneering efforts by establishing some of the earliest water supply and drainage systems, showcasing an early recognition of the importance of sanitation.[26]

As societies transformed,[27] particularly during the medieval era in Europe, managing bodies emerged that were dedicated to disease prevention, sanitary oversight, and the general preservation of communal health. In the late medieval period, philanthropists and political authorities, often with papal approval, began to establish hospitals as institutional mechanisms for caring for the sick. In 1145, Guy of Montpellier established the Holy Ghost Hospital. Another Holy Ghost hospital was constructed by Pope Innocent III personally in Rome in 1204, who also contributed to the creation of similar hospitals around Europe. One of the most prominent initiatives was the establishment of hospitals by the Order of the Knights of St. John, commonly known as the Hospitallers, whose network extended from Malta to the German-speaking lands.[28] Hospitals were also created by a number of other knightly orders along the routes the Crusaders travelled.[29] In the late mediaeval ages, cities and guilds erected hospitals as emblems of civic pride and advancement in their communities. In the latter part of the mediaeval period, charitable giving to hospitals gained greater social visibility and esteem, increasingly regarded as a commendable act aligned with the values of Christian piety and

[24] As well as the importance of effective human rights protection – see A. Kamińska-Nawrot and R. Kozłowski, 'Wprowadzenie', in D. Bieńkowska, A. Kamińska-Nawrot and R. Kozłowski (eds.), *Human security w ochronie zdrowia. Prawo. Bezpieczeństwo. Aksjologia* (2023), 7 at 7-8.
[25] Ibid., at 29.
[26] Porter, *supra* note 23, at 3.
[27] Porter, *supra* note 23, at 86.
[28] G. Rosen, *A History of Public Health* (1958), 85.
[29] Ibid.

social duty. The establishment of a refuge for the needy and the sick became a significant concern for a number of princes and counts[30] and these initiatives represented a shift towards more organized and systematic approaches to public health, with a growing understanding of the interconnectedness between sanitation and the prevention of infectious diseases.

Taken together, the establishment of hospitals reflected a growing recognition of the social importance of health, but these institutions remained tied to local religious or charitable initiatives and lacked integration into broader governance structures. Their activities were reactive and inconsistent, and there were no systematic methods for evaluating population health or coordinating responses between regions. This underscored the eventual need for institutional mechanisms capable of generating reliable knowledge and organising health measures on a larger scale.

1.2. Public health in the eighteenth to early twentieth centuries

The eighteenth century marked the beginning of a more systematic engagement with public health as a domain of state responsibility. Over time, public health initiatives came to encompass not only responses to disease outbreaks but also interventions directed at the social and environmental determinants of ill health.[31] These developments laid the foundation for the emergence of modern public health,[32] which gradually developed a more distinct institutional form during the industrial revolution.[33] The rapid expansion of industrial cities, combined with unsafe working conditions and inadequate sanitation, created environments in which diseases spread easily and public health crises became increasingly frequent.[34] Although the Enlightenment promoted ideals of progress and rational governance, the lived realities of industrialisation exposed the limits of such optimism and underscored the need for coordinated public intervention in matters of health.

Typhus and cholera are now used to illustrate the costs associated with the urbanisation processes that accompanied technological advancement. Typhus is a disease that thrives in

[30] C. Moeller, 'Orders of the Holy Ghost', in *The Catholic Encyclopedia* (1910), *passim*.
[31] J. Tobin, *The Right to Health in International Law* (2011), 36.
[32] Public health is defined as "the science and art of preventing disease, prolonging life and promoting health through organised efforts of society". See Great Britain Department of Health and Social Security, *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function* (1988), 63.
[33] Porter, *supra* note 23, at 57.
[34] A. Gaffney, *To Heal Humankind* (2018), 68.

populations that lack adequate housing, clean water, and sufficient food. It established itself as a feature of poverty among populations living in inner cities, particularly among migrant and transient poor communities.[35] As early industrial societies developed, migration emerged as a defining demographic feature of these societies. It was common for members of the industrial proletariat to relocate many times over the course of their lifetimes in order to follow the geography of the business cycle, with agricultural workers in particular moving into urban centres to become part of the industrial workforce.[36] Typhus became a disease that the poor mobile population carried with them. However, among the epidemic disasters that occurred throughout the nineteenth century, cholera was the most devastating.[37] The Asian cholera epidemic, which originated in India, quickly spread across Europe and the United States. The outbreak of cholera exposed deep-rooted social, political, and economic inequalities related to industrialisation, since the disease disproportionately affected impoverished urban populations living in overcrowded and unsanitary conditions, while wealthier groups were better able to isolate themselves from its impact. It became a lens through which the instability of class relations and the risks inherent in urban mass aggregation were brought into sharp relief.[38] The overcrowded and unsanitary living conditions of rapidly expanding cities facilitated the spread of cholera, which came to epitomise the profound human costs of unregulated economic and industrial transformation in the nineteenth century. This crisis made it necessary to reconsider both prevailing conceptions of epidemic disease and the mechanisms devised for its control. Against this background, authorities began to implement public health measures aimed at improving sanitation and living standards, and efforts were made to develop more standardised frameworks for the governance of public health.[39]

These social and medical crises also provoked a broader intellectual response, which sought to conceptualise the relationship between health, poverty, and governance. In 1848, when Europe experienced a widespread eruption of industrial revolution, a German pathologist Rudolf Virchow developed a notion of "social medicine" that contributed to the broader "right to health" movement of the twentieth century. His medical-political viewpoint was shaped during the 1848 typhus epidemic in Upper Silesia, which occurred just before the revolution in

[35] B. Risse, 'Epidemics and Medicine: The Influence of Disease on Medical Thought and Practice', (1979) 53 *Bulletin of the History of Medicine* 505, at 505.
[36] Porter, *supra* note 23, at 58.
[37] See generally N. Longmate, *King Cholera: The Biography of a Disease* (1966).
[38] Porter, *supra* note 23, at 58.
[39] Rosen, *supra* note 28, at 21, 30, 148.

Berlin. As a medical officer, he arrived in the region of Upper-Silesia to conduct an investigation on typhus. He depicted a distressing and pitiful sight in his correspondence, describing barefoot individuals walking through the snow.[40] However, he was equally horrified by what he perceived as completely insufficient reaction.[41] He also reflected that "no matter whether meteorological conditions, general cosmic changes and such are inculpated, never do these in themselves make epidemics […] they only induce them whenever, through poor social conditions, the people have lived under abnormal conditions for a long time."[42] Highlighting the significance of poverty he added "typhus would not have grown to epidemic proportions in upper Silesia if the population had not been bodily and mentally neglected, and the devastation caused by cholera would be quite negligible if the disease claimed no more victims among the working classes than among the well-to-do."[43]

Virchow saw social factors as the fundamental causes of epidemic outbreaks, a view that remains central to modern understanding of health-related human rights. This perspective anticipates later debates on the multiple dimensions of the right to health, including social determinants of well-being and the criteria of availability, accessibility, acceptability, and quality that structure its contemporary interpretation. He also dismissed the idea of attributing poverty to the reckless inclinations of the poor.[44] He contended that poverty was a key factor in the occurrence of epidemics like typhus. In his Report on the Typhus Epidemic in Upper Silesia, he promptly criticised the oppressive nobility of the region for exploiting the impoverished residents, who consistently saw the fruits of their labour benefit only the landlords.[45] Essentially, the pandemic and its significant death toll were not only biological occurrences, but also social phenomena. In the inaugural edition of his publication, Virchow presented the egalitarian objectives of the movement. In his works he addressed a diverse range of social and political topics related to medicine and endorsed a range of reforms including social welfare, control of working hours, and annual physician recertification.[46] He also discussed the idea of a government's responsibility to guarantee the right to health and healthcare, emphasising that

[40] R. Virchow, 'Report on Typhus Epidemic in Upper Silesia', in L. J. Rather (ed.), *Collected Essays on Public Health and Epidemiology* (1985), 205 at 240.
[41] Ibid.
[42] R. Virchow, 'The Epidemics of 1848', in L. J. Rather (ed.), *Collected Essays on Public Health and Epidemiology* (1985), 113 at 117.
[43] Ibid.
[44] Virchow, *supra* note 40, at 217.
[45] Ibid., at 214-7.
[46] R. Virchow, 'Public Health Services', in L. J. Rather (ed.), *Collected Essays on Public Health and Epidemiology* (1985), 14 at 18-21.

the concept of equal rights to a healthy life stems from the definition of the state as a moral unity of its members, where individuals have equal rights and are obliged to act in solidarity.[47] He argued that "as regards the scope of public health care, it is the community that has the obligation to safeguard the right of each individual to exist, i.e., to exist in health."[48] While it is true that ensuring perfect health or eradicating death is unattainable, "it is possible to make provision for essential substances to be within everyone's grasp and to see to it that the very basis for living is not positively withdrawn or negatively withheld. This opportunity to live is the right of the individual, and the duty of the community."[49]

The structural insights offered by Virchow did not lose relevance in the twentieth century. In contrast, they resurfaced with renewed urgency during the influenza pandemic of 1918-1919, commonly referred to as the "Spanish flu," a designation that reflected Spain's relatively uncensored wartime press rather than the disease's geographic origin. The pandemic, caused by a highly virulent strain of avian H1N1 influenza, was one of the most lethal global health events in recorded history.[50] What distinguished this pandemic was not only its speed and scale (infecting an estimated one-third of the world's population) but also its demographic specificity.[51] Unlike typical influenza, which disproportionately affects children and older adults, the 1918 strain proved particularly deadly among young, otherwise healthy individuals, thereby deepening its socioeconomic impact and destabilising labour markets across numerous states.[52] The world was not prepared to confront a pandemic that ultimately caused up to 100 million deaths.[53]

The pandemic also exposed the lack of coordinated global mechanisms, as there was no shared vision of how the disease should be addressed at the international level. Although some local and national authorities introduced public health measures, such as school closures or mask mandates, these actions were reactive and uncoordinated. There was no supranational institution capable of collecting information systematically or facilitating cross-border

[47] R. Virchow, 'Radicalism and Compromise', in L. J. Rather (ed.), *Collected Essays on Public Health and Epidemiology* (1985), 29 at 29-31.
[48] Virchow, *supra* note 46, at 17.
[49] Ibid. See also F. Huisman and H. Oosterhuis, *Health and Citizenship: Political Cultures of Health in Modern Europe* (2016).
[50] L. O. Gostin, *Global Health Law* (2014), 363.
[51] Ibid.
[52] See C. Langford, 'Did the 1918-19 Influenza Pandemic Originate in China?', (2005) 31 *Population and Development Review* 473.
[53] P. Berche, 'The Spanish Flu', (2022) 51 *La Presse Médicale* 1, at 1.

cooperation. This not only contributed to the uncontrolled spread of the virus but also underscored the need for international mechanisms of epidemic governance; a need that was only partially addressed decades later through the creation of the League of Nations Health Organization (LNHO), which introduced the first institutional structures for cross-border epidemic monitoring, and later with the establishment of the WHO.[54]

The Spanish flu also reaffirmed the fundamentally social character of large-scale health emergencies, since overcrowding, poor housing, wartime malnutrition, and limited access to medical care all contributed to patterns of differential exposure and vulnerability.[55] In this regard, the events of 1918-1919 gave further empirical weight to Virchow's nineteenth-century claim: that epidemics are not simply biological aberrations, but manifestations of deeper social and political issues.

Epidemics such as typhus and cholera exposed the social roots of disease and prompted early conceptualisations of health as a political and legal concern, while the Spanish flu highlighted the insufficiency of national measures in the face of global contagion. These experiences underlined the need for mechanisms that can connect local realities to overarching governance structures, anticipating subsequent efforts at international coordination aimed at transforming public health from a fragmented array of local and charitable initiatives into a sphere of state responsibility.

1.3. AIDS and the limits of public health governance in the late twentieth century

In the following decades, the needs to combat global health-related challenges continued to progress. The first case of AIDS in the United States dates back to 1981, when clinicians in Los Angeles and New York noticed unusual clusters of symptoms and infections in previously healthy young men. These individuals succumbed to uncommon forms of cancer and pneumonia within a span of a few months. The commonality among the males was their homosexuality.[56] Shortly after its emergence, the media quickly labelled the disease as the "gay

[54] This phenomenon coincides with the twentieth-century transformation in the understanding of the nature of human rights; see P. Bała and A. Wielomski, *Prawa człowieka i ich krytyka. Przyczynek do studiów o ideologii czasów ponowożytnych* (2016), 150.

[55] L. Tripp, L. A. Sawchuk and C. J. Farrugia, 'Assessing the 1918/19 Pandemic Influenza and Respiratory Tuberculosis Interaction in Malta: Operationalizing a Syndemic during a Crisis Event', (2025) 10 *Tropical Medicine and Infectious Disease* 149, at e3.

[56] P. A. Treichler, *AIDS, Homophobia, and Biomedical Discourse* (1999), 5, 26.

cancer" or the "gay pneumonia."[57] By mid-1982, the United States Centers for Disease Control had documented 403 cases of AIDS in 24 states.[58] Around the same period, Europe had recognised 200 cases of AIDS, with 42 of them occurring in males of African origin.[59] During that period, several governments in poorer countries rejected the issue, contending that it was exclusive to industrialised society and medical professionals questioned the ability of retroviruses to cause infectious illnesses in humans.[60] Shortly thereafter, individuals who had no previous record of homosexuality were diagnosed with the just identified illness.[61] Individuals who inject drugs, those with haemophilia, and people from Haiti were shown to be disproportionately impacted, resulting in the creation of several risk groups in epidemiological studies.[62] The categorisation of 'risk groups' marked a turning point in how public health relied on indicators to map vulnerability and to guide surveillance practices, as these categories themselves functioned as proxy indicators for elevated susceptibility to infection. By quantifying risk in relation to social identity or behaviour, they enabled epidemiological monitoring but also reinforced stigma.

During the early 1980s, awareness and concern for AIDS remained limited among scientists and public health officials. The knowledge of the disease was fragmentary and there were no established procedures to diagnose, treat, or prevent it. Moreover, the illness became entangled in public debates about sexuality and national security, spheres rarely discussed together.[63] Patrick Buchanan, an American politician, saw AIDS as "nature's retribution" for homosexual persons who had "deviated from natural behaviour", while several conservative religious leaders viewed the epidemic as a kind of divine retribution for immoral actions.[64]

At the beginning of the 1980s, the WHO regarded AIDS as a low priority since there were so few cases of the illness reported outside North America and Europe.[65] Halfdan Mahler, the WHO's former Director-General, first believed that the sickness was predominantly prevalent in the industrialised Western countries. He later admitted, however, that he had

[57] Ibid., at 46.
[58] M. Cueto, T. M. Brown and E. Fee, *The World Health Organization: A History* (2019), 204.
[59] Ibid.
[60] Cueto et al., *supra* note 58, at 204.
[61] Treichler, *supra* note 56, at 243.
[62] Ibid.
[63] Cueto et al., *supra* note 58, at 205.
[64] Ibid.
[65] Ibid.

underestimated both the scale and the gravity of the emerging epidemic.[66] At the time, AIDS seemed of lesser significance compared to malaria, hunger, and other pressing challenges in developing countries. To keep the issue under observation, the WHO organised a meeting on AIDS at the end of 1983.[67] The number of cases then began to rise dramatically, prompting public health professionals and NGOs to pressure health authorities worldwide to acknowledge the seriousness of the epidemic and allocate resources for an adequate response. The determination of its etiological origin, the delineation of clinical symptoms and the development of laboratory tests persuaded many doubters that AIDS was a distinct biological and clinical entity requiring a coordinated political and institutional reaction.

The global response to AIDS highlighted several recurring challenges in public health, despite being coordinated primarily by the WHO. These challenges were evident in the tendency to adopt interventions that were often short-lived or insufficient and in the frequent scapegoating of marginalised communities. They also appeared in policy choices that subordinated individual rights to collective health security, created an artificial separation between prevention and treatment, or relied too heavily on biomedical explanations while neglecting social and behavioural dimensions. An analysis of these shortcomings reveals the persistent difficulties encountered by global actors in responding to a major epidemic during the late twentieth and early twenty-first centuries. As Virchow had argued in the nineteenth century, epidemics often reflect deeper failures of social organisation. The global response to AIDS reaffirmed this insight, showing how disease is shaped and governed by structural inequality, moral judgment, and political neglect.

The AIDS crisis highlighted that the reliance on narrow biomedical categories and fragmented institutional responses left social inequalities unaddressed. The epidemic thus underscored the need for global initiatives to integrate social determinants of health, human rights, and data-driven tools in a way that avoids reinforcing marginalisation.

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[66] *Halfdan Mahler, Who Shifted W.H.O.'s Focus to Primary Care, Dies at 93*, available at www.nytimes.com/2016/12/15/science/halfdan-mahler-who-director-general-dies.html.

[67] WHO, 'Acquired Immunodeficiency Syndrome – An Assessment of the Present Situation in the World: Memorandum from a WHO Meeting', (1984) 62 *Bulletin of the World Health Organization* 419, at 419.

1.4. COVID-19 and the contemporary crisis

In late 2019, the world faced the emergence of a new public health crisis that quickly escalated into one of the most significant global pandemics in recent history. COVID-19, caused by the SARS-CoV-2 virus, was first identified in Wuhan, China, where a cluster of atypical pneumonia cases was reported to the WHO on 31 December 2019.[68] By January 2020, the virus had been identified, and its transmission between humans was confirmed.[69] Within months, COVID-19 spread rapidly across continents, leading to declare it a Public Health Emergency of International Concern (PHEIC) by the WHO on 30 January 2020, and subsequently, a global pandemic on 11 March 2020.[70]

The initial response to COVID-19 was characterised by confusion and fragmented efforts. Many governments underestimated the severity of the virus, delaying the implementation of public health measures such as widespread testing, contact tracing, and social distancing.[71] In several cases, early warnings from scientists and international organisations were ignored, which contributed to the uncontrolled spread of the virus. The crisis was compounded by a lack of clear guidance on treatment protocols and insufficient supplies of personal protective equipment and ventilators. This disarray echoed earlier public health responses, where delays in recognising the severity of the threat resulted in serious consequences.

The effects of the pandemic extended far beyond health systems. By mid-2020, nearly every country had implemented some form of lockdown or mobility restriction, significantly disrupting economies, education systems, and social relations. Marginalized groups (including low-income workers, migrants, and individuals with limited access to healthcare) were disproportionately affected.[72] At the same time, serious disparities emerged between high-income and low-income states, as wealthier ones secured the majority of vaccine supplies while poorer regions struggled to protect their populations.[73] By late 2021, while many high-income states had achieved substantial vaccination coverage, low-income states were still struggling to

[68] *Timeline of WHO's Response to COVID-19*, available at www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline.
[69] Ibid.
[70] Ibid.
[71] L. O. Gostin et al., 'Human Rights and the COVID-19 Pandemic: A Retrospective and Prospective Analysis', (2022) 401 *The Lancet* 154, at 154.
[72] Ibid., at 154-5.
[73] Ibid.

vaccinate even a small percentage of their populations.[74] The phenomenon of vaccine nationalism and unequal access to diagnostics and treatments underscored the fragility of the existing global health governance framework. According to the WHO, more than seven million people have died as a result of COVID-19 since January 2020.[75] Although the WHO played an important role in coordinating the global response, issuing technical guidance, and establishing mechanisms such as the ACT Accelerator,[76] the shortcomings, ranging from delayed national responses and insufficient medical supplies to the persistence of stark global inequalities in access to vaccines and treatments, highlighted the structural limits of the WHO's authority, which depends less on coercion than on persuasion, coordination, and the voluntary cooperation of its member States.[77]

The COVID-19 pandemic exposed serious weaknesses in the global health infrastructure, showing the limits of the WHO's mandate. Confronted with these constraints, the Organisation increasingly relied on technical instruments to assert its relevance and coordinate responses. By utilizing evidence-based methodology, the WHO aimed to better understand the pandemic's impact on individuals and their health-related rights, ensuring that its global response aligned with the actual needs.[78] Indicators, already present in WHO's toolbox, assumed greater operational relevance during the crisis, as they were deployed more systematically to assess conditions worldwide and guide aspects of the Organisation's responses.[79] Data collection supported decision-making at both international and national levels, allowing the Organisation to evaluate different aspects of peoples' experiences, including access to healthcare services, the effects of movement restrictions and disparities in

[74] V. Pilkington, S. M. Keestra and A. Hill, 'Global COVID-19 Vaccine Inequity: Failures in the First Year of Distribution and Potential Solutions for the Future', (2022) 10 *Frontiers in Public Health* 1, at 2-3.
[75] *WHO COVID-19 Dashboard*, available at data.who.int/dashboards/covid19/deaths.
[76] *Timeline of WHO's Response to COVID-19,* available at www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline. See also *What Is the ACT Accelerator*, available at www.who.int/initiatives/act-accelerator/about. According to the WHO: "The Access to COVID-19 Tools (ACT) Accelerator, is a […] global collaboration to accelerate development, production, and equitable access to COVID-19 tests, treatments, and vaccines. Launched at the end of April 2020 […] ACT Accelerator brings together governments, scientists, businesses, civil society, and philanthropists and global health organizations. The ACT Accelerator is organized into four pillars of work: diagnostics, therapeutics, vaccines and the health systems and response connector. Each pillar is vital to the overall effort and involves innovation and collaboration, with WHO playing a key role in all four pillars, as well as leading the cross-cutting Access and Allocation workstream to ensure the equitable allocation of COVID-19 tools."
[77] See Chapter III.
[78] Ibid., at 2.
[79] See for example WHO, *Indicators to Monitor Health-Care Capacity and Utilization for Decision-Making on COVID-19* (2020).

vaccine distribution.[80] Specific indicators such as hospital bed occupancy rates or the availability of personal protective equipment provided the necessary information not only for the WHO but also for its member states and other global health actors.[81]

Although a more detailed analysis of the indicators and their practical application will be presented in Chapter V, it is important at this stage to emphasise how historical public health crises have recurrently demonstrated the interdependence between epidemiological phenomena and broader social, political, and economic structures. The events analysed in this chapter (from Virchow's account of the typhus epidemic, through the social and institutional responses to AIDS, to the recent challenges of COVID-19) illustrate that the effectiveness of health interventions depends not only on clinical or scientific knowledge, but also on the capacity to recognise and address structural determinants of health and persistent patterns of marginalisation.[82] Effective governance of health-related matters thus requires an awareness of the multiple, intersecting dimensions of social life, with indicators serving as a key instrument for making these dimensions visible and actionable in practice. Together, these experiences help explain the evolving rationale behind the current WHO orientation towards data-driven decision-making. The growing complexity of the global health landscape has led to increased reliance on indicators as tools capable of capturing different real-world conditions and informing responses in a more timely and structured manner. Without reliable information on how individuals are affected in different contexts, the coordination of international health action remains fragmented and incomplete.

Consequently, indicators function as instruments that translate both complex social realities and the abstract legal obligations of states into quantifiable categories. In this way, they make such phenomena perceptible and actionable for institutions, guiding policy choices, shaping priorities, directing resources, and enabling compliance monitoring. In addition, by

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[80] See Kingsbury and Donaldson, *supra* note 19, at 3. This observation aligns with Benedict Kingsbury and Megan Donaldson's theory, which concludes that not only "law" but also "law-like structures play an increasingly significant role in global administration." Furthermore, it supports the argument that "human rights law […] requires some measure of transparency, including, potentially, transparency about rulemaking and decisions pursuant to global administration" (at 32), thereby strengthening the "power and authority" of the WHO. This is particularly significant given the "desirability of addressing […] activities in rules on participation, transparency, review, and accountability" (at 10).

[81] See Chapter VI.

[82] See B. Bennett, I. R. Freckelton and G. Wolf, 'COVID-19 and the Future of Australian Public Health Law', (2022) 43 *Adelaide Law Review* 403, at 405. It has been observed in the literature that health should enjoy a particularly strong and genuine form of protection; see A. Mokrzycka, *Prawo do ochrony zdrowia. Konstytucyjny priorytet czy źródło dylematnów w ochronie zdowia?* (2014), 29.

2020, it became clear that for any collective action to be successful, it is crucial to have effective leadership, adequate and fairly allocated resources, as well as public trust,[83] which is called 'global health governance' and will be discussed in detail in the next section.

2. Global health governance

Global health governance implies "the use of formal and informal institutions, rules and processes by states, intergovernmental organizations, and non-state actors to deal with challenges to health that require cross-border collective action to address effectively."[84] Unlike international health governance, which centres primarily on inter-state cooperation and emphasizes the legal duties of states to promote and protect health, global health governance reflects a broader constellation of actors.[85] Alongside states, international organizations, civil society groups, and private philanthropic foundations play a crucial role in setting global health priorities, mobilising resources, and delivering services. The key distinction therefore lies in the multiplicity of actors involved in shaping collective responses to global health needs: whereas international health governance remains state-centred, global health governance acknowledges the influence of diverse non-state participants.[86]

Academic debates on global health governance highlight not only how it can be defined but also what makes it effective in practice. Jeremy Youde identifies several conditions for effective global health governance, including the need to transcend geographical borders,[87] to

[83] W. E. Parmet et al., 'COVID-19: The Promise and Failure of Law in an Inequitable Nation', (2021) 111 *American Journal of Public Health* 47, at 47-8.
[84] D. Fidler, *The Challenges of Global Health Governance* (2010), 3.
[85] R. Dodgson, K. Lee and N. Drager, *Global Health Governance: A Conceptual Review* (2002), 7.
[86] J. Barcik, *Międzynarodowe prawo zdrowia publicznego* (2013), 15.
[87] According to Jeremy Youda, globalization and deterritorialization are major factors driving international concerns over health and illness. The efficiency and rapidity of crossing international boundaries greatly expand the demographic susceptible to infectious diseases. This emphasizes the importance of maintaining vigilant public health systems and monitoring operations to promptly identify issues and take action to prevent the spread. Thus, the global health governance system must balance national, regional, international, and global demands when allocating resources, prioritizing challenges, and mobilizing players for an effective response. See J. Youde, *Global Health Governance* (2012), 1-10.

employ multisectoral approaches,[88] to provide platforms for diverse stakeholder participation,[89] and to rely on transparent processes.[90] These criteria are not merely descriptive; they suggest that global health governance requires mechanisms that enable the integration of multiple perspectives and the transformation of broad commitments into operational practices. In this regard, indicators can function as such a mechanism, offering a shared language that enables actors from different sectors to articulate, compare, and evaluate claims.

Global health governance is a constellation of overlapping and non-hierarchical regimes.[91] In this context, certain global health functions[92] (such as the production of norms, scientific research capacity, and financial transfers) cannot be realised by individual states alone.[93] This analysis highlights the importance of international cooperation and institutional frameworks that render global public health goods accessible across jurisdictions.[94] The reliance on indicators can be situated within this perspective; by translating abstract objectives into measurable criteria, indicators allow different governance regimes to coordinate their activities even if there is no one, central authority.[95]

[88] Health challenges should not be exclusively managed by public health systems. Infectious illnesses are closely linked to politics, culture, social stratification, and economy. To fully comprehend health in a holistic manner, it is essential to involve additional sectors and stakeholders to develop successful solutions that extend beyond only the absence of sickness.

[89] National health ministries' government personnel lack the comprehensive knowledge required to recognize issues, formulate effective solutions, and execute programs. They need to depend on individuals employed across all tiers of government. This involves extending beyond official governmental frameworks to include input from a diverse array of impacted populations and credible sources of information. Implementing a strategic approach would not only boost the chances of success but also promote acceptance and support for the initiatives. When individuals believe that their problems influenced the development of the solution, they are more inclined to embrace that response.

[90] Youde, *supra* note 87, at 3-4.

[91] Fidler, *supra* note 84. In this paper, 'regimes' are understood as sets of rules, institutions, and practices that address specific aspects of health policy.

[92] According to J. Ruger and D. Yach, this term encompasses worldwide advocacy for health, utilization of bio-ethical and human rights instruments, disease surveillance and risk assessment, direct global interventions, investment in critical health issues, and adherence to norms and standards. J. Ruger and D. Yach, 'The Global Role of the World Health Organization', (2009) 2 *Global Health Governance* 1, at 2. See also C. W. Włodarczyk, *Zdrowie publiczne w perspektywie międzynarodowej. Wybrane problemy* (2007), 197-204.

[93] See T. K. Mackey and B. A. Liang, 'Promoting Global Health: Utilizing WHO to Integrate Public Health, Innovation and Intellectual Property', (2012) 17 *Drug Discovery Today* 1254, at 1255-6.

[94] Ruger and Yach, *supra* note 92.

[95] J. Barcik underlines, the multidimensional nature of the phenomenon of public health requires the establishment of legal frameworks for all forms of intervention in this field. See Barcik, *supra* note 86, at 4.

The concept of global administrative law, as developed by Benedict Kingsbury and Megan Donaldson, offers a complementary framework.[96] Rather than existing separately from international law, it provides a lens for understanding how administrative-type rules operate within global governance, extending beyond the traditional limits of state consent.[97] Its emphasis on procedural values (transparency, accountability, participation) has particular significance in health governance, where the legitimacy of decisions depends on inclusive processes involving states, international organisations, and individuals. Indicators intersect with these procedural norms by making institutional practices more visible and broadening participation in decision-making through greater access to data.

Institutions and concepts in international law evolve over time, adapting to new circumstances and challenges.[98] A thorough understanding of an institution's origin, expansion, and durability within the international community necessitates an examination of its development. Although the comprehensive emergence of global health governance did not occur until the 1990s, its roots can be traced back to an earlier era. The evolutionary process began in the mid-nineteenth century when governments first attempted to establish worldwide standards for quarantine operations.[99] Since then, global health governance has become increasingly structured, involving a broader range of actors and shifting from a narrow concern with state self-interest toward recognition of health as an essential dimension of human rights and development. Understanding the origins of current commitments and behavioural expectations therefore demands close attention to this historical development.

In the nineteenth century, European states became increasingly concerned about communicable diseases such as cholera and yellow fever, which often originated in their colonies and threatened their economic and strategic interests. These anxieties were heightened by advances in transportation technology that made travel faster and more widespread, intensifying connections between Europe, the Middle East, and Asia.[100] Notably, the establishment and development of global health governance is linked to the emergence of 'modern' international law. As Martti Koskenniemi observes, the late nineteenth and early

[96] Kingsbury and Donaldson, *supra* note 19. N. Kirsch and B. Kingsbury, 'Introduction: Global Governance and Global Administrative Law in the International Legal Order', (2006) 17 *European Journal of International Law* 1, at 11-12.
[97] Ibid., at 10-9.
[98] M. Koskenniemi, *The Gentle Civilizer of Nations* (2001), 43.
[99] Gostin, *supra* note 50, at 90. See also Section 1.
[100] Cueto et al., *supra* note 58, at 11-12.

twentieth centuries marked a transformative moment in international law, defined by a shift from strictly state-centric diplomacy toward broader ideas of universalism and collective responsibility.[101] This period was characterised by the emergence of a new legal and political 'consciousness' that sought to promote humanitarian goals and to embed ideals of progress and civilisation within the structures of international law.[102]

Accordingly, the early global health initiatives, such as the International Sanitary Conferences, illustrated this shift by seeking to address transnational health threats such as cholera and bubonic plague.[103] This era of international legal development was characterized by the increasing institutionalization of international law,[104] which created platforms through which public health could be addressed by legal and administrative mechanisms at the international level.

Consequently, the health-related efforts were part of a broader phenomenon where international law began to reflect notions stressing cooperation and shared responsibility among states. The establishment of international health organisations, including the LNHO and later the WHO, can thus be seen as a continuation of this trajectory. Their emergence was rooted in late nineteenth- and early twentieth-century innovations, such as the negotiation of international sanitary conventions,[105] the establishment of permanent international health offices,[106] and the growing recognition that effective public health required binding forms of international cooperation.[107] Situating the evolution of global health governance within the wider development of international law makes clear that these mechanisms were not only pragmatic responses to health crises but also reflected a deeper shift: from treating health as a matter of domestic policy to acknowledging it as a legally relevant notion whose protection and promotion required international engagement.

The concept of global health governance shifted from a purely state-centric system to one that encompasses international organisations, non-governmental entities, and commercial

[101] M. Koskenniemi, *supra* note 98, 66-76.
[102] Ibid., at 84-96, 399-406.
[103] N. Howard-Jones, *The Scientific Background of the International Sanitary Conferences 1851–1938* (1975), 7, 9, 12–6, 41.
[104] X. Chen, 'The Institutionalization of International Law at a Crossroads: Pacifists, Jurists, and the Creation of the ILA and the IDI', (2023) 117 *AJIL Unbound* 204, at 207.
[105] Ibid., at 85.
[106] Ibid., at 9.
[107] Ibid., at 86, 93.

players. According to Obijiofor Aginam,[108] as well as Nora Y. Ng and Prah Ruger[109] the evolution of global health governance has been marked by a process of "deterritorializing" health, in the sense of treating health as a global rather than a purely national concern. It has also meant broadening the scope of health to include social, economic, and environmental dimensions, while also recognising how the diffusion of economic models and intellectual frameworks has influenced the institutional architecture of global health governance.[110]

2.1. Early international health cooperation in the nineteenth century

In 1851, the inaugural International Sanitary Conference in Paris was organized by the French Government. Twelve European governments met to address the global spread of cholera, which had transitioned from being confined to India since 1829 to affecting overcrowded European urban centres.[111] The conferences, spanning from 1851 to 1885, primarily focused on cholera outbreaks, emphasizing the need for a uniform maritime quarantine system to defend Western Europe against diseases from "the East."[112] Many states lacked domestic public health legislation, and the Westphalian principle of non-intervention in internal affairs limited the extent of collective measures. By the late 1880s, several international hygienic experts were already arguing that any documents produced in this context should be understood as guidelines rather than binding quarantine obligations.[113]

Medical debates continued into the late nineteenth century contributing to the understanding of cholera transmission. Yet these insights had little immediate effect on practice, as port authorities continued to rely on strict quarantine measures.[114] After six largely fruitless conferences,[115] whose *ad hoc* character and lack of institutional continuity limited their effectiveness, it was the Seventh International Sanitary Conference in Venice in 1892 that

[108] See O. Aginam, *Global Health Governance* (2005), 109-21.
[109] See N. Y. Ng and J. P. Ruger, 'Global Health Governance at a Crossroads', (2010) 3 *Global Health Governance* 1, at 1.
[110] See also J. Youde, 'High Politics, Low Politics, and Global Health', (2016) 1 *Journal of Global Security Studies* 157.
[111] See W. Bynum, 'Policing Hearts of Darkness: Aspects of the International Sanitary Conferences', (1993) 15 *History and Philosophy of the Life Sciences* 421.
[112] Cueto et al., *supra* note 58, at 11.
[113] P. Zylberman, 'Civilizing the State: Borders, Weak States and International Health in Modern Europe', in A. Bashford (ed.), *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* (2006), 21 at 23, 27-8.
[114] Cueto et al., *supra* note 58, at 12.
[115] Howard-Jones, *supra* note 103, at 65.

marked a turning point, focusing on monitoring the Suez Canal and establishing protocols for classifying ships based on cholera cases.[116] The conference also endorsed systematic exchange of epidemic information between states, thereby laying the groundwork for more standardised sanitary regulations in the future.

In 1892, the representatives at the Seventh International Sanitary Conference in Venice adopted the first International Sanitary Convention, that allowed for restricted quarantine procedures and medical inspections for ships transiting the Suez Canal with Muslim passengers travelling to and from Mecca for the yearly hajj pilgrimage.[117] The agreement had a very limited scope, as it only covered a small number of possible cholera cases, but it marked the beginning of efforts to address the issue. According to Norman Howard-Jones, this initial agreement is considered a significant milestone in the history of global collaboration for public health, as the first tangible result of seven international conferences spanning more than forty years.[118] Furthermore, it facilitated further collaborative endeavours. During a conference held in Paris 1894, participating states[119] reached a consensus to extend the scope of the 1892 agreement to include overland transportation and broaden the scope of medical examinations.[120] In 1897, governments expanded the scope of reportable diseases from only cholera to also include plague.[121] Subsequent revisions further extended the scope to yellow fever, smallpox, typhus, and relapsing fever.[122] Governments were required to inform each other about epidemics, have sufficient public health resources at entrance and departure ports, and agree not to implement measures that are more burdensome than those specified by the International Sanitary Convention.[123] Despite its narrow focus, the International Sanitary Convention started the process of instilling the notion that transnational health is a matter that governments should collaborate on.

[116] C. Tsiamis, C. Hatzara and G. Vrioni, 'The Suez Canal under Quarantine: Sanitary History of the Mediterranean Gateway (19th–21st Centuries)', (2022) 136 *SHS Web of Conferences* 1, at 2-4.
[117] Howard-Jones, *supra* note 103, at 45, 63.
[118] Ibid., at 64.
[119] Notably, the United States took part in this conference for the first time.
[120] Howard-Jones, *supra* note 103, at 71.
[121] M. McCarthy, 'A Brief History of the World Health Organization', (2002) 360 *The Lancet* 1111, at 1111.
[122] D. Fidler, 'From International Sanitary Conventions to Global Health Security: The New International Health Regulations', (2005) 4 *Chinese Journal of International Law* 325, at 330.
[123] Ibid., at 329.

2.2. Twentieth-century institutionalisation

The paramount importance of ensuring health to individuals on a global scale was stressed in the post-First World War era.[124] As a response to the First World War, the League of Nations (LON) was established. Although the main objectives of the LON were strategic and political, focusing on attaining peace,[125] security, and safeguarding state sovereignty,[126] Article 23 of the Covenant of the LON[127] imposed obligations on governments to provide decent working conditions and to address international health concerns through preventive and control measures against disease. Member states of the LON were to support and facilitate the creation of the national Red Cross organizations with the goal of enhancing health, preventing disease, and alleviating suffering globally.[128]

Following the First World War, there was a growing consensus on the necessity of creating an international organization specifically dedicated to health. While the International Sanitary Conferences had facilitated some level of cooperation on health issues, their *ad hoc* character made them inadequate for dealing with new health crises and the accelerating expansion of medical knowledge. Furthermore, advancements in travel and communication during this period made the establishment of a more comprehensive international health organization increasingly feasible.[129]

The first step in this direction was the establishment of the International Sanitary Bureau (ISB) in 1902, later known as the Pan American Health Organization. The initiative was driven by several Latin American states, as well as the United States. Its scope, however, remained confined to the Americas, and it lacked the personnel and resources required for a genuinely global mandate.[130] Similarly, the International Office of Public Hygiene (OIHP), created in

[124] Tobin, *supra* note 31, at 23.
[125] The mention of alleviating suffering in Art. 25 was driven by humanitarian concerns for the dire health conditions in states devastated by war. See WHO, *The First Ten Years of the World Health Organization* (1958), 22.
[126] D. Mawar, *States Undermining International Law: The League of Nations, United Nations, and Failed Utopianism* (2021), 99-100.
[127] 1919 Covenant of the League of Nations, 225 CTS 195.
[128] Art. 25 of the Covenant of the LON states that: "The Members of the League agree to encourage and promote the establishment and co-operation of duly authorised voluntary national Red Cross organisations having as purposes the improvement of health, the prevention of disease and the mitigation of suffering throughout the world."
[129] I. Borowy, *Coming to Terms with World Health: The League of Nations Health Organisation 1921-1946* (2009), 13-14.
[130] Ibid., at 26.

Paris in 1907 as a result of efforts led by France, focused primarily on data collection rather than proactive health program implementation.[131] These limitations underscored the need for a new organisation with a permanent bureaucratic framework, a global mandate, and the capacity to engage in direct technical cooperation with its member states.[132]

The establishment of LNHO in 1919 marked a significant step in this evolution.[133] Although the initial proposal to merge OIHP into the LON was unsuccessful due to geopolitical tensions, particularly between French and British interests, the LNHO emerged as an independent entity. It aimed to establish international health standards, promote collaboration among public health officials, and work closely with national health ministries, international organizations, and NGOs.[134] This approach reflected a broader vision of health, understood not only as the absence of disease but also as a foundation for peace and security in the post-war order.[135]

Despite its ambitious objectives, the LNHO faced significant challenges, including financial constraints and personnel shortages. Its reliance on funding from the Rockefeller Foundation's International Health Division[136] underscored the early recognition of the role that non-state actors could play in global health governance.[137] The organisation's operations were then severely disrupted during Second World War, and the dissolution of the LON eliminated the institutional framework on which the LNHO formally relied. Although the LNHO had

[131] N. Howard-Jones, 'The World Health Organization in Historical Perspective', (1981) 24 *Perspectives in Biology and Medicine* 467, at 468

[132] Youde, *supra* note 87, at 57.

[133] The establishment of the LNHO was grounded in Art. 23(f) of the Covenant of the LON, which required the League "to take steps in matters of international concern for the prevention and control of disease." See M. McCarthy, *supra* note 121.

[134] Youde, *supra* note 87, at 57.

[135] Borowy, *supra* note 129, at 24-5.

[136] The goal of Rockefeller Foundation was to develop civilization and advance the well-being of people living in the United States. This included acquiring and disseminating knowledge, preventing and alleviating suffering, and advancing all aspects of human progress. The Rockefellers believed that excellent health is a crucial factor in achieving enhanced global economic and political stability. Additionally, they have the potential to facilitate cross-border health cooperation, which is beyond the capabilities of national governments yet crucial for the well-being of people worldwide. Starting from the first contributions from the Rockefeller family, the International Health Division of the Foundation allocated an annual budget of $18-25 million to promote global health initiatives.

[137] See R. B. Fosdick, *The Story of the Rockefeller Foundation* (1989). P. Weindling, 'Philanthropy and World Health: The Rockefeller Foundation and the League of Nations Health Organisation', (1997) 35 *Minerva* 269. See also J. Farley, *To Cast Out Disease* (2004).

acquired a degree of practical autonomy, its survival was nonetheless jeopardised by the disappearance of the League itself.[138]

Nonetheless, the fact that the LNHO devoted institutional attention to matters of global health in itself marked an evolutionary step in the international approach to health governance. Although its activities were constrained by geopolitical tensions and limited resources, the Organisation laid crucial foundations for future initiatives by developing international health statistics, promoting common standards for disease control, and building networks of experts and institutions that later fed into the creation of the WHO. The readiness of states to collaborate within this framework, even in the face of divergent national interests, demonstrated a growing recognition of the necessity of collective action to address cross-border health threats.[139]

In the beginning, health measures were introduced in an informal and *ad hoc* manner to limit the spread of disease, motivated above all by the economic interests of states in safeguarding trade routes and population stability. With time, these practices were progressively formalised through international organisations and treaties, paving the way for the eventual creation of the WHO as a central actor in global health governance. Accordingly, the origins of contemporary global health governance are better understood as rooted in a mix of precaution and economic self-interest, rather than in purely altruistic concerns.

Across different historical periods, the evolution of global health governance reflected the prevailing concerns and political priorities of each era. In the mid- nineteenth century, early initiatives such as the International Sanitary Conferences were largely reactive, aimed at containing the economic and social consequences of epidemics like cholera and bubonic plague. Yet these arrangements were fragmentary and lacked institutional durability, rendering them ineffective in the face of recurring crises. By the late nineteenth and early twentieth centuries, advances in transportation had deepened global interconnectedness. The creation of the ISB and the OIHP constituted important steps toward institutionalising health governance, but their geographical reach and substantive mandates remained narrow. The interwar period brought a clearer recognition of health as a global public good linked to peace and security. This reconceptualisation was shaped not only by the catastrophic experience of First World War and

[138] Borowy, *supra* note 129, at 17.
[139] Ibid.

the 1918-1919 influenza pandemic, but also by growing economic interdependence and the fear that epidemics could destabilise trade, migration, and political order.[140]

2.3. Post-Second World War reconfiguration

The limitations and fragility of these earlier initiatives underscored the need for a more coherent and durable institutional framework. The devastation of Second World War, combined with the profound geopolitical realignments that followed, generated an acute sense of urgency to confront health challenges through a comprehensive and permanent organisation. The establishment of the WHO in 1948 thus represented the culmination of decades of fragmented efforts. It was conceived as an institution capable of addressing the shortcomings of its predecessors and providing a stable foundation for global health governance.

Although the rhetoric of global health governance increasingly invokes the language of human rights and solidarity,[141] the historical developments analysed in this section reveal a more contingent and uneven trajectory. Rather than reflecting a linear progression from economic self-interest to humanitarianism, the evolution of global health governance is better understood as shaped by shifting geopolitical dynamics. What has altered over time may not be the enduring primacy of national interest and strategic calculation,[142] but rather the frameworks through which such action has been justified and coordinated.

3. World Health Organization

The origins of the WHO can be situated within the emergence of global health governance, which began to take shape in the mid-nineteenth century as a structured international response to transnational health threats. These early initiatives arose primarily in reaction to pandemic risks emanating from regions beyond Western Europe. With the advent of steamship and railway technology, international trade and mobility expanded rapidly, enabling diseases such as cholera, yellow fever, and bubonic plague to spread far beyond their

[140] B. Towers, 'Red Cross Organisational Politics, 1918-1922: Relations of Dominance and the Influence of the United States', in P. Weindling (ed.), *International Health Organisations and Movements, 1918–1939* (1995), 36 at 43-7.
[141] Barcik, *supra* note 86, at 110.
[142] See M. A. Peters et al., 'The WHO, the Global Governance of Health and Pandemic Politics', (2020) 54 *Educational Philosophy and Theory* 707.

usual locations in colonies and impoverished states, reaching economically developed states in the Western part of the world. Physicians and politicians recognised the need of safeguarding people against epidemic breakouts through the implementation of uniform quarantine measures and other border health restrictions.[143] Over time, the management of health on a global scale became a distinct domain of public health; not only a governmental priority, but also a safeguard for international trade and a field that generated new medical expertise and diplomatic practices.

An important point on this trajectory was President Franklin D. Roosevelt's Four Freedoms Speech of 1941.[144] President Roosevelt emphasized the crucial significance of 'freedom from want' in a historic address, setting the groundwork for the acknowledgment of social and health-related rights.[145]There was a growing acknowledgment[146] that states had an obligation to address the economic and social needs of their citizens, not only for practical reasons but as a fundamental human rights issue.[147]

During the UN Conference on International Organization in 1945, health was identified as a matter of particular importance.[148] Influenced by the positions of the Brazilian and Chinese delegations,[149] the delegates agreed to include a reference to health in Article 55 of the UN Charter,[150] stipulating that: "With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote: (a) higher standards of living, full employment, and conditions of economic and social progress and development; (b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and (c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion." This decision also laid the groundwork for the International Health Conference, which was convened in New York the following year.[151]

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[143] Cueto et al., *supra* note 58, at 10.
[144] S. Rosenman, *The Public Papers and Addresses of Franklin D. Roosevelt Compiled with Special Material and Explanatory Notes* (1941), 65-6.
[145] Tobin, *supra* note 31, at 25.
[146] Porter, *supra* note 23, at 56, 162, 232. Borowy, *supra* note 129, at 23. Youde, *supra* note 87, at 3.
[147] Tobin, *supra* note 31, at 25.
[148] UN, *Documents of the United Nations Conference on International Organization, San Francisco, 1945*, Vol. II (1945), 103.
[149] WHO, *supra* note 125, at 38. The Brazilian delegation submitted a memorandum in which it quoted a statement by Cardinal Spellman that: "Medicine is one of the pillars of peace."
[150] 1945 Charter of the United Nations, 1 UNTS XVI.
[151] K. Lee, *The World Health Organization* (2009), 13.

The International Health Conference comprised representatives from all UN member states, as well as sixteen non-member-states and various private and intergovernmental organisations such as the Rockefeller Foundation and the Pan American Sanitary Bureau. Representatives from the LNHO and OIHP were also present at the meeting, as its decision would have a significant impact on their futures.[152] Some individuals inside OIHP contended that it had the capability and should continue to exist as an independent entity. However, these arguments lost credibility when states expressed their unwillingness to provide financial backing to both LNHO and OIHP.[153] The delegates unanimously resolved to assimilate and assume the responsibilities of both LNHO and OIHP, and some of the initial leaders of the newly formed WHO were drawn from both organisations.

Interestingly, as Kelley Lee points out, the future mission of WHO as a body providing, *inter alia*, social fairness was at times associated with the propagation of a postwar socialist vision of the world.[154] Such associations were often exaggerated, yet they reflected the prominent role of socialist states and their allies, particularly in Eastern Europe and parts of the Global South, in advancing a broad conception of social medicine. These states emphasised equality of access, strong state responsibility, and attention to social and economic determinants of health. In contrast, Western governments, led by the United States, promoted a narrower view of WHO's role, limited primarily to technical cooperation and disease control. This ideological divergence resulted in fundamentally different understandings of the objectives that should underpin international health collaboration and of the scope of WHO's authority.[155] There was a query regarding the automatic inclusion in the WHO upon becoming a member of the UN. In the end, the delegates unanimously supported the principle of universal membership, which allowed any governments that joined the UN to also join WHO, unless they explicitly chose not to. Non-member states and territories had the option to become associate members of the WHO, even if they were not part of the UN.[156] This decision thereby promoted an inclusive understanding of those who may contribute to the advancement of global health collaboration.

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[152] W. R. Sharp, 'The New World Health Organization', (1947) 41 *American Journal of International Law* 509, at 510.

[153] N. Howard-Jones, *International Public Health Between the Two World Wars* (1978), 79-80.

[154] Lee, *supra* note 151, at 35. See also B. C. Iacob, 'Health as a Human Right and Eastern European Anticolonialism', in R. Grosescu and N. Richardson-Little (eds.), *Socialism and International Law: The Cold War and Its Legacies* (2024), 137 at 140-55.

[155] Lee, *supra* note 151, at 35.

[156] Lee, *supra* note 151, at 21.

Although the WHO Constitution was created rather quickly, its actual implementation was severely delayed. The "Magna Carta for World Health"[157] was made available for signing and ratification on 22 July 1946, and it required 26 ratifications in order to become effective. The condition was not satisfied until 7 April 1948. The delay was a result of broader discussions about internationalism following a destructive war, as well as the growing tensions associated with the emerging Cold War.[158] States engaged in debates over whether WHO's mission should embody a solidarist vision of broad international responsibility for health, or whether it should instead respect a more pluralist orientation that left states significant discretion in shaping their own health policies. It's important to recognize that international evolution is not straightforward, and despite a growing consensus on health cooperation, governments are not always willing to share power or sovereignty, as certain states expressed concerns that the operations of the WHO might significantly impact their sovereignty and independence.[159]

With the onset of Cold War tensions, global health became entangled in the ideological and geopolitical rivalries of the period. The WHO Constitution of 1946 had proclaimed the right to health as a universal entitlement, grounded in a broad social vision that extended beyond medical care to include the underlying conditions necessary for well-being. However, by the early 1950s the Organisation had shifted towards a narrower, technically oriented agenda. Instead of advancing the constitutional commitment to health as a comprehensive right, the WHO prioritised disease control programmes and the provision of technical assistance.[160] This turn reflected both the Organisation's limited resources and the political constraints of the Cold War, which discouraged engagement with broader social determinants of health. These changes did not take place immediately after the war. Under its first Director-General, Brock Chisholm, closely identified with the British tradition of social medicine,[161] WHO initially advanced an ambitious and socially oriented vision.[162] The Organisation endorsed the idea of the right to

[157] F. P. Grad, 'The Preamble of the Constitution of the World Health Organization', (2002) 80 *Bulletin of the World Health Organization* 981. See also T. Parran and F. G. Boudreau, 'The World Health Organization: Cornerstone of Peace', (1946) 36 *American Journal of Public Health and the Nations Health* 1267.
[158] Lee, *supra* note 151, at 14.
[159] A. Kamradt-Scott, *Managing Global Health Security. The World Health Organization and Disease Outbreak Control* (2015), 22-4.
[160] Cueto et al., *supra* note 58, at 63.
[161] T. M. Brown, M. Cueto and E. Fee, 'The World Health Organization and the Transition from "International" to "Global" Public Health', (2006) 96 *American Journal of Public Health* 62, at 64.
[162] According to G. Rosen, social medicine "[…] investigates the social and medical conditions of specific groups, and establishes such causal connections as exist between these conditions [and] sets up standards for the various groups that are being studied, and indicates measures that might be taken to relieve conditions and to achieve the

health as a positive entitlement, consistent with its Constitution, and linked this right to the obligation of governments to address the social determinants of health. This approach sought to foster solidarity[163] among member states and to frame health not merely as the absence of disease but as a value requiring active state engagement.[164]

Chisholm was succeeded in 1953 by Marcolino Candau, a Brazilian epidemiologist, who served as Director-General for more than two decades; his appointment marked a decisive shift in the WHO's institutional orientation. In the context of intensifying Cold War tensions, Candau redirected the Organisation towards a technocratic and ostensibly apolitical approach.[165] The WHO increasingly prioritised "vertical" programmes (targeting specific diseases) over more systemic investments in comprehensive national health systems.[166] This model, while operationally efficient, tended to marginalise local participation and deprioritised broader socio-economic determinants of health. As a result, top-down interventions dependent on external technologies and expertise frequently displaced more integrated, community-based strategies.

This narrowing of institutional focus was accompanied by a deliberate withdrawal from normative engagement. The WHO explicitly declined to participate in the contemporaneous efforts to codify the right to health in international legal instruments, and when consulted on the Organisation's stance during the drafting of the ICESCR, Candau replied that the WHO had no comments to provide.[167] The Organisation thus refrained from promoting health as a legal entitlement, even as it nominally retained the constitutional commitment to "the highest attainable standard of health."[168] The most probable justification for this position is the recognition that engaging in human rights discourse would inevitably entail involvement in broader political debates. Given the WHO's stated intention to remain apolitical, it was

standards that have been advanced." See G. Rosen, 'What Is Social Medicine? A Genetic Analysis of the Concept', (1946) 21 *Bulletin of the History of Medicine* 674, at 730.

[163] Gaffney, *supra* note 34, at 156.

[164] B. M. Meier, 'The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All', in J. Harrington and M. Stuttaford (eds.), *Global Health and Human Rights: Legal and Philosophical Perspectives* (2012), 171.

[165] Tobin, *supra* note 31, at 32.

[166] Brown et al., *supra* note 161, at 65.

[167] Meier, *supra* note 164, at 173.

[168] As S. Moyn emphasised "There is perhaps no better testament to the fact that human rights died through birth than that they could prompt no more general campaign of thinkers volunteering to defend them, or even define them." S. Moyn, *The last utopia: human rights in history* (2010), 75.

therefore strategically prudent to avoid such engagement. This retreat from the normative legal sphere coincided with the WHO's increasing reliance on technical mechanisms of influence.

In the absence of enforcement tools, the Organisation sought alternative means of guiding state conduct. One of the most prominent instruments in this regard has been the use of indicators. Instead of imposing obligations, indicators allowed the WHO to shape global health governance through the production of structured knowledge-standardising expectations, defining metrics of success, and enabling cross-national comparisons. Indicators operated as instruments of indirect steering: they do not compel but rather guide policy priorities by generating ostensibly neutral data. In this way, indicators became important to the WHO's soft governance strategy, substituting quantification for regulation and permitting the Organisation to exert influence while avoiding direct encroachment on state sovereignty.

3.1. The structure of the WHO

The WHO, an intergovernmental organization with 194 member states,[169] operates under a governance structure that reflects its foundational principles of inclusivity and equity.[170] The principle of "one nation, one vote"[171] shapes decision-making within the Organisation, but this egalitarian framework often contrasts with the practical realities of operational and financial constraints. Since its establishment in 1948, the WHO's core governance structure has remained largely unchanged, comprising the World Health Assembly (WHA), the Executive Board (EB), the Secretariat being headed by the Director-General (D-G), and six regional offices supported by 147 country offices.

The WHA serves as the main governing body, meeting annually in Geneva to, *inter alia*, set policies[172], approve budgets[173], and elect the D-G[174]. While resolutions are typically achieved through consensus, significant decisions, such as constitutional amendments or conventions, require a two-thirds majority[175]. This procedural rigidity often reflects broader geopolitical dynamics, where power imbalances among states can manifest despite the principle

[169] *Countries*, available at www.who.int/countries.
[170] The Preamble to the WHO Constitution.
[171] Art. 59 of the WHO Constitution.
[172] Art. 18(a) of the WHO Constitution.
[173] Art. 18(f) of the WHO Constitution.
[174] Art. 18(c) of the WHO Constitution.
[175] Art. 60(a) of the WHO Constitution. See WHA, *Rules of Procedure of the World Health Assembly*, Res. WHA8.26 and Res. WHA8.27, Rule 71.

of equal representation. For instance, debates over funding mechanisms and policy priorities have exposed fractures within the WHA, particularly between high-income and low-income states.[176]

The WHA, as the principal decision-making body of the WHO, has long relied on indicators to support the implementation and monitoring of state obligations. Between 2000 and 2013, the WHA adopted 248 resolutions, of which 144 entailed monitoring a total of 100 specific indicators and targets.[177] These indicators covered a wide range of thematic areas, including epidemic preparedness, immunisation, communicable and non-communicable diseases, maternal and child health, as well as water and sanitation safety. This institutional reliance on quantifiable data is particularly visible in resolution WHA71.8, adopted in 2018, which introduced a set of "progress indicators" to monitor global access to assistive technologies. The resolution mandated WHO to report on implementation at defined intervals, thus embedding indicators directly within the Assembly's follow-up mechanisms.[178] Indicators, in this setting, are not merely passive tools of measurement but operate as governance

[176] In 2022, during the 75th World Health Assembly, member states adopted a landmark resolution to reform the WHO's financing model by significantly increasing the proportion of the organization's budget funded through assessed (i.e. mandatory) contributions. Under the previous model, more than 80% of the WHO's budget was derived from voluntary earmarked contributions, often linked to the priorities of individual donor states. The reform aimed to raise the share of assessed contributions to 50% of the core budget by 2030–2031, thereby enhancing the financial independence and institutional stability of the Organisation. As the D-G Tedros Adhanom Ghebreyesus noted, this decision marked a pivotal step toward strengthening the WHO's ability to act as an impartial and effective coordinating authority in global health. However, the process exposed differing views between countries with varying income levels, particularly regarding the distribution of financial responsibilities and policy priorities. See *World Health Assembly Agrees Historic Decision to Sustainably Finance WHO,* available at www.who.int/news/item/24-05-2022-world-health-assembly-agrees-historic-decision-to-sustainably-finance-who. *Statement of the Slovak Republic 75th World Health Assembly Item 13 Sustainable Financing: Report of the Working Group*, available at apps.who.int/gb/statements/WHA75/PDF/Slovakia-13.pdf. *Punto 13 – Financiación sostenible: informe del Grupo de Trabajo Doc. A75/9*, available at apps.who.int/gb/statements/WHA75/PDF/Argentina-13.pdf. *75th Session of the World Health Assembly Bangladesh Statement*, available at apps.who.int/gb/statements/WHA75/PDF/Bangladesh-13.pdf. *Malaysia 75th Session of the World Health Assembly Geneva, Switzerland 22–28 May 2022*, available at apps.who.int/gb/statements/WHA75/PDF/Malaysia-13.pdf. *Déclaration de Madagascar au nom de la Région Afrique relative au rapport de la 7ème réunion du groupe de travail sur le financement durable*, available at apps.who.int/gb/statements/WHA75/PDF/Madagascar-13.pdf. *Building an Inclusive Global Fund to Address Pandemic Preparedness and Response beyond COVID-19: Policy Principles and Strategic Considerations*, available at www.who.int/publications/m/item/building-an-inclusive-global-fund-to-address-pandemic-preparedness-and-response-beyond-covid-19--policy-principles-and-strategic-considerations. WHO, *Rapid Assessment of WHA Resolutions: Indicators and Reporting Requirements 2000-2013*, UHC2030 (2014).

[177] WHO, *supra* note 176.

[178] WHA, *Progress Indicators for Access to Assistive Technology* (2018).

instruments that enable monitoring and coordinated adjustments across heterogeneous legal and political systems.

The primary role of the EB includes implementing WHA policies and providing guidance on technical and operational matters.[179] The EB has the authority to implement emergency actions to address urgent situations such addressing new illnesses or coordinating humanitarian aid.[180] However, its effectiveness is often tempered by resource limitations and the need to navigate divergent member-state interests. The challenges of coordination were starkly illustrated during the COVID-19 pandemic, where conflicting national priorities and uneven resource distribution hindered unified action.[181] The EB has also contributed to the institutionalisation of indicators as tools of programmatic monitoring. In its 146th session, the Board considered and supported a proposal for the Decade of Healthy Ageing 2020-2030, which explicitly incorporated a framework to track progress based on quantifiable data. This framework was built upon a set of indicators previously used in the Global Strategy and Action Plan on Ageing and Health, and aimed to provide baseline data and disaggregated assessments aligned with Sustainable Development Goal indicators.[182] This reflects the EB's active role in mainstreaming indicators as instruments of governance, beyond merely technical monitoring, by embedding them in global strategies designed to shape national policy responses.

The Secretariat, led by the D-G, is the operational backbone of the WHO, responsible for executing policies and managing day-to-day activities.[183] The D-G, as the primary global health authority, is responsible for managing the Organisation's personnel and financial resources, conducting negotiations and mediating conflicts, representing the Organisation in

[179] Art. 28 of the WHO Constitution.

[180] Art. 28(i) of the WHO Constitution stipulates that: "The functions of the Board shall be: […]to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular it may authorize the Director-General to take the necessary steps to combat epidemics, to participate in the organization of health relief to victims of a calamity and to undertake studies and research the urgency of which has been drawn to the attention of the Board by any Member or by the Director-General."

[181] *Chapter 2. Current Context: The COVID-19 Pandemic and Continuing Challenges to Global Health*, available at www.who.int/about/funding/invest-in-who/investment-case-2.0/challenges. *WHO Welcomes Historic Commitment by World Leaders for Greater Collaboration, Governance and Investment to Prevent, Prepare for and Respond to Future Pandemics*, available at www.who.int/news/item/20-09-2023-who-welcomes-historic-commitment-by-world-leaders-for-greater-collaboration--governance-and-investment-to-prevent--prepare-for-and-respond-to-future-pandemics.

[182] WHO EB, *Decade of Healthy Ageing. Development of a Proposal for a Decade of Healthy Ageing 2020–2030*, (2019).

[183] Arts. 30 and 31 of the WHO Constitution.

public, and upholding high ethical standards and political neutrality.[184] Comprising approximately 8,000 professionals,[185] the Secretariat operates with a degree of independence designed to insulate it from undue political influence.[186] However, the reliance on voluntary contributions from member states and private donors often subjects the Organisation to external pressures, what raises questions about its financial autonomy and impartiality.[187] To mitigate these pressures, the Secretariat increasingly deploys indicator frameworks to justify programming decisions and assert epistemic authority *vis-à-vis* donors and member states. For example, in the field of infection prevention, the Secretariat has adopted a structured indicator framework that not only monitors national progress but also informs WHO's own allocation of technical assistance.[188]

The regional offices, established under Chapter XI of the WHO Constitution, exemplify the Organisation's decentralized approach to governance.[189] They are located in Washington (Region of the Americas), Copenhagen (European Region), Cairo (Eastern Mediterranean Region), Brazzaville (African Region), New Delhi (South-East Asia Region), and Manila (Western Pacific Region), each addressing health challenges specific to its constituency. The establishment of these offices served a dual purpose: fostering stronger institutional links with member states and integrating pre-existing regional health organizations into the WHO framework.[190] The regional offices were created as a solution to address the diverse health challenges of different global regions while ensuring representation and decentralization.[191] However, their creation was deeply embedded in the political, historical, and cultural dynamics

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[184] J. Frenk and S. Moon, 'Governance Challenges in Global Health', (2013) 368 *New England Journal of Medicine* 936. G. L. Burci and C. H. Vignes, *World Health Organization* (2004), 50.

[185] *Governance*, available at www.who.int/southeastasia/about/governance.

[186] Art. 37 of the WHO Constitution.

[187] S. K. Reddy, S. Mazhar and R. Lencucha, 'The Financial Sustainability of the World Health Organization and the Political Economy of Global Health Governance: A Review of Funding Proposals', (2018) 14 *Globalization and Health* 1, at 6-7. See D. Sridhar, J. Frenk, L. O. Gostin and S. Moon, 'Global Rules for Global Health: Why We Need an Independent, Impartial WHO', (2014) 348 BMJ g3841. See also S. Khieng and H. Dahles, 'Resource Dependence and Effects of Funding Diversification Strategies Among NGOs in Cambodia', (2014) 26 *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations* 1412.

[188] *Supplementary Annex 2. Global Actions and Indicators for the WHO Secretariat and International and National Stakeholders and Partners in the Context of the Global Action Plan on Infection Prevention and Control (IPC) and the Related Monitoring Framework*, available at www.who.int/publications/m/item/Supplementary-annex-2-draft-global-action-plan-IPC.

[189] Art. 44 of the WHO Constitution. Lee, *supra* note 151, at 49.

[190] Lee, *supra* note 151, at 51.

[191] The regional offices were estabilished between 1949 and 1952. Their creation was based upon Art. 44 of the WHO Constitution, which allows the Organization to "establish a regional organization to meet the special needs of [each – M.B.] such area." See Burci and Vignes, *supra* note 184, at 53-7.

of the post-Second World War era. Some authors even claim that the regionalization of the WHO structure is the result of a "struggle" for distributive power.[192] The Southeast Asia Regional Office, for example, emerged not only as a hub for public health initiatives but also as a "contact zone" where nationalistic and colonial interests clashed, particularly in the context of decolonization and Cold War geopolitics.[193] Some critics also argue that regional offices create an excessive layer of bureaucracy between WHO headquarters and member states, frequently staffed by officials whose qualifications and accountability to the WHO leadership are called into question.[194] Additionally, the autonomy and political dynamics of regional offices also sparked debates about their role within the WHO framework. Critics argue that their decentralized structure sometimes results in uneven policy implementation and resource distribution, which was evident during the COVID-19 pandemic.[195]

This structure not only allows for greater sensitivity to regional priorities but also influences the practice of using indicators, since measurement tools are frequently adjusted to reflect local health realities and data capacities. A prominent example is the WHO African Region's "Framework for Integrating Country and Regional Health Data in the African Region: Regional Health Data Hub 2024-2030". This initiative aims to consolidate health information from national and regional sources into a coherent, standardized data system. It established an indicator-based digital platform designed to support strategic health decision-making, comparative performance assessment, and cross-country benchmarking.[196] Another example is the WHO South-East Asia Region, which has developed indicator-based mechanisms to track both health system performance and progress towards international commitments. Its 2024 report "Monitoring Progress on UHC, Health-Related SDGs, and Health Systems in the WHO South-East Asia Region: Core Indicators and Health Trends 2024" sets out a consolidated framework of indicators that enables member states to measure advances in Universal Health Coverage (UHC) and in health-related Sustainable Development Goals (SDGs) in a comparable manner across the region. This document not only operationalises global commitments but also

[192] T. Hanrieder, 'Regionalization in the World Health Organization', in T. Rixen, L. A. Viola and M. Zürn (eds.), *Historical Institutionalism and International Relations: Explaining Institutional Development in World Politics* (2016), 96 at 97.
[193] M. Saavedra, 'Politics and Health at the WHO Regional Office for South East Asia: The Case of Portuguese India, 1949–61', (2017) 61 *Medical History* 380, at 385-91, 399.
[194] K. Buse, J. V. R. Prasada Rao and V. Lin, 'WHO Regional Elections – More Transparency and Scrutiny Essential', (2023) 401 *The Lancet* 1925, at 1925.
[195] Ibid.
[196] See WHO African Region, *Framework for Integrating Country and Regional Health Data in the African Region: Regional Health Data Hub 2024–2030* (2024).

reflects region-specific priorities, including financial protection, service coverage, and equity of access.[197] The integration of such tailored indicator frameworks by regional offices illustrates how WHO leverages quantification as a decentralized governance tool.

3.2. Mission of the WHO

The WHO Constitution was influenced by the post-war idealism[198], particularly belief in health as a universal human right, commitment to international solidarity, and confidence that newly established international institutions could play a decisive role in securing peace and social welfare. The delegates in the early plenary sessions were optimistic and full of expectations about the potential of the Organisation.[199] Julio Bustos, the Chilean delegate to the International Health Conference in 1946, stated that: "The adoption of the WHO Constitution would signify that, in the future, health would be no longer a matter of private interest to the individual and to the State, but a matter of social interest and worldwide implications."[200] Given the language used, it appears that the creation of the WHO was not only a historic milestone but also the beginning of a new, more inclusive, and expansive approach to health as a matter of international concern.

The WHO Constitution clearly designates the WHO as the primary global health authority, directing it to serve as the leading and coordinating body for international health efforts, in cooperation with UN agencies, national health ministries, and professional organizations.[201] The first Article of the Constitution sets out a broad mission: to achieve the highest attainable standard of health for all people.[202] The preamble defines health as "a state of complete physical, mental, and social well-being and not just the absence of disease or infirmity." The preamble further emphasizes human rights by stating that the highest level of

[197] See WHO Regional Office for South-East Asia, *Progress on the Decade for Strengthening Human Resources for Health in the South-East Asia Region: 2015-2024* (2021).
[198] See also critically about the concept of 'idealism' in international legal thought: D. Long and P. Wilson, *Thinkers of the Twenty Years' Crisis: Inter-War Idealism Reassessed* (1995).
[199] T. Parran, 'Charter for World Health', (1946) 61 *Public Health Reports* 1265, at 1265.
[200] WHO, *Official Records of the World Health Organization No. 2: Proceedings and Final Acts of the International Health Conference Held in New York from 19 June to 22 July 1946* (1948), 66-7.
[201] Art. 2 of the WHO Constitution.
[202] Art. 1 of the WHO Constitution stipulates: "The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health."

health is a basic right for all individuals regardless of race, religion, political belief, economic or social condition.[203]

Article 2 of the WHO Constitution confers upon the Organisation significant normative authority to fulfil its mandate, authorising the WHA to establish "conventions, agreements, and regulations, and provide recommendations regarding global health issues." The Organisation primarily exercises this authority through 'soft' powers, including recommendations and other non-binding measures adopted by the WHA, the EB, or the Secretariat.[204] Among these soft governance mechanisms, indicators have become an increasingly prominent tool through which WHO operationalises its mandate. They enable the Organisation to shape expectations regarding state conduct, monitor progress towards agreed goals, and facilitate comparative evaluation across jurisdictions. Their incorporation into WHA, EB, and Secretariat documents illustrates how quantification functions as a governance mechanism rather than a mere technical exercise.[205]

3.3. Prerogatives of the WHO

The WHO Constitution serves as the foundational legal document that delineates the Organisation's mission, principles, and functions as outlined in Articles 2, 19, 20, and 21. These

[203] Preamble to the Constitution of the WHO states that: "THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States. The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development. The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures. ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Art. 57 of the Charter of the United Nations."

[204] G. Walt, 'WHO under Stress: Implications for Health Policy', (1993) 24 *Health Policy* 125, *passim*.

[205] The distinction between governance mechanism and technical exercise lies in the fact that, when treated as a governance mechanism, indicators are not only instruments for collecting and processing data but also tools that structure behaviour. By contrast, understood as a purely technical exercise, quantification would remain confined to the neutral recording of empirical phenomena.

provisions establish the normative framework for the WHO's operations, allowing the Organisation to act as a central authority in global health governance. Article 2(a) designates the WHO as the directing and coordinating authority on international health work, meaning that it may convene states, issue recommendations and technical standards, and coordinate collective responses to cross-border health threats. By granting such expansive authority, the WHO is positioned not merely as a technical body but as the meaningful global health actor while the scope of WHO's mandate reflects member states' recognition of the need for global health governance body.

The WHO Constitution's provisions on collaboration, particularly Article 2(b), emphasize the WHO's role in fostering partnerships with other international bodies. Such collaborations are not only procedural and theoretical goal but serve a normative purpose, advancing the integration of health into global development frameworks. The partnerships mentioned include cooperating with organizations such as the International Labor Organization (ILO) and the Food and Agriculture Organization (FAO), reflecting the interconnectedness of health with broader socio-economic and environmental context.[206]

An important pillar of the WHO's normative functions is its role in developing, disseminating, and utilizing health-related expertise. Article 2(q) directs the Organisation to "provide information, counsel, and assistance in the field of health." This function underscores the WHO's responsibility to act as a repository of global health knowledge, synthesizing scientific research, technical insights, and policy recommendations. The normative importance of expertise is also emphasized in Article 2(d), which mandates the WHO to "furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments." The WHO's emphasis on expertise extends to the promotion of research and innovation as reflected in Articles 2(j)(n)(o). Article 2(n) highlights the Organisation's responsibility to "promote and conduct research in the field of health," including studies on administrative and social aspects of global health as mentioned in Articles 2(f)(p). Consequently, expertise serves not only as a means for addressing health challenges but remains a legitimizing tool, bolstering the Organisation's credibility in global health governance.

[206] In practice, these collaborations are formalised through agreements endorsed by the WHA, such as the 1947 arrangement between WHO and FAO that established the Codex Alimentarius Commission or developed through joint programmes with the ILO on occupational health and safety.

The WHO is mandated to provide direct assistance to member states. Article 2(r) empowers the Organisation to "assist in developing an informed public opinion among all peoples on matters of health." The provisions of Articles 2(c)(e)(f)(g) further highlight the dual role of the WHO: both as an implementer of health programmes and as a facilitator of global cooperation. Field operations, guided by Articles 2 (l)(m)(q), are crucial for addressing health inequities, particularly in low-resource settings where national health systems lack capacity. Moreover, according to Articles 2(h)(i)(s)(t)(u), member states accepted the authority of the WHO to operate as a procedures and standards creator, which corresponds with Article 2(k) granting the Organisation powers to adopt legal instruments.

Article 19 authorizes the WHA to adopt conventions or agreements with a two-thirds majority vote. Additionally, Article 20 introduces an obligation for member states to act on such conventions within eighteen months. If a state does not accept a convention, it must justify its position with a formal statement conveyed to the WHO. This provision underscores both the urgency of global health governance and the aspiration for collective and coordinated action. Nevertheless, as argued by Lawrence Gostin,[207] it may conflict with the principle of state sovereignty, since it constrains states' discretion in deciding whether to participate in international legal obligations.

The D-G is entrusted with supervisory powers consistent with the requirement for treaty participants to provide annual reports on implementation.[208] Member states must provide yearly reports on the actions and advancements made in enhancing health. They are also required to share health information when requested by the EB.[209]

The WHO possesses the authority to establish regulations on matters such as sanitation, quarantine, disease prevention, nomenclature of diseases, diagnostic procedures, and standards for biological and pharmaceutical products in international trade.[210] Article 22 of the WHO Constitution states that regulations become binding for all members after the WHA adopts them, unless members inform the D-G of their rejection or reservations within a set timeframe. States must either deliberately opt out, or they will be automatically bound. The WHO Constitution allows for the enforcement of mandatory duties without a state's

[207] Gostin, *supra* note 50, at 110.
[208] Arts. 20 and 62 of the WHO Constitution.
[209] Chapter XIV of the WHO Constitution.
[210] Art. 21 of the WHO Constitution.

explicit agreement, a feature that remains exceptional in international law. Historically, two types of regulations were created: the Nomenclature Regulations[211] and the IHR.[212] The significance of these regulations lies in their capacity to standardize health practices across diverse jurisdictions, thereby promoting equity and accountability. In parallel, the WHO has relied on different kind of technical documents, which very often include indicators, to monitor effectiveness of its strategies as well as adjusting policies it renders.[213] While lacking coercive force, such tools form a key component of the WHO's broader strategy of influence through coordination and standardisation in global health governance.

The WHO imposes obligations on states regarding the monitoring and supervision of the implementation of commitments undertaken within the framework of the Organisation. Member states are required to submit annual reports to the D-G. These reports include information on the measures taken and the progress achieved in improving the health conditions of their populations, as well as on actions undertaken in response to the recommendations issued by the Organisation and in relation to conventions, agreements, and regulations.[214] States are also obliged to communicate any significant health-related matters arising within their territory and to provide statistical reports, as well as, upon request of the EB, any additional information concerning health issues.[215]

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[211] WHA, *WHO Nomenclature Regulations 1967*, WHA20.18 (1967). Under the Nomenclature Regulations the WHO has the authority to create and update global classifications of illnesses, causes of death, and public health practices, as well as to standardize diagnostic methods. The inaugural WHA in 1948 approved WHO Regulations No. 1 on illness and Cause of Death Nomenclature, establishing a global procedure for illness categorization. The standards make it easier to compare morbidity and mortality statistics internationally by establishing consistent naming conventions. States must adhere to the Nomenclature Regulations by utilizing the latest edition of the International Classification of Diseases (ICD).

[212] The WHA implemented the International Sanitary Regulations (ISR) in 1951 as WHO Regulations No. 2, which addressed six quarantinable diseases: cholera, plague, epidemic louse-borne typhus, relapsing fever, smallpox, and yellow fever. The twenty-second assembly in 1969 updated and consolidated the International Sanitary Regulations (ISR) and named them the IHR. The IHR had minor amendments, with the twenty-sixth assembly in 1973 revising cholera standards, and the thirty-fourth assembly in 1981 eliminating smallpox due to its universal eradication the year before. The IHR 2005, which originally included just cholera, bubonic plague, and yellow fever, was revised in 1995 during the forty-eighth assembly. In response to the SARS and avian influenza outbreaks in the early 2000s, the assembly extensively amended the IHR in 2005.

[213] For the extensive work on WHO's use of indicators to guide institutional priorities and assess the performance of its activities, see WHO, *Thirteenth General Programme of Work (GPW13): Methods for Impact Measurement* (2020).

[214] Arts. 61, 62 of the WHO Constitution.

[215] Arts. 63, 64 of the WHO Constitution.

3.4. Documents used by the WHO to act in global health governance

As Ellen Hey noted "Some soft law instruments are part of legally relevant infrastructure and may have normative effect."[216] The WHO supports international law by affirming legal norms through codes of practice,[217] global initiatives,[218] action plans,[219] and other instruments.[220] The WHO's deployment of different legal instruments can be perceived as strategic, as it reflects key theories of state's compliance with international law. The WHO's practice exemplifies the assumptions of managerial theory, which posits that states are more likely to comply with international norms when normative expectations are accompanied by technical guidance and non-adversarial compliance mechanisms.[221] By issuing detailed technical documents or model frameworks, the WHO promotes an environment in which states are encouraged (and assisted) to internalise international health standards. The WHO's reliance on non-binding guidance should not be misinterpreted as a weakness. Rather, it represents a strategic adaptation to the constraints of multilateral diplomacy, by employing instruments that are politically viable while remaining legally relevant.[222]

The WHO has always tended to depend on technical and scientific documents based on the best available data.[223] This approach has enabled the Organisation to extend its influence

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[216] E. Hey, 'Making Sense of Soft Law', in *The Hague Academy Collected Courses Online / Recueil des cours de l'Académie de La Haye en ligne* (2024), 54.

[217] See as an example: WHO, *Global Code of Practice on the International Recruitment of Health Personnel* (2010).

[218] See *Global Initiative for Childhood Cancer*, available at www.who.int/initiatives/the-global-initiative-for-childhood-cancer

[219] See *Global Action Plan on Physical Activity 2018-2030*, available at www.who.int/initiatives/gappa/action-plan.

[220] Based on E. Hey's conceptualisation of soft law, the legal character of WHO instruments must be understood within the broader debate on the normativity of soft law. In order to make sense of such instruments, one must ask how they contribute to the development of normativity in international law. Three main roles can be distinguished. First, they may serve as input for developing legal infrastructure, performing a *de lege ferenda* function by reflecting what the law could or should become, with their normative effects only discernible in hindsight. Second, they may form part of the legal infrastructure, helping to define the competences of states and international bodies within complex decision-making processes. Third, they may operate as part of regulation, aimed at governing conduct within existing legal infrastructures, with their normative effect often reinforced by references in hard law. WHO instruments fit most closely within this third category. Hey, *supra* note 216, at 53, 99-100, 103.

[221] A. T. Guzman, 'International Law: A Compliance Based Theory', (2001) 47 *UC Berkeley Public Law and Legal Theory Working Paper Series* 1, at 6-8.

[222] Such "infinite variety" of legal acts is recognised as a characteristic of international law. J. Klabbers, 'The Redundancy of Soft Law', (1996) 65 *Nordic Journal of International Law* 167, at 167.

[223] K. Ó. Cathaoir, M. Hartlev and C. Brassart Olsen, 'Global Health Law and Obesity: Towards a Complementary Approach of Public Health and Human Rights Law', in B. Toebes and G. L. Burci (eds.), *Research Handbook on*

across a wide array of areas, including malaria eradication, tobacco control, and the regulation of breast milk substitutes,[224] suggesting that this strategy holds potential for addressing global health challenges, even though its success is not assured.

Some researchers argue that the WHO should use its legislative power to establish greater number of binding laws in order to tackle global health issues effectively.[225] This line of criticism, however, overlooks the fact that states are more inclined to adopt comprehensive standards if they are not obligated by law to do so,[226] since instruments of a more 'delicate' nature can serve as the foundation for future accords, offering more possibilities for enforcement and accountability. The WHO has faced persistent difficulties in fulfilling its mandate to establish binding international documents, primarily because global health challenges are complex and deeply intertwined with other areas of international law (such as trade and environmental protection) thereby complicating efforts to achieve broad consensus among member states.

However, the limitations of soft instruments in certain domains have led to calls for a more robust legal architecture. This tension is illustrated by the case of the IHR, which, as a rare example of a binding WHO instrument, demonstrates both the promise and pitfalls of hard regulation. The IHR, focusing on preventing, protecting, and controlling the spread of infectious diseases, is an example of legally binding document rendered by the WHO. Even though it took a decade to negotiate the IHR, the instrument has nevertheless faced broad criticism due to the lack of clarity in several of its aspects (the notification system, uncertain about the criteria for declaring a PHEIC, and lacking accountability for breaches).[227] States have frequently neglected to report[228] disease outbreaks to the WHO,[229] failed to

Global Health Law (2018), 427 at 432. See J. Klabbers, 'The Normative Gap in International Organizations Law: The Case of the World Health Organization', (2019) 16 *International Organizations Law Review* 272, at 272-98.

[224] D. Fidler, 'International Law and Global Public Health', (1999) 48 *Kansas Law Review* 1, at 15.

[225] See D. Fidler, 'The Future of the World Health Organization: What Role for International Law?', (2021) 31 *Vanderbilt Journal of Transnational Law* 1079.

[226] C. M. Chinkin, 'The Challenge of Soft Law: Development and Change in International Law', (1989) 38 *International and Comparative Law Quarterly* 850, at 862–3.

[227] *The Outbreak of COVID-19 Coronavirus: Are the International Health Regulations Fit for Purpose?*, available at www.ejiltalk.org/the-outbreak-of-covid-19-coronavirus-are-the-international-health-regulations-fit-for-purpose/. See WHO, *Implementation of the International Health Regulations (2005). Responding to Public Health Emergencies. Report by the Director-General* (2015).

[228] Under Arts. 6 and 7 of the IHR, there is an obligation to report "[…] all events which may constitute a public health emergency of international concern […]" as well as "[…] unexpected or unusual public health event […]."

[229] *China Silences Critics Over Coronavirus Outbreak*, available at www.nytimes.com/2020/01/22/health/virus-corona.html.

adequately prepare for public health emergencies as required by the IHR and disregarded WHO recommendations during emergency responses by implementing actions like border closures that could have infringed human rights obligations.[230] Consequently, despite the binding nature of this document, it remained largely ineffective. The amendments adopted in 2024, while not fundamentally altering the structure of the IHR, illustrate the continuing attempts to recalibrate the balance between state sovereignty and collective responsibility in global health governance. By giving attention to matters such as equity, financial support, and enforcement, the revised text acknowledges that global health regulation cannot be confined to technical standards alone. It reflects a recognition that political choices and distributive justice shape the effectiveness of international health cooperation.[231] The effectiveness of this recalibration will depend on the willingness of states to apply the new commitments in practice and to confront the entrenched inequalities that have repeatedly weakened collective responses.

One should mention that states generally are increasingly consenting to less binding legal acts over time, making soft law the most likely approach to global governance currently.[232] The character of such instruments can facilitate consensus in challenging regions with varying national objectives and private business interests. The Doha Declaration on the TRIPS Agreement and Public Health[233] may serve as an example of the use of soft law to specify the hierarchy of norms in cases where international trade law and global health law conflicted.[234] Further, soft law rendered by the WHO can serve as a foundation for treaties, particularly in complex technological fields or where states require room for political agreement which is

[230] Gostin et al., *supra* note 3, *passim*.

[231] R. Habibi, M. Eccleston-Turner and G. L. Burci, 'The 2024 Amendments to the International Health Regulations: A New Era for Global Health Law in Pandemic Preparedness and Response?', (2025) *Journal of Law, Medicine & Ethics* 1, at 3.

[232] A. T. Guzman and T. Meyer, 'International Soft Law', (2010) 2 *Journal of Legal Analysis* 171, at 171. See also J. Kyl, D. J. Feith and J. Fonte, 'The War of Law: How New International Law Undermines Democratic Sovereignty', (2013) 92 *Foreign Affairs* 115.

[233] WTO, *Declaration on the TRIPS Agreement and Public Health*, WT/MIN(01)/DEC/2 (2001).

[234] S. Sekalala and H. Masud, 'Soft Law Possibilities in Global Health Law', (2021) 49 *Journal of Law, Medicine & Ethics* 152, at 153. The Doha Declaration enabled governments to prioritize access to pharmaceuticals as a component of the right to health above intellectual property rights, thus guaranteeing access to generic medications. The practical significance of the Declaration lay in confirming that WTO members could lawfully use compulsory licensing and parallel importation to ensure access to affordable medicines in the context of public health crises, most notably the HIV/AIDS epidemic. This interpretation eased tensions between TRIPS obligations and states' duties to protect public health, reinforcing that intellectual property rights should not override access to medicines. On the intersection of international trade and public health within the framework of the WTO, see Ł. Gruszczyński and L. Helińska, 'Trade and Health and Safety – TBT and SPS Rules', in V. Vadi and D. Collins (eds.), *Routledge Handbook on International Economic Law* (2026), 223 at 224-8, 235-6.

observable on the example of the Framework Convention on Tobacco Control.[235] It was established in 2003 following a sequence of seventeen resolutions on tobacco control rendered by the WHA from 1970 to 1988 and was developed based on the foundation laid by the WHO Tobacco Free Initiative in 1998.[236]

Moreover, states' preference for flexible instruments, as explained by rationalist approaches, highlights the calculated trade-offs between costs and benefits[237]. Non-binding frameworks often minimize sovereignty costs while maintaining avenues for international collaboration. As illustrated above, the IHR, which was preceded by decades of initiatives rooted in flexibility and adaptability, shows how incremental progress can lead to binding agreements when states are ready to commit. By setting global health standards and cultivating a collective understanding of health priorities, the WHO leverages its authority to encourage voluntary compliance.

The WHO's efforts in areas such as mental health, reproductive health, and environmental protection exemplify how the Organisation's technical expertise helps states adapt their domestic systems to international benchmarks, fostering compliance through influencing reality rather than coercion.[238] For example, the WHO's diagnostic tools in the fields of sexual and reproductive health,[239] mental health,[240] and environmental protection[241] integrate indicators to assess the effectiveness of legislative frameworks. Beyond merely recording quantitative data, indicators serve as instruments that translate broad normative commitments into measurable standards. They allow for the monitoring of states' progress, reveal gaps between formal obligations and actual implementation, and finally – provide a basis for policy adjustment and international comparison. In this sense, indicators operate both as technical devices for data collection and as governance tools that shape expectations about how legal commitments should be realised in practice.

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[235] 2003 WHO Framework Convention on Tobacco Control, 2302 UNTS 166.
[236] See for example WHO, *Towards a WHO Framework Convention on Tobacco Control*, WHA52.18 (1999).
[237] A. van Aaken, 'Rationalist and Behavioralist Approaches to International Law' in J. L. Dunoff and M. A. Pollack (eds.), *International Legal Theory Foundations and Frontiers* (2022), 261 at 268-9.
[238] M. A. Young, 'Implementing International Law: Capacity-Building, Coordination and Control', (2023) 12 *Cambridge International Law Journal* 4, at 14-19.
[239] WHO, *Reproductive, Maternal, Newborn and Child Health and Human Rights: A Toolbox for Examining Laws, Regulations and Policies* (2014).
[240] WHO, *Quality Rights Tool Kit: Assessing and Improving Quality and Human Rights in Mental Health and Social Care Facilities* (2012).
[241] WHO, *Environmental Health Indicators: Framework and Methodologies* (1999).

However, WHO's acts may not possess the requisite enforceable commitments to compel governments to act. For example, the WHO Global Code of Practice on the International Recruitment of Health Personnel has had no impact on domestic policies and practices due to its vague wording and lack of enforceable commitments to deter the recruitment of crucial health personnel across states.[242] As a result, some argue that relying on 'soft' legislation can lead to the Organisation being viewed as weak.[243] Benedict Kingsbury argues, international law should be seen not merely as a set of rules and decisions but as a dynamic social practice.[244] Compliance with international law (here: human rights standards related to health), therefore, should be understood as a process involving multiple interacting institutions rather than a narrow focus on legal obligations. In the contemporary world, compliance mechanisms operate through diverse causal pathways.[245] As Oran R. Young suggests these mechanisms often work in tandem, creating a complex interplay between states' internal policy processes, domestic interest groups, and international normative frameworks.[246]

The WHO has come to rely on indicators not only as important instruments of governance. Their value lies in translating general commitments into specific and comparable data points, which makes documents issued by the WHO appear more credible. Through their repeated use by different occasions, indicators create patterns of expectation: states are encouraged to treat quantified targets as standards even when they are not legally binding[247]. Additionally, quantification conveys an impression of neutrality and precision[248], which may strengthen the acceptance of WHO guidance. Indicators therefore stabilise norms and facilitate coordination, but they cannot resolve deeper systemic constraints on their own. Chapters V returns to this question, examining in detail how indicators operate at the intersection of law and politics.

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[242] J. Edge and S. Hoffman, 'Empirical Impact Evaluation of the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) on Government, Civil Society and Private Sectors in Australia, Canada, United Kingdom and United States of America', (2011) 9(60) *Globalization and health* 1, at 7-8.
[243] Sekalala and Masud, *supra* note 212, at 153.
[244] B. Kingsbury, 'The Concept of Compliance as a Function of Competing Conceptions of International Law', (1998) 19 *Michigan Journal of International Law* 345, at 345-58.
[245] O. R. Young, 'Hitting the Mark', (1999) 41(8) *Environment: Science and Policy for Sustainable Development* 20, at 20.
[246] Ibid.
[247] S. E. Merry, *The Seductions of Quantification: Measuring Human Rights, Gender Violence, and Sex Trafficking* (2016), 11.
[248] Ibid., at 20.

3.5. Criticism of the Organisation

The WHO has been the subject of longstanding and recurrent criticism for its limited effectiveness in responding to global health challenges. Observers have pointed to institutional fragmentation, as well as to constraints arising from voluntary funding mechanisms, which restrict the Organisation's ability to act independently.[249] Concerns have also been raised about the erosion of its normative role, as the WHO has increasingly relied on technical guidance and soft instruments rather than binding legal acts. In moments of crisis (such as the COVID-19 pandemic) its perceived proximity to politically influential member states raised doubts about the impartiality and responsiveness of its institutional practice. These critiques suggest that the WHO has struggled to fulfil its intended function as the central coordinating authority in global health, particularly under conditions of political polarization and financial dependence. The present section examines the criticism that have been directed at the WHO, while the subsequent section will turn to a more analytical inquiry into whether, and to what extent, indicators can offer a meaningful response to these concerns.

In the mid-1990s, Fiona Godlee published a comprehensive critique of the WHO, targeting its management, efficacy, policy decisions, headquarters-regional disputes, power conflicts, and operational capabilities.[250] Simultaneously, a self-study conducted by the WHO assessed the Organisation's effectiveness in fulfilling its core responsibilities and resulted in reform suggestions, focusing on improving its technical expertise and coordination efforts.[251] Furthermore, in order to review the WHO Constitution and recommend changes that would prioritize coordination, the development of health policies, norms and standards, promoting health for all, advice, and technical cooperation as the Organisation's primary functions, special meetings in 1996 were called by the EB.[252]

In 1996, a conference for scholars and practitioners organised by the Rockefeller Foundation titled "Enhancing the Performance of International Health Institutions" took place in Pocantico, New York. The event aimed to assess the adequacy of the institutional structure in international health for the interdependence of global health in the twenty-first century. The Pocantico report concluded that: "WHO should be the 'normative conscience' for world

[249] Gostin, *supra* note 50, at 124. Fidler, *supra* note 84, at 23.
[250] F. Godlee, 'WHO in Retreat: Is It Losing Its Influence?', (1994) 309 BMJ 1491, at 1491–3.
[251] WHO, *Report of the Executive Board Working Group on the WHO Responses to Global Change* (1993).
[252] WHO, *Review of the Constitution and Regional Arrangements of the World Health Organization, Report of the Special Group, Executive Board 101st Session* (1997).

health"; "WHO should assume leadership in achieving more coherence and equity in the system"; and "the emphasis on technical assistance has often come at the expense of the normative role."[253] With the aim of making the WHO an indisputable leader in the field of global health, there was a very clear focus on the worldwide activities of the Organisation.[254] An efficient global governance structure is urgently needed in the realm of human health. This need is apparent since most new global health participants concentrate on operational duties, leading to a higher requirement for WHO core global operations.[255]

The WHO has been criticised for 'lack of effectiveness'[256] due to inadequate leadership, financial constraints (and concerns related to money allocation) as well as decision-making,[257] and having no power under international law to enforce their legal instruments. David P. Fidler further argues that the globalisation of public health has challenged and weakened the notion of state sovereignty, creating tensions between the interests of member states and the influence of private funders.[258] In the early postwar decades, the WHO concentrated on supporting national health systems, especially in newly decolonised states. This approach reached its peak in the 1970s with the 'health for all' agenda. From the 1980s, however, the rise of neoliberal policies redirected health development towards the World Bank, which promoted privatisation and budget cuts.[259] As a result, the WHO was left with a reduced role, focused mainly on regulating and assessing health systems that had already been weakened by these reforms. Simultaneously, the growing dependence on voluntary contributions from high-income states increased the leverage of wealthier countries over the Organisation, encouraging it to prioritise narrow, disease-specific programmes rather than broader systemic reform.[260] These shifts eroded the WHO's independence and limited its ability to respond effectively to global health crises.

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[253] Retreat Pocantico, *Enhancing the Performance of International Health Institutions* (1996).
[254] D. Jamison, J. Frenk and F. Knaul, 'International Collective Action in Health: Objectives, Functions, and Rationale', (1998) 351 The Lancet 515, *passim*.
[255] Ruger and Yach, *supra* note 92.
[256] S. Andresen, *Leadership Change in the World Health Organization: Potential for Increased Effectiveness?* (2002).
[257] Brown et al., *supra* note 161, at 62-3, 68.
[258] Fidler, *supra* note 225, at 1106.
[259] L. Jones and S. Hameiri, *supra* note 5, at 2066.
[260] O. Iwunna, J. Kennedy and A. Harmer, 'Flexibly Funding WHO? An Analysis of Its Donors' Voluntary Contributions', (2023) 8 BMJ *Global Health* 6, *passim*.

The WHO's budget constraints compelled it to assume what has been described as a "meta-governance role,"[261] relying on voluntary compliance and lacking direct intervention capacity, what leads to inadequate support for poorer states and weak implementation of health standards. During crises like the H5N1 bird flu, swine flu, and Ebola, the WHO's underfunding and reliance on *ad hoc* responses from powerful states highlighted its limitations.[262]

The IHR were not accompanied by any additional financial or operational resources that would have enabled the WHO either to intervene directly in health crises or to meaningfully support member states in domestic implementation. In practice, poorer states, often portrayed as the origin points of emerging infectious diseases, were compelled to restructure their fragile health systems in order to contain threats that primarily endangered wealthier states. The latter, however, often provided only minimal and inconsistent assistance. Moreover, in many developing contexts, the implementation of the IHR agenda remained disconnected from domestic political processes and priorities, which resulted in shallow or symbolic compliance, even when limited international aid was made available.

During the H5N1 avian influenza epidemic, the World Bank and the WHO estimated that effective global containment could require up to $800 billion, given projections that the outbreak might cause between 50 and 350 million deaths.[263] Yet, in 2006-2007 international donors pledged only $2.7 billion, and by the end of 2008, barely 72% of that already insufficient sum had been disbursed. Less than half of the delivered funds were directed to support country-level programmes, creating a substantial funding gap.[264] For example, Indonesia, the epicentre of the epidemic with a population of over 242 million people, received only $132 million, a sum grossly disproportionate to its needs.[265] Powerful poultry firms, where the disease was most concentrated, managed to deflect initiatives towards smaller backyard farmers, undermining containment efforts.[266] This situation highlighted the disjunction between the ambitious scope of international guidelines and the realities of their implementation, which was hampered by inadequate resources and selective political will.

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[261] Jones and Hameiri, *supra* note 5, at 2066.
[262] See WHO, *Report of the Ebola Interim Assessment Panel* (2015), 6-7.
[263] M. Brahmbhatt, *Avian Influenza: Economic and Social Impacts* (2005), 4.
[264] UN System Influenza Coordinator and World Bank, *Responses to Avian Influenza and State of Pandemic Readiness: Fourth Global Progress Report* (2008), 13-20.
[265] Ibid.
[266] Jones and Hameiri, *supra* note 5, at 2069.

International organizations are inherently political entities. For this reason, the WHO often seeks consensual solutions to avoid stigmatizing individual states and to mitigate political tensions. The academics has recently concentrated on the uneasy relationship between knowledge and politics inside the operations of the WHO. The antagonism between these two characteristics was visible and disputed before the COVID-19 epidemic, but it has intensified significantly in recent times. Eyal Benvenisti highlighted the difference between political collaboration difficulties, which include processes to ensure compliance, and technical coordination issues, which do not require such structures.[267] Other scholars[268] acknowledge that the WHO engages in autonomous decision-making less often than it could.[269] This tension becomes visible in situations where the WHO must decide how and when to communicate information about outbreaks. On the one hand, scientific considerations require rapid and transparent reporting. On the other hand, governments often fear the economic and political consequences of such announcements, for example the imposition of travel bans, trade restrictions, or damage to their international reputation. The WHO Secretariat is therefore placed in a position where epidemiological data are not transmitted in a purely scientific manner but are filtered through processes of political negotiation.

The WHO's effectiveness is heavily contingent upon the willingness of its member states to cooperate. In practice, the Organisation depends on their voluntary provision of data, willingness to engage in analysis, and readiness to coordinate international activities.[270] As Łukasz Gruszczyński and Margherita Melillo underlined, since the WHO lacks formal legal tools to compel cooperation, maintaining friendly relations with its members is crucial, especially, that the Organisation faces budgetary constraints and depends on voluntary contributions from both member states and private actors.[271] Renu Singh has taken a different

[267] E. Benvenisti, 'The WHO – Destined to Fail?: Political Cooperation and the COVID-19 Pandemic', (2020) 114 *American Journal of International Law* 588, at 590.

[268] A. P. Cortell and S. Peterson, 'Dutiful Agents, Rogue Actors, or Both? Staffing, Voting Rules, and Slack in the WHO and WTO' in D. G. Hawkins et al. (eds.), *Delegation and Agency in International Organizations* (2006), 266-71.

[269] Such phenomenon is called an 'agency slack' which is described as an "independent action by an agent that is undesired by the principal. Slack occurs in two primary forms: shirking, when an agent minimizes the effort it exerts on its principal's behalf, and slippage, when an agent shifts policy away from its principal's preferred outcome and toward its own preferences." D. G. Hawkins et al. (eds.), 'Introduction' in *Delegation and Agency in International Organizations* (2006), 3 at 7.

[270] Ł. Gruszczyński and M. Melillo, 'The Uneasy Coexistence of Expertise and Politics in the World Health Organization: Learning from the Experience of the Early Response to the COVID-19 Pandemic', (2021) *International Organizations Law Review* 1.

[271] Ibid., at 9-11.

approach to the issue, asserting that the combination of politics and knowledge has resulted in several initiatives that have ultimately been successful (e.g. building up an innovative framework such as the Access to COVID-19 Tools Accelerator).[272] Some authors believe that, even within the current organizational and legal constraints, the WHO may still be able to manage the cohabitation of the political and professional parts of its job more successfully.[273] At the same time, the Organisation is sometimes criticised for insufficiently recognising the inevitable political dimension of global health governance[274] and is urged to draw on lessons from past disease outbreaks before engaging more actively with the political aspects of its mandate[275].

The COVID-19 pandemic represented both a major organisational challenge and a potential opportunity for the WHO to demonstrate leadership and consolidate its role in global health governance. Its performance during this period was subjected to unprecedented scrutiny.[276] Accusations have been made that the WHO collaborated with China to minimize the seriousness of the epidemic in the initial phases of the pandemic. It has been criticized for its delayed designation of a PHEIC and for perceived shortcomings in advice regarding face masks and travel restrictions. Additionally, the Organisation in that period was described as "marginalized amid acrimony between the United States and China."[277]

When COVID-19 began to exhibit pandemic potential, the WHO was thrust to the forefront of international politics and expected to provide timely and effective resolutions to shared issues. Global dissatisfaction emerged swiftly. Donald Trump became one of the Organisation's most vocal critics, accusing the Organisation of making misleading statements and praising China for its transparency and health measures.[278] President Trump often criticized the Organisation for being China-centric and condemned the delayed creation of a Public Health

[272] M. Kavanagh, R. Singh and M. Pillinger, 'Playing Politics. The World Health Organization's Response to COVID-19' in S. Greer, E. King, E. Massard da Fonseca and A. Peralta-Santos (eds.), *Coronavirus Politics: The Comparative Politics and Policy of COVID-19* (2021), 34, *passim*.
[273] J. E. Alvarez, 'The WHO in the Age of the Coronavirus', (2020) 114(4) *American Journal of International Law* 578, at 579-85.
[274] S. E. Davies and C. Wenham, 'Why the COVID-19 Response Needs International Relations', (2020) 96 *International Affairs* 1227, at 1227.
[275] Ibid., at 1248-9.
[276] See also Gruszczyński and Melillo, *supra* note 270.
[277] Jones and Hameiri, *supra* note 5, at 2057.
[278] *Donald J. Trump*, available at x.com/realDonaldTrump/status/1262577580718395393?s=20.

Emergency of International Concern.[279] Instead of offering a substantive critique of the Organisation's governance structures, Trump's statements were primarily a political manoeuvre aimed at shifting blame for the global pandemic away from his own administration and onto the WHO and, by extension, China.[280] The WHO stance on China was criticized by more than just the United States. Several states, together with other experts and observers, concluded that the WHO might have taken further action. Such critiques, however, often disregarded the structural and political constraints within which the WHO operates, resulting in expectations that were in many respects unrealistic.[281]

Some scholars, including Łukasz Gruszczyński and Margherita Melillo,[282] argue that the WHO's approach to China deliberately strategic rather than merely passive. The WHO inclination to promote cooperation and reduce political tensions over the COVID-19 pandemic was reinforced by the need to provide extensive information on the outbreak of the virus.[283] This was initially achievable alone *via* continuous collaboration with China. The Emergency Committee's first statement highlighted the importance of accessing relevant data.[284] However, the WHO believed that praising China instead of criticizing it was the most effective way for the Organisation to fulfil its duties as a knowledge authority.[285] While it is true that the WHO's reaction may have been delayed, it is essential to recognise that the Organisation operates within a complex and politically charged environment. Such accusations highlight the structural challenges faced by an institution that functions among sovereignly equal states yet remains constrained by the political dynamics and bargaining power of its members. The WHO does not act in a vacuum: its decision-making processes are frequently shaped by the preferences of its most powerful states, especially those providing substantial

[279] *Donald Trump Coronavirus Press Briefing Transcript April 14: Trump Halts WHO Funding*, available at www.rev.com/blog/transcripts/donald-trump-coronavirus-press-briefing-transcript-april-14-trump-halts-who-funding.

[280] *Trump Attacks W.H.O. Over Criticisms of U.S. Approach to Coronavirus*, available at www.nytimes.com/2020/04/07/us/politics/coronavirus-trump-who.html

[281] *World Needs a Better World Health Organisation*, available at www.economist.com/international/2020/09/12/the-world-needs-a-better-world-health-organisation.

[282] Gruszczyński and Melillo, *supra* note 270, at 13-20.

[283] *WHO Let the Bats Out?*, available at www.ejiltalk.org/ejil-the-podcast-who-letthe-bats-out.

[284] WHO, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019* (2019).

[285] Gruszczyński and Melillo, *supra* note 270, at 18-20.

financial contributions or exercising geopolitical influence.[286] This feature is not unique to the WHO but is characteristic of international organisations more broadly.[287]

The reliance of the WHO on its member states resonates with broader critiques in international law, particularly those emerging from post-colonial theories.[288] Such approaches argue that international organisations frequently mirror and reinforce global power asymmetries, in which decision-making is shaped less by collective consensus than by the preferences and interests of dominant states.[289] The accusation of favouritism towards China can also be analysed through the lens of these power dynamics. As such, the WHO's approach may reflect an effort to balance competing interests in a polarized global health landscape. However, the criticism[290] directed at the WHO highlights a fundamental tension in global health governance: the need to act decisively and impartially while navigating the pressures and expectations of different actors. To mitigate these constraints, the WHO has increasingly relied on indicators, which by their quantifiable and standardised nature offer a stronger perception of neutrality and objectivity in advancing global health objectives. Taken together, these assessments reveal a consistent pattern of criticism portraying the WHO as an organisation constrained by structural dependence on member states and weakened by financial reliance on voluntary contributions, whose role is increasingly limited to technical guidance. Against this background of recurrent doubts about its impartiality and capacity to act decisively, reform proposals have sought to recalibrate the Organisation's mandate and strengthen its institutional authority.

Prior to the announcement of the United States withdrawal from the WHO in July 2021, Germany and France initiated discussions with the United States administration on possible reforms of the Organisation. This points to an acknowledgment of the necessity for

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[286] L. O. Gostin, D. Sridhar and D. Hougendobler, 'The Normative Authority of the World Health Organization', (2015) 129 *Public Health* 854, at 860.

[287] B. S. Chimni, 'International Institutions Today: An Imperial Global State in the Making', (2004) 15 EJIL 1, at 3.

[288] See A. Anghie, 'The Evolution of International Law: Colonial and Postcolonial Realities', (2006) 27 *Third World Quarterly* 739.

[289] Ibid., at 742-51.

[290] See Barcik, *supra* note 86, at 212-13. J. Barcik draws attention to the following issues in this context: the need to ensure proper democratic legitimacy, which is essential for legitimising decisions made in the field of public health; the introduction of transparent principles of accountability for such decisions; the adoption of mechanisms to guarantee a fair global distribution of health risks, aimed at reducing the gap between developed and developing states, a concern closely linked to the notion of distributive justice; and finally, the necessity of grounding global health governance in the paradigm of human rights protection, including the right to health.

modifications to the existing structure. Although the WHO has its limits, the COVID-19 pandemic has highlighted the crucial importance of the Organisation. Germany and France have submitted a "Non-paper"[291] outlining proposals to increase financial contributions and to improve early warning and monitoring mechanisms in relation to epidemics and pandemics.

The first priority identified in the non-paper was the need to increase financial contributions. Any meaningful reform of the WHO must begin with the recognition that the Organisation can only operate effectively if it has adequate and predictable resources at its disposal. The non-paper also underscores the need for revision of WHO's budgeting process, increasing budget transparency, accountability and transparency of financial expenditure.[292]

Second, the non-paper highlights the risk of fragmentation and duplication of efforts arising from the proliferation of international actors in the field of health. Enhancing the regulatory capability of the WHO is therefore presented as a way to reaffirm its distinct role and ensure coherence.[293] Strengthening this role would at the same time allow other public-private actors and philanthropists to continue their initiatives, but in alignment with the common standards developed by the WHO. The subsequent action suggested in the non-paper is weak, however, as it fails to specify the means by which conformity with the standards would be ensured, which should ideally be done through the implementation of Article 19 of the WHO Constitution (which empowers the WHA to adopt international conventions or agreements within the Organisation's mandate).[294]

A further lesson drawn from the COVID-19 pandemic is the need for the WHO to establish more robust and durable governance frameworks.[295] The non-paper explicitly suggests the establishment of a subcommittee inside the EB to oversee and monitor health emergencies and crises. When declaring a PHEIC, it is important to have efficient systems in place to assure compliance during global health crises. These processes should be engaged to guarantee that everyone has access to and can afford diagnostics, treatments, and immunisations relevant to the pandemic. Only through such arrangements can transparency and consistency in the

[291] Government of France and Government of Germany, *Non-paper on strengthening WHO's leading and coordinating role in global health. With a specific view on WHO's work in health emergencies and improving IHR implementation* (2020).
[292] Ibid., at 5.
[293] Ibid.
[294] See G. Velásquez, *Vaccines, Medicines and COVID-19: How Can WHO Be Given a Stronger Voice?* (2022), 104.
[295] Government of France and Government of Germany, *supra* note 268, at 5.

implementation of the IHR at the national level be realistically achieved. The WHO occupies a distinctive position within the landscape of global health governance, combining its role as a knowledge authority grounded in scientific evidence with the constant need to negotiate with member states, whose decisions are frequently shaped by political considerations rather than substantive public health concerns. Within this context, indicators emerge as a particularly significant tool through which the WHO seeks to steer states toward actions it regards as appropriate and necessary for the protection of global health.

3.6. Indicators as a response to the institutional critique

This section argues that indicators, when rigorously conceptualised and systematically operationalised, provide a partial yet significant response to some of the most enduring criticisms directed at the WHO. Rather than functioning solely as neutral metrics, indicators perform multiple roles that intersect with key dimensions of global governance: they establish expectations and shape policy adaptation in ways that operate without coercion.[296] In doing so, indicators may enable the WHO to exercise influence in contexts where direct regulation or binding instruments remain politically unattainable.

First, indicators strengthen the Organisation's capacity to provide legal guidance. By transforming broad health standards into quantifiable parameters (for example, maternal mortality ratios, vaccination coverage, or access to essential health services), they render abstract legal and ethical commitments empirically traceable.[297] This process enhances the clarity of obligations (for instance, under the right to health) and helps to concretise the WHO's constitutional mandate in ways that can be monitored and assessed over time, even without formal legal enforcement. Moreover, this approach allows the Organisation to maintain a degree of formal detachment from politically charged human rights debates, while still exerting substantive influence on how human rights norms are interpreted and implemented, since indicators are often presented as neutral and objective tools.[298]

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[296] P. Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31,* UN Doc E/CN.4/2003/58 (2003), paras. 36, 48, 51, 71.

[297] UN OHCHR, *Report on Indicators for Monitoring Compliance with International Human Rights Instruments,* UN Doc HRI/MC/2006/7 (2006), para. 14.

[298] This issue will be developed in Chapter V.

Second, indicators function as instruments of accountability. Although the WHO lacks the authority to compel states to act, it can nonetheless generate reputational incentives and political pressure through the public reporting of national performance.[299] By incorporating reporting and evaluation mechanisms into programmatic documents,[300] the Organisation shifts the locus of enforcement from coercion toward transparency and disclosure. Member states, donors, and civil society actors can draw on the published data to demand justification, expose disparities, and coordinate collective responses to global health emergencies.

Third, and perhaps most importantly in light of recurrent critiques, indicators allow the WHO to pursue what may be described as operational coherence. As noted earlier, one of the recurring critiques has been the fragmentation of the Organisation's activities and its inability to coordinate across levels and regions. Indicators can mitigate this weakness by providing a common evaluative framework capable of aligning the objectives of the Secretariat, the regional offices, and national authorities.[301] Their standardised form facilitates data integration, enables cross-national comparison, and allows WHO guidance to be calibrated against real-world implementation gaps.[302] A clear example is the Regional Health Data Hub for the African Region (2024-2030), which directly links national data systems to regional strategies by employing indicators to determine priorities, allocate technical assistance, and organise cross-border action.[303]

In this respect, indicators function as a partial substitute for the WHO's absence of coercive authority, being an alternative mode of governance rooted in information. They do not replace law but operate in parallel with legal instruments, thereby enhancing the probability that WHO-recommended practices will be taken up and that national policies will be adjusted in line with WHO guidance.

Nonetheless, the use of indicators carries inherent risks. They can reinforce, conceal underlying normative disagreements or foster an illusion of objectivity when, in fact, they

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[299] See UN OHCHR, *Human Rights Indicators: A Guide to Measurement and Implementation*, UN Doc. HR/PUB/12/5 (2012).

[300] WHO EB, *Options to streamline the reporting of and communication with Member States*, EB132/5 Add.4 (2013), paras. 21-2.

[301] K. E. Davis, B. Kingsbury and S. E. Merry, 'Indicators as a Technology of Global Governance', (2012) 46 *Law & Society Review* 71, at 74-5.

[302] S. McInerney-Lankford and H. O. Sano, *Human Rights Indicators in Development* (2010), 15.

[303] WHO African Region, *Framework for Integrating Country and Regional Health Data in the African Region: Regional Health Data Hub 2024–2030*, AFR/RC74/7 (2024), paras. 1, 10-11, 30, 37.

reproduce existing global power asymmetries.[304] Moreover, reliance on indicators does not resolve the WHO's dependence on member-state goodwill or remedy the political constraints on its decision-making. Nevertheless, when deployed with institutional safeguards such as transparent and participatory methodology, indicators can strengthen the Organisation's credibility and resilience.[305]

In conclusion, the WHO's increasing reliance on indicators should be interpreted not merely as a technical innovation but as a deliberate institutional strategy designed to address persistent structural constraints. They offer an alternative vocabulary for international institutional authority, which is grounded not in legal command but in transparent knowledge production and reputational leverage. Indicators reflect a broader transformation in the architecture of global governance; wherein coercive enforcement is replaced by mechanisms based on persuasion. While they cannot substitute for new obligations, they enable the WHO to extend its influence and assert relevance under conditions of legal and political constraint.

[304] Davis et al., *supra* note 301, at 72, 81.
[305] Merry, *supra* note 247, at 166, 205.

Chapter III

The dynamics of health-related human rights: fragmentation, inequalities and fluidity of standards

The COVID-19 pandemic has thrust people's health into the spotlight, exposing global disparities in health care access and challenging states' ability to fulfil their health-related human rights obligations.[306] It has revealed the fragility of health systems worldwide and the inequalities that pervade both national and global health governance.[307] The rapid spread of the virus demanded immediate action, yet many states, particularly in the Global South, lacked the resources to respond effectively, resulting in widespread health inequities.[308] As explained in Chapter II[309], although international organizations such as the WHO have played a crucial role in coordinating responses to the pandemic, significant disparities in health care access have demonstrated the limitations of the current legal framework in ensuring the equitable distribution of health resources.[310]

Public health cannot be achieved without strong legal foundations.[311] Health, as a fundamental attribute of the individual, has a modal character and, depending on the factual circumstances, is linked both to civil and political rights as well as to economic, social, and cultural rights.[312] Thus, the human rights dimension of health extends beyond a single entitlement and intersects with various rights, such as the rights to life, privacy, and non-discrimination.[313] Each of these contributes to shaping the conditions under which individuals

[306] L. O. Gostin, E. A. Friedman and S. A. Wetter, 'Responding to Covid-19: How to Navigate a Public Health Emergency Legally and Ethically', (2020) 50 *Hastings Center Report* 8, at 9–11. See also L. Forman and J. C. Kohler, 'Global Health and Human Rights in the Time of COVID-19: Response, Restrictions, and Legitimacy', (2020) 19 *Journal of Human Rights* 547.

[307] C. Bambra et al., 'The COVID-19 Pandemic and Health Inequalities', (2020) 74 *Journal of Epidemiology & Community Health* 964, at 964.

[308] L. Forman, C. Correa and K. Perehudoff, 'Interrogating the Role of Human Rights in Remedying Global Inequities in Access to COVID-19 Vaccines', (2022) 24 *Health and Human Rights Journal* 121, at 122-3.

[309] See Sections 2 and 3 of Chapter II.

[310] B. M. Meier et al., 'The World Health Organization in Global Health Law', (2020) 48 *Journal of Law, Medicine & Ethics* 796, at 798.

[311] L. O. Gostin, 'Public Health Law: A Renaissance', (2002) 30 *Journal of Law, Medicine & Ethics* 136, at 136.

[312] R. Tabaszewski, *Prawo do zdrowia w systemach ochrony praw człowieka* (2016), 207.

[313] Ibid., at 15-16, 48-53, 64. See M. Wiącek, 'Prawo do ochrony zdrowia', in W. Brzozowski, A. Krzywoń and M. Wiącek (eds.), *Prawa człowieka* (2021), 313 at 313-15.

can lead a healthy life. Yet the unifying standard, and the most comprehensive legal expression of these interconnections, is the right to health.[314] The relationship between the right to health and health-related human rights is not hierarchical.[315] The right to health encompasses two interrelated dimensions: access to timely and appropriate health care, and the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions.[316] Health-related rights (such as the rights to life, privacy, and non-discrimination)[317] operate both as enabling conditions for the enjoyment of health and as safeguards that constrain how health measures are designed and implemented.[318] The relationship between the right to health and health-related rights is thus reciprocal. On the one hand, the right to health guides the interpretation of neighbouring rights by requiring states to take positive measures, such as protecting life during epidemics.[319] On the other hand, health-related rights (such as privacy, equality, and informed consent) set boundaries on how far public health measures may go, ensuring that interventions remain consistent with human rights standards.[320]

The significance of the right to health of individuals has long been recognised, however, the precise content and scope of this right remain subjects of debate and interpretation.[321] This chapter aims to provide an analysis of the key aspects of this right, focusing on its complex and evolving nature. It will highlight the need for tools to define state obligations under the right to health and assess their compliance with these duties (Section 1).

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[314] Since the adoption of the WHO's Constitution in 1946, the international community has recognised the enjoyment of the highest attainable standard of health as a fundamental human right. This recognition has subsequently been reaffirmed in a number of widely ratified international human rights treaties. Although these instruments vary significantly in their formulations and legal scope, it has become common practice to refer to them collectively under the term "right to health." Accordingly, this term will be used throughout this work to denote the human right to the highest attainable standard of health. See V. A. Leary, 'The Right to Health in International Human Rights Law', (1994) 1 *Health and Human Rights* 24, at 26.

[315] CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, UN Doc E/C.12/2000/4 (2000), paras. 3-4. Leary, *supra* note 314, at 39.

[316] CESCR, *supra* note 315, at para. 9. B. Toebes, *The right to health as a human right in international law* (1999), 243-58. P. Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/HRC/7/11 (2008), 51

[317] Barcik, *supra* note 86, at 70.

[318] Tobin, *supra* note 31, at 187.

[319] Ibid., at. 133.

[320] CESCR, *supra* note 315, at paras. 3-4. Leary, *supra* note 314, at 28.

[321] See CESCR, *supra* note 315. J. V. McHale and E. M. Speakman, 'Fundamental Rights to Health Care and Charging Overseas Visitors for NHS Treatment: Diversity across the United Kingdom's Devolved Jurisdictions,' in C. Ó Néill et al. (eds.), *Routledge Handbook of Global Health Rights* (2021), 279. E. Riedel, 'The Right to Health under the ICESCR,' in A. von Arnauld et al. (eds.), *The Cambridge Handbook of New Human Rights* (2020), 107.

A potential way to address this issue involves the use of indicators.[322] They can translate complex and often imprecise legal standards into clearer form, further making it possible to evaluate whether states are meeting their commitments linked to the right to health. Indicators can also form a part of a methodology to detect inequalities thus enhancing coherence and coordination within the global health governance landscape.

Section 2 explores the content of the AAAQ framework, as articulated in General Comment No. 14 and elaborated through subsequent institutional practice. This structure constitutes a significant first step toward clarifying the normative content of the right to health. At the same time, it provides a necessary foundation for the development of indicators that explicitly refer to each of its components, thereby facilitating the monitoring and evaluation of state performance (as demonstrated in Chapters IV, V and VI). Importantly, the AAAQ framework itself does not resolve all questions concerning the operationalisation of the right to health; rather, it sets the stage for the use of indicators as a second step, allowing normative standards to be translated into measurable criteria of implementation.

Section 3 turns to persistent challenges in the implementation of the right to health, particularly in the context of public health emergencies such as the COVID-19 pandemic. It focuses on two areas where state obligations remain difficult to operationalise: the principle of progressive realisation and the tension between individual rights and collective health imperatives. In both domains, the absence of stable and measurable criteria exposes the limitations of normative frameworks alone, underscoring the need for tools that not only enable the assessment of compliance but also guide implementation, monitor progress, and reveal disparities in the enjoyment of the right to health.

Finally, Section 4 argues that, when carefully designed and applied, indicators can contribute to bridging this gap by making the AAAQ dimensions of the right to health empirically observable and evaluable. Indicators do not replace existing standards, nor do they create new normative frameworks. Rather, they function as instruments that further develop and specify standards already articulated in legal instruments, translating them into operational categories for implementation, monitoring, and evaluation. This argument will be further developed in Chapters IV, V and VI, where the analysis turns to the concrete ways in which

[322] See Barcik, *supra* note 86, at 48-9.

indicators have been employed in practice as operational tools shaping global health governance.

1. International protection of the right to health

The normative and conceptual framework underpinning the right to health can be traced back to various international instruments, beginning with the preamble to WHO Constitution, which defines health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[323] The WHO Constitution explicitly recognises the enjoyment of the highest attainable standard of health as a fundamental right of every human being, thereby establishing health as a matter of international concern.[324]

This broad understanding of health was further reflected in the Universal Declaration of Human Rights (UDHR),[325] which, while not a treaty, laid the foundation for subsequent international instruments.[326] As Louis Henkin observed "With time, the Universal Declaration has itself acquired significant legal status. Some see it as having given content to the Charter pledges, partaking therefore of the binding character of the Charter as an international treaty. Others see both the Charter and the Declaration as contributing to the development of a customary law of human rights binding on all states."[327] As much of the UDHR is widely regarded as reflective of customary international law,[328] a question arises as to whether the right to health, as articulated in Article 25 UDHR, shares this status. However, despite broad declaratory support and its widespread recognition in treaty law, the right to health cannot be

[323] 1946 Constitution of the World Health Organization, 14 UNTS 185.
[324] Preamble to the WHO Constitution states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." See also WHO, *Report of the WHO informal consultation on health and human rights*, WHO/HPD/98.1 (1998), 10-11.
[325] UN General Assembly, *Universal Declaration of Human Rights*, Res 217 A (III) (1948).
[326] H. Hannum, 'The Status of the Universal Declaration of Human Rights in National and International Law', (1998) 3 *Health and Human Rights* 317, at 317–340. M. Robinson, 'The Universal Declaration of Human Rights: The International Keystone of Human Dignity', in B. van der Heijden and B. Tahzib (eds.), *Reflections on the Universal Declaration of Human Rights* (1998), 253 at 253–4. See Tobin, *supra* note 31, at 30-2.
[327] L. Henkin, *The Age of Rights* (1990), 19.
[328] Leary, *supra* note 314, at 32.

regarded as a norm of customary international law, as neither consistent state practice nor a sufficiently clear *opinio juris* can be identified.[329]

Nevertheless, Article 25 of the UDHR declares that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care."[330] The International Covenant on Economic, Social and Cultural Rights (ICESCR) likewise recognises the right to health. Its Article 12 affirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and outlines specific measures that states must take in this context.[331] These measures include, *inter alia***,** the reduction of infant mortality, the improvement of mental and industrial hygiene, the prevention, treatment and control of epidemic diseases, together with the creation of conditions ensuring access to medical services and medical attention for all.[332] The Convention on the Rights of the Child (CRC),[333] in its Article 24, recognises the right of the child to the enjoyment of the highest attainable standard of health and requires states to take appropriate measures to ensure access to necessary medical assistance, preventive care, and nutrition. Similarly, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[334] in Articles 12 and 14(2)(b), obliges states to eliminate discrimination in health care and to ensure women equal access to health services, including those related to family planning and maternal health.

Although all instruments mentioned affirm the importance of health, they do so using different language and with varying degrees of legal precision. The WHO Constitution conceptualises health as a fundamental right and a precondition for peace and security, but does so in aspirational language, embedded in institutional objectives rather than enforceable legal standards.[335] Article 25 UDHR, while similarly broad in scope, subsumes health under the broader right to an adequate standard of living, and links it with socio-economic entitlements such as food, housing, and social protection. By contrast, Article 12 ICESCR formulates the right to health as an autonomous legal entitlement and enumerates specific obligations of states

[329] E. D. Kinney, 'The International Human Right to Health: What Does This Mean for Our Nation and World?', (2001) 34 *Indiana Law Review* 1457, at 1464-7. See also Barcik, *supra* note 86, at 145-8.
[330] Art. 25 of the UDHR.
[331] Art. 12(1) of the ICESCR.
[332] Art. 12(2) of the ICESCR.
[333] 1989 Convention on the Rights of the Child, 1577 UNTS 3.
[334] 1979 Convention on the Elimination of All Forms of Discrimination against Women, 1249 UNTS 13.
[335] Preamble to the WHO Constitution.

(such as reducing infant mortality and ensuring access to medical services) that reflect a more detailed commitment. This divergence in formulation does not, however, signify contradiction. Rather, it reflects the distinct legal and political contexts within which each instrument was drafted and adopted. The WHO Constitution presents health in aspirational terms, embedded within the Organisation's institutional mandate and emphasising its programmatic role as a foundation for peace and security. The UDHR, by contrast, incorporates health into the broader right to an adequate standard of living, consistent with its non-binding character but also indicative of its holistic conception of human dignity. The ICESCR provides the most detailed and legally precise articulation, recognising the right to health as an autonomous entitlement and enumerating obligations of states, albeit subject to progressive realisation. Viewed together, these instruments are not mutually exclusive but rather complementary expressions of a single legal idea: that human health, as an essential condition for the exercise of other rights and for human existence itself, must be accorded explicit recognition and protection within international law. This marks an evolution from aspirational principle towards more specific commitments and also foreshadows later developments, including the AAAQ framework and the use of indicators, which seek to bridge the gap between abstract formulations and practical implementation.

In addition to the universal instruments, regional human rights treaties also recognise health-related entitlements, albeit in divergent ways. The African Charter on Human and Peoples' Rights (ACHPR)[336] expressly guarantees the right to health in Article 16; and the Inter-American system protects the right to health through Article 10 of the Additional Protocol of San Salvador[337] and, more broadly, via Article 26 of the American Convention on Human Rights (ACHR)[338] as interpreted by the Inter-American Court of Human Rights (IACtHR). By contrast, the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)[339] contains no stand-alone right to health. In the Council of Europe system, the lack of formal recognition of the right to health in the ECHR text in recent decades has been

[336] 1981 African Charter on Human and Peoples' Rights ("Banjul Charter"), OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58.
[337] 1988 Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador", OAS Treaty Series No. 69.
[338] 1969 American Convention on Human Rights "Pact of San José, Costa Rica," 1144 UNTS 123.
[339] 1953 European Convention for the Protection of Human Rights and Fundamental Freedoms, ETS No. 5.

complemented by Strasbourg case law,[340] beginning with the Feldbrugge v. Netherlands[341] case. The lack of references to health is also addressed in the European Social Charter[342] in its Article 11, recognizing the right to use all necessary means to achieve the best possible state of health. Existing gaps are also filled by the provisions of the Oviedo Convention,[343] beginning with the regulations contained in its Article 3, which specifies the pursuit of equitable access to quality healthcare. These heterogeneous formulations reinforce the central claim advanced in this chapter: the content of the right to health remains difficult to delineate with precision and requires further operational clarification.[344]

This lack of clarity has limited the development of consistent legal standards and has generated ongoing debate over the nature and extent of state responsibilities[345] within the international human rights framework.[346] In the absence of a unified and enforceable legal standard, such ambiguity has opened space for alternative regulatory techniques. One such technique is the use of indicators by actors such as the WHO[347], whose role in global health governance remains crucial. Through the development and deployment of indicators, the WHO has sought to operationalise the right to health within governance practice, providing measurable criteria for assessing both state performance and institutional accountability. Although such indicators lack formal legal character, they often assume a *quasi*-normative function: by filling gaps left by indeterminate treaty provisions, they shape expectations and influence patterns of compliance. Their significance, however, extends beyond the WHO as a

[340] Health-related claims typically assessed through Arts. 2, 3 and 8 of the ECHR. The ECtHR in its jurisprudence quite frequently refers to recommendations of the Committee of Ministers in the health sector (*Biriuk v. Lithuania*, Judgment of 25 November 2008, ECtHR Case No. 23373/03, para. 21), as well as to conventions such as the Oviedo Convention (*Glass v. the United Kingdom*, Judgment of 9 March 2004, ECTHR Case No. 61827/00, para. 58; *Vo v. France*, Judgment of 8 July 2004, ECtHR Case No. 53924/00, paras. 35, 84) and Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (*S. and Marper v. the United Kingdom*, Judgment of 4 December 2008, ECtHR Case Nos. 30562/04 and 30566/04). See also *Panaitescu v. Romania*, Judgement of 10 April 2012, ECTHR Case No. 30909/06.

[341] *Feldbrugge v. Netherlands*, Judgement of 29 May 1986, ECtHR Case No. 8562/79.

[342] 1996 Revised European Social Charter, ETS No. 163.

[343] 1999 Convention on Human Rights and Biomedicine ("Oviedo Convention"), ETS No. 164.

[344] Tabaszewski, *supra* note 312, at 36-7.

[345] ECtHR has repeatedly emphasised that human rights treaties establish "objective obligations" that transcend reciprocal engagements between states. This feature allows the principles to remain dynamic and capable of evolving, yet it also contributes to uncertainty regarding their precise scope at any given moment. See UN General Assembly, *Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law. Report of the Study Group of the International Law Commission Finalized by Martti Koskenniemi*, UN Doc. A/CN.4/L.683 (2006), 69.

[346] Barcik, *supra* note 86, at 74. Tobin, *supra* note 31, at 53-68, 369-70.

[347] See Section 3 of Chapter II.

global administrative actor. For example, within the framework of the ICESCR, indicators have been taken up by the CESCR to specify the scope of state obligations and to assess progress under the principle of progressive realisation.[348] In this respect, indicators serve as instruments that connect the generality of treaty language with the operational demands of global health governance. The following section examines this function in greater detail through the lens of the AAAQ framework, which provides the conceptual foundation for much of the subsequent indicator practice.

2. Clarifying the content and scope of the right to health: the AAAQ framework as a baseline

The starting point for any reflection on the right to health requires decoding of the term of health. The first recital of the preamble to the WHO Constitution, as noted above, defines health as "a state of complete physical, mental and social well-being and not merely absence of disease or infirmity." This definition is often criticised as overly ambiguous and impractical.[349] Thus, any attempt to convert health into legally relevant concept would place an overwhelming responsibility on states to provide a nearly flawless level of health for each individual.[350] The complexity of 'health' makes it challenging to provide a concise definition, as it encompasses all aspects of human existence and includes features related to both health care and illness.[351] It extends beyond medical care and the treatment of illness to encompass the broader social determinants of well-being, thereby intersecting with a range of economic, social and cultural rights. Such multidimensional character has also been reflected in the jurisprudence of international courts and tribunals, where health-related claims have arisen not only in relation

[348] See Chapter V.

[349] R. Saracci, 'The World Health Organisation Needs to Reconsider Its Definition of Health', (1997) 314 BMJ 1409, at 1409. See also N. Sartorius, 'The Meanings of Health and Its Promotion', (2006) 47 *Croat Med J* 662, at 662. T. Schramme, 'Health as Complete Well-Being: The WHO Definition and Beyond', (2023) 16 *Public Health Ethics* 210, at 211. D. Callahan, 'The WHO Definition of "Health"', (1973) 1 *Hastings Center Studies* 77, at 77. L. Kass, 'Regarding the End of Medicine and the Pursuit of Health', (1975) 40 *The Public Interest* 11, at 14. A. J. Card, 'Moving Beyond the WHO Definition of Health: A New Perspective for an Aging World and the Emerging Era of Value-Based Care', (2017) 9 *World Med & Health Policy* 127, at 127. C. K. Fallon and J. Karlawish, 'Is the WHO Definition of Health Aging Well? Frameworks for "Health" After Three Score and Ten', (2019) 109 *Amercian Journal of Public Health* 1104, at 1104.

[350] Barcik, *supra* note 86, at 2-3.

[351] See generally S. A. Valles, *Philosophy of Population Health* (2018). T. Schramme, *Theories of Health Justice* (2018).

to health care services but also in connection with rights such as privacy and environmental protection. For instance, in Verein KlimaSeniorinnen Schweiz and Others v. Switzerland,[352] the European Court of Human Rights (ECtHR) recognised that environmental degradation may directly affect individuals' enjoyment of Convention rights, thereby illustrating the intricate linkages between health, environmental conditions, and the broader spectrum of human rights.[353] This jurisprudential trend has been further reinforced by the recent advisory opinion of the International Court of Justice (ICJ) on states' obligations in relation to climate change, which underscored that the right to a clean, healthy, and sustainable environment is inseparably linked to the effective protection of human's health and other fundamental rights.[354] The ICJ's advisory opinion thus strengthens the view that health, as a legally relevant notion, must be interpreted in an integrated manner that captures the interplay of medical, social, and environmental determinants of well-being.[355]

The present section addresses the conceptual and legal challenges in operationalising the right to health within international law. While this right appears in various legal contexts (as noted in Section 1 above), the analysis will focus primarily on Article 12 ICESCR and its interpretation by the CESCR. This emphasis is justified not only by the Covenant's central position in articulating the legal content of the right to health, but also by its influence on subsequent institutional practice. In particular, the interpretive framework developed under the ICESCR, most notably the AAAQ structure, has provided a conceptual foundation that has been taken up and adapted by the WHO in its own indicator-based monitoring tools.

The right to health, as stated in CESCR General Comment No. 14, covers socio-economic factors that create conditions for maintaining health.[356] The CESCR also emphasizes the right to health refers to "the highest attainable standard of physical and mental health",

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[352] *Verein KlimaSeniorinnen Schweiz and Others v. Switzerland,* Judgment of 9 April 2024, ECtHR Case No. 53600/20.

[353] See *López Ostra v. Spain*, Judgment of 9 December 1994, ECtHR Case No. 16798/90. *Guerra and Others v. Italy*, Judgment of 19 February 1998, ECtHR Case No. 14967/89. *Fadeyeva v. Russia*, Judgment of 9 June 2005, ECtHR Case No. 55723/00. *Budayeva and Others v. Russia*, Judgment of 20 March 2008, ECtHR Case Nos. 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02. *Tătar v. Romania*, Judgment of 27 January 2009, ECtHR Case No. 67021/01. These cases illustrate the Court's recognition that environmental degradation and related risks may directly interfere with rights protected under the Convention, thereby underscoring the interdependence between health, environmental conditions and broader human rights guarantees.

[354] *Obligations of States in respect of climate change,* Advisory Opinion of 23 July 2025 (not yet published).

[355] See *Human Rights in the ICJ's Climate Opinion: A Comparative Evaluation*, available at verfassungsblog.de/human-rights-in-the-icjs-climate-opinion.

[356] CESCR, *supra* note 315, at para. 4.

considering that this level is contingent on economic resources and abilities, and is rarely achievable as a condition of universal perfect health.[357] It is indeed correct, as Audrey Chapman has observed, that the ICESCR's recognition of the right to health embodies a broad and aspirational vision that resists straightforward operationalisation in practice. [358] This difficulty stems both from the open-textured language of Article 12 and from the multidimensional character of health itself. Yet this assessment warrants refinement: the aspirational nature of the provision should not be regarded as a weakness, but rather as a deliberate feature that permits adaptation to diverse national contexts and to evolving public health challenges. Accordingly, while Chapman's argument accurately highlights the challenges of operationalisation, it overlooks the constructive potential of such openness when structured through interpretive tools such as the AAAQ framework and indicators.

In order to clarify[359] the obligation under Article 12 of the ICESCR, in General Comment No. 14, the CESCR introduced the AAAQ framework.[360] This framework encompasses four essential elements that must be met for states to fulfil the obligations concerned: availability, accessibility, acceptability, and quality. The AAAQ framework was developed as a basic tool for interpreting Article 12 of the ICESCR, offering an initial step towards clarifying the normative content of the right to health. Its practical relevance, however, requires a second step: the operationalisation of each dimension through indicators. By defining measurable parameters (such as infant mortality rates, the density of health care personnel, or the availability of essential medicines) indicators translate abstract legal commitments into concrete points of performance.[361] In this way, they allow not only for the assessment of whether states formally recognise the right to health, but also for an evaluation of the extent to which it has been realised in practice. This two-step approach both clarifies state obligations and provides a methodologically robust means of tracking implementation in practice.

[357] CESCR, *supra* note 315, at para. 5.

[358] A. R. Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (2016), 1-17.

[359] See A. Kubów, 'Prawo do ochrony zdrowia. Teoria a rzeczywistość', in O. Kowalczyk and S. Kamiński (eds.), *Zabezpieczenie społeczne a prawa społeczna. Wybrane zagadnienia* (2021), 57 at 61.

[360] CESCR, *supra* note 315, at paras. 12-13.

[361] The right proclaimed in Art. 12 of the ICESCR is of an open character, allowing it to encompass all relevant determinants, including those that are only gradually being recognised. In this context, the WHO plays an important role in identifying and interpreting emerging dimensions of the right to health; see B. Pawelczyk, 'Art. 12 Prawo do ochrony zdrowia', in Z. Kędzia and A. Hernandez-Połczyńska (eds.), *Międzynarodowy Pakt Praw Gospodarczych, Socjalnych i Kulturalnych. Komentarz*, 595 at 600.

In what follows, each dimension of the AAAQ framework will be examined both in light of its legal meaning and in terms of its amenability to measurement through context-sensitive indicators.

2.1. Availability

The notion of availability requires that health care facilities, goods, and services function and are available in sufficient quantity to meet the needs of the people in the population. Such resources include providing adequate hospitals, clinics, essential medicines, and medical professionals.[362] The COVID-19 pandemic vividly demonstrated the fragility of this requirement, as many states (particularly those with limited resources) were unable to ensure the availability of essential health care infrastructure and services.[363]

The right to health does not by itself guarantee access to health services in the absence of concrete governmental action. The gap between formal legal recognition of the right to health and its actual implementation becomes particularly visible in global inequalities in access to health care.[364] This is not merely a matter of legal commitment, but also reflects underlying disparities in financial resources, administrative capacity, and institutional governance.[365] For instance, in March 2020, the indicator on intensive care unit (ICU) capacity across 47 sub-Saharan African states stood at an average of nine ICU beds per one million people, an evidently inadequate level in light of the demands imposed by the pandemic.[366] Moreover, a study of 64 ICUs in sub-Saharan Africa found that 45 % of COVID-19 patients who died had never received oxygen therapy at all.[367] This discrepancy between formal legal entitlements and their realization becomes most conspicuous during global health emergencies. It cannot be resolved

[362] CESCR, *supra* note 315, at para. 12(a).
[363] N. A. Pradhan et al., 'Resilience of Primary Health Care System across Low- and Middle-Income Countries during COVID-19 Pandemic: A Scoping Review', (2023) 21 *Health Research Policy and Systems* 1, at 2. See also X. Hunt et al., 'Impacts of the COVID-19 Pandemic on Access to Health Care among People with Disabilities: Evidence from Six Low- and Middle-Income Countries', (2023) 22 *International Journal for Equity in Health* 172.
[364] See WHO, *World Health Statistics 2021: Monitoring Health for the SDGs, Sustainable Development Goals* (2021).
[365] J. Coggon and B. Kamunge-Kpodo, 'The Legal Determinants of Health (in)Justice', (2022) 30 *Medical Law Review* 705, at 705-9, 711-17.
[366] WHO African Region, *New WHO Estimates: Up to 190 000 People Could Die of COVID-19 in Africa If Not Controlled* (2020).
[367] H. R. Graham et al., 'Reducing Global Inequities in Medical Oxygen Access: The Lancet Global Health Commission on Medical Oxygen Security', (2025) *The Lancet Global Health* 528, at 537.

solely through normative commitment stating that health facilities must be available; rather, it requires instruments that help identify which aspects of a state's health system ought to be prioritised, where investment is most urgently needed, and how limited resources can be allocated in a manner consistent with human rights obligations.

Further, the case of Africa exposes deep-rooted inequities in funding and global solidarity mechanisms. Legal recognition of the right to health remains deeply aspirational when states lack the resources and institutional structures needed to deliver it in practice.[368] These challenges related to the availability of health care resources underscore the need for reliable indicators that can monitor baseline infrastructure across states. Availability-focused indicators (such as the number of hospital beds, ICU capacity *per capita*, or access to oxygen therapy) enable the identification of structural deficiencies long before they manifest as systemic crises. Their integration into institutional monitoring would allow both national and international actors to pre-emptively address the systemic issues that compromise the right to health.

2.2. Accessibility

Accessibility of health care facilities, goods, and services encompasses several dimensions, including non-discrimination, physical accessibility, economic accessibility (affordability), and access to information. The CESCR has emphasized that health care services must be accessible to all;[369] particularly to marginalized and vulnerable groups such as

[368] The issue of health care resources availability was also addressed by international human rights bodies in several cases, most notably in Suárez Peralta v. Ecuador by the IACtHR. In this case, the Court ruled that Ecuador had violated the right to health by failing to provide adequate medical services, resulting in harm to the applicant. The Court thus emphasized that the right to health is not merely aspirational but imposes concrete obligations on states to ensure that health care services are available and accessible, even during periods of economic constraint or crisis. This focus on availability is particularly relevant in the context of global health crises like the COVID-19 pandemic, where disparities in health care availability were sharply exposed, both within states and internationally. See *Suárez Peralta v. Ecuador*, Judgment of 21 May 2013, IACtHR (Ser. C) No. 261, paras. 134–54.
[369] CESCR, *supra* note 315, at para. 12(b).

indigenous people,[370] women,[371] children,[372] or persons with disabilities.[373] The COVID-19 pandemic has revealed significant global disparities in health care accessibility, understood not merely as the presence of medical resources but as the ability of individuals and groups to obtain and benefit from them. Even where vaccines were available, barriers such as discriminatory distribution or logistical obstacles meant that vulnerable populations were disproportionately affected. The inequitable allocation of COVID-19 vaccines, despite their availability at the global level, therefore raised serious concerns about patterns of exclusion in access to health care. While high-income states were able to secure large quantities of vaccines early on, many low-income states faced significant delays in vaccine delivery, leaving their populations vulnerable to the virus. The COVAX initiative, led by the WHO and its partners, aimed to address these disparities by ensuring equitable access to vaccines for all states. However, the initiative fell short of its goals due to logistical challenges, political factors, and "vaccine nationalism."[374]

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[370] See *Yanomami v. Brazi*l, Res. No. 10/85, 5 March 1985, IACmHR Case No. 7615. The case involved allegations that the displacement of indigenous people from their ancestral territories resulted in numerous deaths due to influenza, measles, and other illnesses. The IACmHR determined that the Government's failure to provide alternative housing constituted a violation of the rights to life, liberty, and personal security. It recommended that the Government implement health measures to safeguard the lives and health of indigenous individuals vulnerable to infectious or contagious diseases.

[371] See *Szijjarto v. Hungary*, Communication No. 4/2004 of 29 August 2006, UN Doc. CEDAW/C/36/D/4/2004. CEDAW Committee determined that the process requiring a pregnant woman on an operating table to consent to sterilisation in a language she could not understand constituted a violation of her right to adequate health care services and her right to make autonomous decisions regarding the number of her children. See also *K.N.L.H. v. Peru*, Communication No. 1153/2003 of 22 November 2005, UN Doc. CCPR/C/85/D/1153/2003/Rev.1. The UN HRC determined that denying a 17-year-old girl an abortion, even though the foetus was anencephalic and the pregnancy posing significant risks to the mother's physical and mental health, constituted a violation of the mother's rights to non-discrimination, respect for private life, and protection against inhuman and degrading treatment.

[372] See Committee on the Rights of the Child, *Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Canada*, UN Doc. CRC/C/15/Add.261 (2005). The CRC Committee expressed apprehension regarding the possible negative impacts on a child's health resulting from reliance on traditional medical practices, such as the consultation of witchdoctors instead of modern medical facilities and the withholding of water from children afflicted with diarrhoea.

[373] See *X v. Argentina*, Communication No. 8/2012 of 18 June 2014, UN Doc. CRPD/C/11/D/8/2012. The CRPD Committee acknowledged that the author's complaint regarding discrimination by the authorities is justified, since the officials neglected to consider his disability and health status when assigning him to the central prison hospital of the Ezeiza Federal Penitentiary Complex and failed to implement the necessary reasonable accommodations for his personal safety. This resulted in the cessation of the rehabilitation mandated by his attending physicians and the infringement of his right to the highest attainable standard of health without discrimination, as well as his right to achieve maximum independence and full ability.

[374] D. Fidler, 'Vaccine Nationalism's Politics', (2020) 369 *Science* 749, at 749.

The COVAX initiative was established as a global collaboration co-led by the WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations. Its primary goal was to ensure fair and equitable access to COVID-19 vaccines, particularly for low- and middle-income states that lacked the financial and logistical resources to compete with wealthier states in securing early vaccine supplies.[375] COVAX was designed to pool financial contributions from high-income states, using these funds to pre-purchase vaccines for global distribution. It aimed to deliver two billion vaccine doses by the end of 2021, ensuring that at least 20% of the population in participating states, especially the most vulnerable, would be vaccinated.[376]

Despite its aspirations, several factors contributed to the initiative falling short of its targets. One of the most significant issues was vaccine nationalism. High-income states, driven by domestic pressures to vaccinate their populations as quickly as possible, entered into bilateral agreements with vaccine manufacturers, securing vast quantities of vaccines outside the COVAX framework. This undermined the pooled purchasing power of COVAX and led to global supply shortages that delayed vaccine deliveries to lower-income states.[377] Additionally, manufacturing delays and supply chain disruptions compounded the problem. Vaccine production, which was already stretched thin, could not meet the global demand. Many of the major vaccine-producing states, such as India, also imposed export restrictions during critical periods, further hindering COVAX's ability to distribute vaccines equitably.[378]

Logistical challenges within COVAX itself also contributed to its underperformance. The initiative struggled with coordinating the distribution of vaccines to states with weaker health care infrastructure. Many low-income states lacked the necessary cold-chain storage systems and logistical networks to efficiently distribute vaccines, particularly those that required ultra-low temperature storage, such as the Pfizer-BioNTech vaccine.[379] Furthermore, political factors, including the uneven commitments of donor states and the slow mobilization of funds, delayed the procurement and delivery process. The failure of wealthier states to

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[375] *COVAX. Working for Global Equitable Access to COVID-19 Vaccines*, available at www.who.int/initiatives/act-accelerator/covax.

[376] *COVAX Explained*, available at www.gavi.org/vaccineswork/covax-explained.

[377] Fidler, *supra* note 374, at 749.

[378] C. N. Koller et al., 'Addressing Different Needs: The Challenges Faced by India as the Largest Vaccine Manufacturer While Conducting the World's Biggest COVID-19 Vaccination Campaign', (2021) 2 *Epidemiologia* 454, at 456.

[379] O. J. Wouters, et al., 'Challenges in Ensuring Global Access to COVID-19 Vaccines: Production, Affordability, Allocation, and Deployment', (2021) 397 *The Lancet* 1023, at 1029.

prioritize global cooperation over national interests exposed significant flaws in the structure of international health governance. This left COVAX underfunded and unable to meet its ambitious goals, highlighting the broader systemic inequities in global health responses to pandemics.[380]

Ultimately, while COVAX played an important role in delivering vaccines to states that might have otherwise had no access at all, it did not achieve its goal of equitable vaccine distribution. The initiative's shortcomings demonstrate the need for stronger international mechanisms to ensure that during future global health crises, access to life-saving medical interventions is not determined by economic power but by principles of fairness and solidarity. In this context, accessibility-related indicators can serve as diagnostic tools to evaluate whether health care systems ensure equal and timely access to services, particularly for vulnerable groups. For example, indicators such as average distance to health facilities, out-of-pocket expenditures as a share of household income and disaggregated vaccine-coverage rates make it possible to assess whether (and how) formal obligations and standards are translated into actual accessibility. Without such empirical measures, legal commitments risk remaining merely theoretical. Unfortunately, indicators have not been sufficient to overcome the entrenched structural deficiencies that require broader institutional reform,[381] they nonetheless provide a means of assessing whether specific initiatives launched as part of global health governance mechanisms (such as COVAX) are meeting their stated objectives or falling short in practice.

2.3. Acceptability

The notion of acceptability requires that all health care facilities, goods, and services respect medical ethics, be culturally appropriate, and remain sensitive to the diverse needs of individuals and communities.[382] This aspect of the right to health demands that health care interventions align with the cultural values, social practices, and ethical standards of the populations they serve. It was asserted by the ECtHR in several cases, that states should generally be granted a broad margin of appreciation for issues that involve sensitive moral and

[380] A. de Bengy Puyvallée and K. T. Storeng, 'COVAX, Vaccine Donations and the Politics of Global Vaccine Inequity', (2022) 18 *Globalization and Health* 26, at 32-3.
[381] See Section 4 of Chapter VI.
[382] CESCR, *supra* note 315, at para. 12(c).

ethical dilemmas, such as medically assisted reproduction and surrogate motherhood.[383] However, when a crucial aspect of an individual's identity is involved, the margin allowed to states is narrowed.[384] During the COVID-19 pandemic, the importance of acceptability became particularly evident in the implementation of public health measures such as lockdowns, quarantine mandates, and vaccine rollouts. These measures, while necessary for public health, often sparked intense debates about individual autonomy, cultural rights, and the ethical implications of mandatory vaccination policies.[385]

Acceptability is a crucial yet often underestimated aspect of the right to health. Public health interventions that fail to incorporate local cultural norms and beliefs may face significant resistance, undermining their effectiveness.[386] In several states, including France, vaccine hesitancy was particularly pronounced in rural areas where distrust of government institutions and cultural practices (as well as misinformation) led to widespread resistance to vaccination efforts.[387] This hesitancy not only slowed vaccination rates but also highlighted the tension between public health imperatives and respect for individual rights.

Thus, one of the key challenges in promoting acceptability during the pandemic was to balance the urgency of public health interventions with respect for individual autonomy and cultural diversity. Mandatory vaccination policies, for instance, raised questions about personal freedom and patient's informed consent.[388] In several cases, populations resisted vaccination due to historical mistrust of government health care programs, concerns over vaccine safety, or religious objections.[389] This resistance illustrates a broader global pattern, where public health measures are sometimes perceived as external impositions rather than initiatives developed in partnership with local communities. Governments and health authorities have sought to address these challenges through public awareness campaigns and initiatives aimed at promoting vaccine acceptability. In India, for instance, the government launched extensive media

[383] *S.H. and Others v. Austria*, Judgment of 3 November 2011, ECtHR Case No. 57813/00, paras. 94-7. *Mennesson v. France*, Judgment of 26 June 2014, ECtHR Case No. 65192/11, paras. 78-9. *Paradiso and Campanelli v. Italy*, Judgment of 24 January 2017, ECtHR Case No. 25358/12, paras. 182-4, 194.
[384] *Mennesson v. France*, *supra* note 383, at paras. 77, 80.
[385] L. O. Gostin and L. F. Wiley, *Public Health Law: Power, Duty, Restraint* (2016), 47-9.
[386] Fidler, *supra* note 374, at 749. See also Wouters et al., *supra* note 379, at 1023-6.
[387] See G. Nogara et al., 'Misinformation and Polarization around COVID-19 Vaccines in France, Germany, and Italy', (2024) *WebSci '24: 16th ACM Web Science Conference* 119.
[388] L. O. Gostin and D. A. Salmon, 'The Dual Epidemics of COVID-19 and Influenza', (2020) 324 JAMA 335, at 335.
[389] A. A. Malik et al., 'Determinants of COVID-19 Vaccine Acceptance in the US', (2020) 26 *EClinicalMedicine* 100495, at 5–8.

campaigns targeting rural populations, aimed at dispelling myths and misinformation about vaccines.[390] Similarly, in the United States, outreach efforts focused on building trust within marginalized communities, particularly among African American and Latino populations, who had historically experienced discrimination in health care settings.[391]

However, these efforts have revealed broader structural issues within global health governance. The top-down approach often adopted by international organizations and governments during the pandemic highlighted the limits of public health strategies that prioritize efficiency and coverage over cultural sensitivity and community participation. The lack of meaningful engagement with local communities, especially in marginalized or rural areas, has shown that public health interventions cannot be truly effective if they are not perceived as legitimate or acceptable by the populations, they are intended to serve.[392]

Ultimately, the notion of acceptability underscores the importance of viewing health not simply as a biological or technical issue, but as a deeply social and cultural one. Public health measures that fail to engage with cultural norms and ethical concerns risk alienating the very populations they are meant to protect. The COVID-19 pandemic has provided a stark reminder that health interventions must be rooted in a framework of respect for human dignity and cultural diversity. Moving forward, global health governance must evolve to better integrate the acceptability of health facilities, ensuring that health care interventions are not only effective but also embraced by the communities they seek to serve.[393] Indicators focusing on acceptability (although occurring less frequently in practice) can help track whether health care provision respects cultural, ethical, and informational standards. For instance, data on informed consent procedures, the availability of culturally adapted materials, or patient satisfaction surveys may reveal the extent to which services align with human dignity and community needs. As the UN Children's Fund (UNICEF) shows, the notion of acceptability has potential to work only if linked to specific indicators.[394]

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[390] *COVID-19 Vaccine Communication Strategy*, available at www.covid19dashboard.mohfw.gov.in/pdf/Covid19CommunicationStrategy2020.pdf, 12-15.

[391] Centers for Disease Control and Prevention, *Building Confidence in COVID-19 Vaccines Among Your Patients* (2021), 7–9.

[392] A Puyvallée and Storeng, *supra* note 380, at 2-5.

[393] L. O. Gostin, S. Moon and B. M. Meier, 'Reimagining Global Health Governance in the Age of COVID-19', (2020) 110 *American Journal of Public Health* 1615, at 1615-18.

[394] UNICEF, *Availability, Accessibility, Acceptability and Quality Framework* (2019), *passim*.

2.4. Quality

The notion of quality requires that health care facilities, services, and goods be scientifically and medically appropriate and adhere to the highest standards of care. The CESCR has emphasized that for the right to health to be fully realized, health services must be not only available, accessible, and acceptable but also of high quality, providing effective treatment.[395]

Italy's struggles during the early phases of the pandemic became emblematic of how even well-funded health care systems can falter when quality is compromised due to resource scarcity. As one of the first European states to be hit by COVID-19, Italy's health care system (although well-regarded for its universal coverage) faced significant strain during the initial months of the crisis. The rapid surge in COVID-19 cases, particularly in northern Italy, overwhelmed hospitals and exposed severe deficiencies in preparedness and the capacity to maintain high-quality care.[396] In regions like Lombardy, one of the wealthiest areas in Europe, the pandemic led to overcrowded ICUs, shortages of ventilators, and exhausted health care workers, many of whom lacked adequate personal protective equipment. Hospitals were forced to make difficult decisions about resource allocation, prioritizing patients with better chances of survival due to the scarcity of ICUs and ventilators.[397] These ethical dilemmas, while necessary under the circumstances, illustrated the impact of reduced quality on patient outcomes.

Moreover, the rapid deployment of emergency measures, including makeshift hospitals and the fast-tracking of medical procedures, raised concerns about the quality of care in some settings. Despite the heroic efforts of health care professionals, the health care system's inability to meet the sheer demand for services led to inconsistent care standards, with some

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[395] CESCR, *supra* note 315, at para. 12(d). See *Alyne da Silva Pimentel Teixeira v. Brazil,* Communication No. 17/2008 of 27 September 2011, CEDAW/C/49/D/17/2008. The CEDAW Committee found that the quality of health services provided to the deceased woman was inadequate, resulting in a violation of her human rights. This included multiple failings: the omission of basic blood and urine tests, a 14-hour delay in performing curettage surgery to remove retained afterbirth and placenta, which likely contributed to severe haemorrhaging and ultimately her death. The initial procedure was conducted in a health facility lacking adequate equipment, and her transfer to a municipal hospital was significantly delayed, taking eight hours because the hospital refused to release its only ambulance for transport, while her family was unable to secure a private one. Furthermore, upon arrival at the municipal hospital, she was transferred without her clinical records, and her care was grossly neglected. She remained largely unattended in a makeshift area in the hospital corridor for 21 hours until her death.

[396] A. Remuzzi and G. Remuzzi, 'COVID-19 and Italy: What Next?', (2020) 395 *Lancet* 1225, at 1225-7.

[397] L. Rosenbaum, 'Facing Covid-19 in Italy - Ethics, Logistics, and Therapeutics on the Epidemic's Front Line', (2020) 382 *New England Journal of Medicine* 1873, at 1873.

patients receiving suboptimal treatment simply because hospitals were overwhelmed.[398] The crisis also revealed gaps in Italy's long-term care facilities, where thousands of elderly residents died, many without receiving adequate medical attention due to systemic neglect and an overburdened health infrastructure.[399] While Italy's health care system had robust coverage, the pandemic exposed how fragile quality can be when health systems are not equipped to handle sudden surges in demand.[400] The Italian government responded by investing in expanding ICU capacity and improving health care infrastructure, but the human cost of the early months of the pandemic underscored the importance of ensuring that health care systems are resilient enough to maintain quality standards even in times of crisis.[401] In this context, indicators related to quality (such as staffing adequacy, or compliance with basic procedural safeguards) could have served as warning signals before capacity thresholds were exceeded. Systematic use of such indicators prior to the crisis might have supported earlier identification of risk areas and improved preparedness measures, resulting in more timely interventions. Their consistent integration into health system governance thus remains essential for guiding resource allocation and reinforcing the operational dimension of the right to health.[402]

2.5. From AAAQ to indicators: translating legal norms into measurable standards

The AAAQ framework has emerged as an important tool for clarifying the normative content of the right to health in international law.[403] By disaggregating state obligations into

[398] E. Livingston and K. Bucher, 'Coronavirus Disease 2019 (COVID-19) in Italy', (2020) 323 JAMA 1335, *passim*.

[399] *Lessons from Italy's Response to Coronavirus*, available at hbr.org/2020/03/lessons-from-italys-response-to-coronavirus.

[400] E. Parotto et al., 'Exploring Italian Health Care Facilities Response to COVID-19 Pandemic: Lessons Learned from the Italian Response to COVID-19 Initiative', (2023) 10 *Frontiers in Public Health* 1, at 4.

[401] B. Armocida et al., 'The Italian Health System and the COVID-19 Challenge', (2020) 5 *Lancet Public Health* 253, at 253-4.

[402] See A. G. de Belvis et al., *Health Systems in Transition: Italy* (2022).

[403] See Global Nutrition Cluster Technical Alliance, Ethiopia Nutrition Cluster and UNICEF, *Availability, Accessibility, Acceptability and Quality (AAAQ) Framework: A Tool to Identify Potential Barriers to Accessing Services in Humanitarian Settings – Customized for Ethiopia Context* (2023). See also DIHR, *The Availability, Accessibility, Acceptability and Quality (AAAQ) Toolbox: Realising Social, Economic and Cultural Rights through Facts Based Planning, Monitoring and Dialogue* (2015). L. Montel et al., 'Implementing and Monitoring the Right to Health in Breast Cancer: Selection of Indicators Using a Delphi Process', (2023) 22 *International Journal for Equity in Health* 142. B. M. Meier et al., 'Accountability for the Human Right to Health through Treaty Monitoring: Human Rights Treaty Bodies and the Influence of Concluding Observations', (2017) 13 *Glob. Publ. Health* 1558. D. Skempes and J. Bickenbach, 'Developing Human Rights Based Indicators to Support Country Monitoring of Rehabilitation Services and Programmes for People with Disabilities: A Study Protocol', (2015) 15 *BMC International Health and Human Rights* 25. K. Perehudoff, 'Universal Access to Essential Medicines as Part

four dimensions (availability, accessibility, acceptability, and quality) it provides a structured lens through which legal standards can be observed. Yet the framework's utility extends beyond conceptual clarification. In the context of this dissertation, AAAQ is perceived as a step toward rendering the right to health assessable. The purpose of revisiting the AAAQ framework here is not to treat it as an alternative to indicators but to demonstrate its function as a preliminary structuring device, revealing the need for further operationalisation as the framework must be further specified through indicators aligned with each of its components.[404]

In D.G. v. Poland,[405] the ECtHR evaluated the failure of the Polish authorities to ensure adequate medical care and dignified conditions for a detainee with multiple sclerosis. Although the judgment was grounded in Article 3 ECHR rather than explicitly invoking the AAAQ framework, the Court's reasoning addressed its constituent elements. It identified the lack of appropriate facilities (availability),[406] physical barriers and delayed transfers (accessibility),[407] neglect of ethical obligations and individualized care (acceptability),[408] and deficient medical supervision (quality).[409] The case illustrates how the AAAQ framework can function as a heuristic lens in understanding health-related obligations under the ECHR. Such an approach may be seen as consistent with Article 31(3)(c) of the Vienna Convention on the Law of Treaties (VCLT)[410], which permits recourse to 'any relevant rules of international law applicable in the relations between the parties.' While the Court has not expressly relied on the AAAQ, the framework (having been elaborated through the practice of the CESCR and other UN bodies) can be regarded as a relevant interpretive reference point when assessing the content of Convention obligations.

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of the Right to Health: A Cross-National Comparison of National Laws, Medicines Policies, and Health System Indicators', (2020) 13 *Global Health Action* 1699342.

[404] The following section analyses a selection of judgments and decisions issued by regional human rights bodies, each based on a distinct legal framework (namely, the ECHR, the ACHR, and the ACHPR). While the legal basis of these cases differs, the reasoning adopted by the courts and commissions consistently engages with dimensions of the right to health that resonate with the interpretation of Article 12 of the ICESCR. These cases were selected deliberately for their illustrative capacity to illustrate how the right to health can be made operational through judicial interpretation.

[405] *D.G. v. Poland*, Judgment of 12 May 2013, ECtHR Case No. 45705/07.

[406] Ibid., at paras.146, 149, 158.

[407] Ibid., at paras.150, 157, 172.

[408] Ibid., at paras.147, 155.

[409] Ibid., at paras.163, 164.

[410] 1969 Vienna Convention on the Law of Treaties, 1155 UNTS 331.

The case of Poblete Vilches v. Chile,[411] adjudicated by the IACtHR, exemplifies the judicial use of the AAAQ framework in assessing systemic health care failures. The Court found that Chile violated the right to health under Article 26 of the ACHR, which enshrines the principle of progressive realisation of economic, social, and cultural rights, due to multiple deficiencies in the care provided to an elderly patient who died after being denied adequate treatment.[412] Through the AAAQ lens, the judgment identified specific shortcomings, including the unavailability of ICU beds and ventilators, discriminatory allocation of resources on the basis of age, the absence of informed consent, and deficient quality of care. This structured assessment demonstrated the framework's ability to translate abstract obligations into concrete evaluative criteria and reinforce state accountability. From the perspective of this dissertation, the case illustrates not only the strengths but also the limits of the AAAQ framework. While the Court succeeded in identifying broad systemic deficiencies, its findings necessarily remained general. In such circumstances, the use of indicators can help to translate these broad judicial observations into specific criteria. Indicators such as ICU beds per 100,000 population, 24-hour access to mechanical ventilation, time-to-admission thresholds or audited consent-form completion rates would not replace the Court's analysis but could complement it by providing clear yardsticks for policy change, supporting the design and implementation of systemic reforms and facilitating supervision of state compliance with the right to health over time.

Another example of a case in which an international human rights body used the AAAQ framework is the case of Sudan Human Rights Organisation and Centre on Housing Rights and Evictions v. Sudan.[413] Although the African Commission on Human and Peoples' Rights (ACmHPR) did not analyse the individual elements of the framework in detail, it explicitly invoked the framework and found that its implied obligations had not been met.[414] On this basis, it held that Sudan had violated Article 16 of the ACHPR, which guarantees the right of every individual to the best attainable state of physical and mental health.[415] The absence of indicators in the Commission's reasoning underscores a recurrent limitation: without indicators such as service-coverage ratios, facility-to-population densities, travel-time measures to primary care, or quality-assurance compliance rates, the finding risks remaining without

[411] *Poblete Vilches et al. v. Chile*, Judgment of 8 March 2018 (Merits, reparations and costs), IACtHR (Ser. C) No. 349.
[412] Ibid., at para.120.
[413] *Sudan Human Rights Organisation and Centre on Housing Rights and Evictions v. Sudan*, Communication 279/03-296/05 of 27 May 2009.
[414] Ibid., at para. 209.
[415] Ibid., at para. 212.

significant operational effect, as it is difficult to translate into a concrete remedial plan capable of systematic follow-up.

The foregoing examples suggest that the AAAQ framework provides a valuable interpretive structure for delineating the scope of the right to health. The AAAQ functions primarily as a diagnostic tool: it organises and structures the analysis of state obligations. Indicators may hold potential in this regard, but their usefulness in adjudicatory settings is necessarily constrained by the socio-economic character of the right to health, which requires sensitivity to national conditions rather than rigid reliance on numerical thresholds. Properly designed and applied with caution, indicators could nonetheless serve as a supplementary reference point, particularly in the monitoring of compliance or in the elaboration of remedial measures following a judgment.

The DIHR has sought to operationalise the AAAQ framework by proposing concrete indicators for each of its dimensions.[416] The DIHR has proposed indicator sets for each dimension, including facility-to-population ratios (availability),[417] distance- and time-based access metrics and affordability thresholds (accessibility),[418] the existence, quality, and regular auditing of culturally appropriate and informed-consent procedures (acceptability),[419] and the level of documented compliance with WHO clinical standards (quality).[420] Such initiatives illustrate the transition from abstract legal duties to measurable benchmarks of implementation, thereby confirming both the practical potential of the AAAQ framework and the methodological choices involved in its translation into evaluative tools.

The value of this approach lies in its capacity to render the right to health more concrete. It enables comparisons across jurisdictions, permits the tracking of progress over time, and facilitates the identification of structural gaps in health care provision. In this respect, the DIHR proposal illustrates how indicators can transform general legal standards into measurable implementation targets that connect normative commitments with concrete actions to be introduced. Moreover, such indicators enable the monitoring of whether states comply with

[416] DIHR, *AAAQ & Sexual and Reproductive Health and Rights International Indicators for Availability, Accessibility, Acceptability and Quality* (2017).
[417] Ibid., at 37.
[418] Ibid., at 38-9.
[419] Ibid., at 39.
[420] Ibid., at 40.

their obligations in practice rather than merely acknowledging them in principle.[421] This should not be understood as a departure from law, but as a means of reinforcing its practical effect by linking AAAQ-derived obligations to specific reference points.

However, the proposal also raises important methodological considerations. Quantifiable measures such as facility-to-population ratios or compliance with WHO standards capture only a limited portion of the AAAQ framework's content. Dimensions such as dignity or non-discrimination are inherently resistant to numerical representation, creating the risk that easily measurable variables will disproportionately shape evaluative outcomes. This tendency, repeatedly observed in the literature on indicators (and further analysed in Chapter V), suggests that exclusive reliance on quantitative tools may inadvertently marginalise aspects of the right that are normatively central but empirically elusive. There is also the danger of construct invalidity and of strategic manipulation by reporting actors, unless quantitative indicators are systematically triangulated with qualitative assessments and subjected to regular methodological review.

The design of indicators is not a neutral technical exercise.[422] Each decision about what to measure and how to measure it reflects an implicit judgment about priorities in health policy and, by extension, about the substance of the specific right itself. For example, privileging facility-to-population ratios foregrounds infrastructure, whereas emphasising disaggregated vaccine coverage foregrounds equity. Indicators therefore not only monitor compliance but also shape the very meaning of what compliance entails. These embedded judgments are influenced by the profile of indicator designers; their educational background, professional training, disciplinary orientation, or the traditions of human rights scholarship in which they were formed all influence which aspects of the right to health are prioritised and how obligations are conceptualised.

The DIHR proposal demonstrates both the potential and the inherent limitations of indicator-based approaches to operationalising the AAAQ framework. It offers concrete reference points that can improve transparency and support systematic monitoring, yet it also risks reducing the complexity of international human rights obligations to an overly restrictive

[421] An interesting example of monitoring the right to health in the national context through the use of various types of quantitative and qualitative data was presented in M. Nowicka, *Prawo do ochrony zdrowia. Raport z monitoringu* (2002).
[422] See Chapter V.

range of quantifiable metrics. Without the integration of qualitative assessments and procedures attuned to contextual variation, indicators alone cannot adequately reflect the full scope of state duties under the right to health.

To conclude, the AAAQ framework demonstrates its value as an interpretive device for delineating the scope of state obligations under the right to health. Its operationalisation through indicators offers important advantages: it can make abstract standards more concrete, enable cross-country comparisons, and support systematic monitoring of compliance. At the same time, reliance on indicators entails significant risks. Indicators should therefore be regarded as useful tools for reinforcing the practical effect of AAAQ-derived interpretations, but only if designed and applied with caution. The following chapters develop this point by analysing their practical use across different international and institutional settings.

3. Operationalizing the right to health during the COVID-19 pandemic

The operationalisation[423] of the right to health presents long-standing conceptual and practical difficulties, particularly during global health emergencies. Although the right to health has recognised legal basis, the precise scope and modalities of state obligations remain frequently indeterminate across legal frameworks. The COVID-19 pandemic rendered these discrepancies particularly salient, exposing both the variability in how states interpret their legal duties and the limited capacity of the international system to monitor or evaluate states' efforts.

In this context, indicators have emerged as a response to the structural weaknesses of the current legal and institutional framework. The right to health is formulated in broad and indeterminate terms, which complicates the identification of specific duties and expected outcomes. Indicators contribute to overcoming this indeterminacy by translating general legal obligations into operational reference points that can guide policy and practice. In this way,

[423] The term 'operationalisation' denotes the process of translating broad and abstract treaty provisions into concrete and practicable measures that can be implemented through public policies, institutional practices, and health interventions. In contrast to legal interpretation, which is primarily concerned with clarifying the normative content of rights, operationalisation emphasises their implementation in real life. Its aim is to ensure that rights yield tangible benefits for individuals and communities, while also requiring compromise and adaptation to complex political and social contexts. See P. Hunt, 'Interpreting the International Right to Health in a Human Rights-Based Approach to Health', (2016) 18 *Health and Human Rights* 109.

they make it possible to assess whether states have taken measures that may reasonably be construed as fulfilling their health-related commitments.

This section explores two dimensions of this gap in implementation: the legal indeterminacy of the principle of progressive realisation (3.1), and the tensions between individual rights and collective public health measures during the pandemic (3.2). In both contexts, indicators have potential to function as instruments to clarify the legal content of the right to health and to track compliance over time.

3.1. The principle of progressive realization:

A shield or a sword?

One of the biggest challenges in interpreting the right to health under the ICESCR arises from the principle of progressive realisation, set out in Article 2(1) of the Covenant. This provision recognises that states may not be able to fully realize economic, social, and cultural rights immediately due to resource constraints and other limitations. Instead, they are obliged to take steps toward the full realization of the rights "to the maximum of their available resources."[424] While this flexibility makes the Covenant adaptable to the different capacities of states, it also generates legal uncertainty: the principle can be invoked to justify delays or limited measures, creating difficulty in distinguishing between genuine resource limitations and instances of insufficient political will, especially in the context of public health crises.[425] The progressive realisation of the right to health over time should not be interpreted as depriving the state's obligations of substantive content. Rather, it implies that the state bears a particular and continuing duty to advance as effectively as possible towards the full realisation of this right.[426] As Bartosz Pawelczyk noted, the progressive nature of the obligation thus stands in opposition, first, to stagnation (meaning the cessation of continuous monitoring and the search for solutions in the organisation of health care) and second, to retrogression (understood as the

[424] L. O. Gostin and B. M. Meier, *Foundations of Global Health & Human Rights* (2020), 54.
[425] International Commission of Jurists, *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights* (1997). K. Orzeszyna, M. Skwarzyński and R. Tabaszewski, *Prawo międzynarodowe praw człowieka* (2022), 60. See K. Young, 'Waiting for Rights: Progressive Realization and Lost Time', (2019) 509 *Boston College Law School Legal Studies Research Paper* 1, at 11.
[426] Pawelczyk, *supra* note 361, at 607.

reduction of the scope or quality of health care in comparison to the existing level of protection).[427]

To address the issue mentioned, human rights practice has turned to indicators. By providing measurable reference points, indicators facilitate the evaluation of state conduct and allow for regular monitoring of compliance. Their role is to ensure that progressive realisation is not invoked as a justification for inaction in situations where a state has the objective capacity to act but fails to do so. The CESCR has sought to mitigate this uncertainty by underlining that certain 'core obligations' under the right to health take immediate effect and are not subject to progressive realisation.[428] These include, *inter alia*, the guarantee of non-discriminatory access to health care, the provision of essential primary health services, and the adoption of a comprehensive national health strategy.[429] Core obligations establish a minimum standards but do not exhaust the content of the right to health. In this regard, indicators provide a more systematic framework for clarification of states' obligations and evaluation of states' conduct. Within the UN human rights system, the tripartite typology of structural, process, and outcome indicators has been employed to capture different dimensions of state performance: the adoption of relevant legal and institutional frameworks (structural), the implementation of policies and allocation of resources (process), and the measurable enjoyment of rights by the population (outcome).[430] Taken together, these dimensions permit a more coherent assessment of whether states are translating their formal commitments into concrete actions and whether such measures result in demonstrable improvements in the enjoyment of the right to health.[431] The following Chapter develops this issue in greater detail.

However, the most persistent difficulty in applying the principle of progressive realisation lies in assessing whether a state has genuinely mobilised the maximum of its available resources. To address this problem, two principal methodological approaches have been developed through the use of indicators.[432] The ratio approach does so by comparing social outcomes (such as child survival rates, access to safe drinking water, or life expectancy) with a

[427] Ibid.
[428] CESCR, *supra* note 315, at para. 30.
[429] Ibid., at paras. 30-1.
[430] O. de Schutter, *International human rights law: cases, materials, commentary* (2014), 480.
[431] B. M. Meier et al., 'Examining the Practice of Developing Human Rights Indicators to Facilitate Accountability for the Human Right to Water and Sanitation', (2014) 6 *Journal of Human Rights Practice* 159, at 166-7.
[432] S. Fukuda-Parr et al., 'Measuring the Progressive Realization of Human Rights Obligations: An Index of Economic and Social Rights Fulfillment', (2008) *Economics Working Papers* 1, at 13.

state's per capita income.[433] Under this method, a wealthy state with poor social indicators is assessed more critically than a poorer state with similar outcomes, on the assumption that greater resources should translate into more effective rights fulfilment.[434] A second, more sophisticated approach, known as the Achievement Possibilities Frontier, situates each state's performance against the best results historically achieved by states with comparable income levels.[435] Where outcomes fall significantly below this empirical frontier, it may indicate that a state has failed to utilise its resources to their fullest extent.[436] Both approaches embed indicators in an evaluative framework that measures what can reasonably be expected given a country's level of development.[437] While neither method provides a definitive legal test of compliance, they show how indicators can serve as tools to evaluate whether states are meeting their obligations under Article 2(1) of the Covenant, offering a more objective basis for distinguishing genuine resource constraints from insufficient political will.[438] At the same time, they carry risks of oversimplification as well as political manipulation if applied without methodological safeguards.[439]

3.2. Balancing individual rights and public health

The COVID-19 pandemic has exposed the tension between individual rights and public health imperatives, particularly in the context of restrictive public health measures such as lockdowns, quarantine mandates, and vaccination requirements. While under international law states have a duty to protect public health, they must also respect the human rights of individuals, including the right to privacy and freedom of movement.

During the pandemic, many states implemented strict public health measures aimed at controlling the spread of the virus. These measures, while necessary from a public health perspective, prompted concerns about their compatibility with individual rights. For example, in Italy and Spain, lockdowns introduced by governments led to significant restrictions on the right to freedom of movement, prompting questions concerning their proportionality under

[433] de Schutter, *supra* note 430, at 510.
[434] Ibid.
[435] Fukuda-Parr et al., *supra* note 432, at 19.
[436] Ibid.
[437] de Schutter, *supra* note 430, at 509.
[438] B.M. Meier et al., *supra* note 431, at 161.
[439] de Schutter, *supra* note 430, at 492.

human rights law.[440] In some cases, these restrictions have disproportionately affected marginalized groups who were more likely to face economic hardships as a result of the lockdowns.[441] The issue of vaccine mandates has also been controversial. While vaccines are widely regarded as essential for controlling the spread of COVID-19,[442] mandatory vaccination policies have sparked debates about individual autonomy and informed consent. In France, for example, the government's decision to mandate vaccinations for health care workers led to protests, with critics arguing that the policy violated their right to bodily autonomy.[443] However, proponents of vaccine mandates argue that these policies are necessary to protect public health and prevent the further spread of the virus. Closer adherence to WHO guidance documents (including those providing indicators)[444] might have fostered a more coordinated global response and enhanced the proportionality and consistency of restrictive measures across jurisdictions.

The tension between public health imperatives and individual rights has been considered by international human rights bodies on various occasions. A leading example is Vavřička and Others v. the Czech Republic,[445] decided by the ECtHR in 2021. The case concerned the legality of mandatory childhood vaccination and its compatibility with Article 8 ECHR (the right to respect for private life). [446] The Court found that the Czech vaccination policy pursued a legitimate aim (protection of public health) and constituted a proportionate interference, justified within a democratic society.[447] Importantly, the Court reaffirmed the broad margin of appreciation accorded to states in shaping health policy, especially when based on scientific consensus.[448] It also emphasised the notion of social solidarity, affirming that

[440] See A. Spadaro, 'COVID-19: Testing the Limits of Human Rights', (2020) 11 *European Journal of Risk Regulation* 317.
[441] Bambra et al., *supra* note 307, at 964-7.
[442] WHO, *Monitoring Metrics Related to the Global Covid-19 Vaccination Strategy in a Changing World: July 2022 update* (2022), 3. See also B. Greenwood, 'The Contribution of Vaccination to Global Health: Past, Present and Future', (2014) 369 *Philosophical Transactions of the Royal Society B Biological Sciences* 20130433. J. P. Damijan, S. Damijan and Č. Kostevc, 'Vaccination Is Reasonably Effective in Limiting the Spread of COVID-19 Infections, Hospitalizations and Deaths with COVID-19', (2022) 10(5) *Vaccines* 678.
[443] J. King, O. L. M. Ferraz and A. Jones, 'Mandatory COVID-19 Vaccination and Human Rights', (2021) 399(10321) *Lancet* 220, at 220–2. See also L. O. Gostin, 'COVID-19 Vaccine Mandates – A Wider Freedom', (2021) 2(10) JAMA *Health Forum* e213852.
[444] See WHO, *Considerations for Implementing and Adjusting Public Health and Social Measures in the Context of COVID-19: Interim Guidance* (2020).
[445] *Vavřička and Others v. the Czech Republic*, Judgment of 8 April 2021, ECtHR Case No. 47621/13.
[446] Ibid., at para. 310.
[447] Ibid., at paras. 284-5.
[448] Ibid., at para. 280.

individuals may bear certain obligations to protect vulnerable members of society.[449] Although the judgment did not concern COVID-19 directly, its reasoning may have broader implications for evaluating pandemic-related vaccine mandates under international human rights law.[450] By affirming both the legitimacy of compulsory vaccination as a means of protecting public health and the broad margin of appreciation afforded to states in health policy matters, the Court provided a framework that could be applied by analogy to COVID-19 vaccination requirements. In particular, the emphasis on proportionality, scientific consensus, and social solidarity suggests that, provided such conditions are met, mandatory COVID-19 vaccination policies could also be regarded as compatible with Article 8 ECHR.

In Crăciun et al. v. Romania,[451] the ECtHR considered legality of the denial of temporary prison leave during the pandemic. The applicants, all detainees, sought permission to attend the funerals of close relatives but were refused on the grounds of COVID-19 restrictions. The ECtHR found a violation of Article 8 ECHR, holding that the authorities failed to justify the interference as necessary in a democratic society.[452] It noted the state's reliance on general references to the health crisis without concrete evidence of risk, thereby failing to meet the proportionality requirement.[453] This case illustrates that public health considerations must be balanced through case-by-case analysis.

It was asserted that "Like perhaps no previous crisis, COVID-19 has revealed the specific conditions of vulnerability that different groups of migrants [...] face when confronted with disasters",[454] as it happened in Bah v. the Netherlands.[455] The applicant challenged the continuation of his detention during the initial lockdown, arguing that the inability to attend a

[449] Ibid., at para. 306.

[450] *Do Compulsory Vaccinations against COVID-19 Violate Human Rights?,* available at voelkerrechtsblog.org/do-compulsory-vaccinations-against-covid-19-violate-human-rights. *Are COVID-19 Vaccine Mandates Human Rights Violations?*, available at www.weforum.org/agenda/2022/01/are-covid-19-vaccine-mandates-a-human-rights-violation/ See Z. Zaid, W. S. Hernowo and N. Prasetyoningsih, 'Mandatory COVID-19 Vaccination in Human Rights and Utilitarianism Perspectives', (2022) 11 *International Journal of Public Health Science* 967. WHO, *COVID-19 and Mandatory Vaccination: Ethical Considerations. Policy Brief 30 May 2022* (2022). *COVID-19: Human Rights and Vaccination*, available at www.amnesty.org.au/covid-19-human-rights-and-vaccination/. M. E. Addadzi-Koom, 'No Jab, No Entry: A Constitutional and Human Rights Perspective on Vaccine Mandates in Ghana', (2022) 24 *Health and Human Rights Journal* 47, *passim*.

[451] *Crăciun et al. v. Romania*, Judgment of 16 May 2024. ECtHR Case No. 512/21.

[452] Ibid., at para.14.

[453] Ibid., at paras. 10-11.

[454] J. Twigg, R. Matthews and L. Guadagno, *Inclusion of Migrants and Refugees in Preparedness and Response to Biological Disasters: Case Study of the COVID-19 Pandemic* (2024), 5.

[455] *Bah v. the Netherlands*, Decision of 22 June 2021, ECtHR Case No. 35751/20.

court hearing in person violated his right under Article 5(4) ECHR. The Court, however, declared the application inadmissible as being manifestly ill-founded.[456] It acknowledged the exceptional logistical difficulties caused by the pandemic, emphasised that the applicant was legally represented, and accepted that the state's response fell within the margin of appreciation.[457] The case reflects the Court's readiness to tolerate certain procedural limitations when justified by urgent public health constraints.

In the context of restrictive public health measures, WHO emphasised the need to balance the protection of public health with the preservation of individual rights. With regard to necessity of measures adopted by states, it proposed a structured system of assessment built around three dimensions: transmissibility (e.g. confirmed cases, test positivity rates, wastewater surveillance), impact on morbidity and mortality (e.g. hospitalisations and ICU admissions), and impact on the health system (e.g. occupancy of general and intensive-care beds, regardless of cause).[458] On this basis, governments were advised to classify the epidemiological situation into five situational levels, each linked to a calibrated set of measures of increasing stringency.[459] This method was meant to make sure that limitations were raised or lowered based on measurable risks, and that they were not kept in place for longer than necessary.[460] Proportionality required balancing the benefits of public health measures against their burdens on individuals and communities. WHO documents accordingly stressed the need to collect indicators on socio-economic and human rights impacts, including mental health, education, economic security, gender-based violence and food security,[461] while also monitoring the disproportionate effects on vulnerable groups and linking epidemiological data with social-protection schemes.[462] The inclusion of economic data, such as employment and household expenditure, was similarly encouraged to capture the wider distributional effects of restrictions.[463] Indicators do not provide a definitive answer as to whether limitations are proportionate, but they create a structured evidentiary basis for such an assessment.[464] By

[456] Ibid., at para. 47.
[457] Ibid., at para. 44.
[458] WHO, *Considerations for Implementing and Adjusting Public Health and Social Measures in the Context of COVID-19: Interim Guidance* (2023), 3, 6, 17.
[459] Ibid., at 9.
[460] Ibid. at 1.
[461] WHO, *Global guidance on monitoring public health and social measures policies during health emergencies* (2024), 1.
[462] Ibid., at 25.
[463] Ibid., at 26.
[464] WHO, *supra* note 458, at 8.

anchoring legal analysis in systematically collected data, they were aimed at enhancing transparency and supporting the continuous recalibration of measures in response to evolving conditions, while avoiding the risk of mechanistic application that would neglect contextual factors.[465]

4. Conclusions: Toward a better framework for the right to health

The COVID-19 pandemic has exposed the weaknesses of global health governance landscape. It revealed how much the right to health is interconnected with issues of resource distribution and international cooperation. International human rights law provides an essential normative framework for the right to health, but the pandemic has demonstrated that the current legal and institutional mechanisms are inadequate to address the complexities of public health crises. For the future, the framework for ensuring the right to health should be clarified. This will require not only a re-evaluation of states' obligations but also strengthened forms of international cooperation.

The COVID-19 pandemic has revealed three central lessons: first, the global health governance system remains inefficient (4.1); second, persistent global health inequalities hinder the attainment of universal health care (4.2); and third, the standards governing the right to health remain insufficiently determinate, complicating its effective protection (4.3). These lessons underline the need for a more robust, standardised, and transparent mechanism for guiding and monitoring state compliance with health-related obligations. Accordingly, indicators emerge as a potentially valuable tools in this context.

4.1. First lesson:

The global health governance system is inefficient

One of the lessons from the COVID-19 pandemic is that the current global health system has proved insufficient to deliver a coherent and timely response to public health emergencies while ensuring that states comply with their obligations under international law.

[465] WHO, *supra* note 461, at 5. WHO, *Public Health Criteria to Adjust Public Health and Social Measures in the Context of COVID-19: Annex to Considerations in Adjusting Public Health and Social Measures in the Context of COVID-19* (2020), 3.

As the preceding discussion has shown, the broad formulation of the right to health and the principle of progressive realisation have generated uncertainty as to the scope of state obligations; this uncertainty was further magnified during the pandemic by the absence of clear international enforcement structures. While the primary responsibility for the realisation of the right to health rests with states (public authorities), this does not contradict the view that certain obligations in this area also lie with non-state actors.[466] General Comment No. 14 emphasises the role played by the agencies and programmes operating within the UN system, with particular attention to the importance of the WHO.[467] States are expected to make use of the technical support and opportunities for cooperation offered by this organisation, especially in the process of formulating and implementing health strategies, as well as in collecting and submitting information for reporting purposes.[468]

During the pandemic, states worldwide faced similar difficulties in addressing the crisis and the need for coordinated international action became more pressing than ever. As noted by scholars such as Irene Domenici and Pedro A. Villarreal, the COVID-19 pandemic exposed the structural fragmentation and inefficiencies of the current global health architecture.[469] The WHO, although playing a central role in coordinating the international response, lacks the enforcement mechanisms necessary to compel compliance with health standards.[470] This institutional limitation, together with the economic and technological constraints faced by many states, contributed to inconsistent and often inadequate national responses, which in turn resulted in considerable human suffering.

In light of these systemic weaknesses, some scholars, including Lawrence O. Gostin, have called for the negotiation of a global health treaty that would serve as a binding legal instrument to remedy deficiencies in the current system and foster greater solidarity in times of crisis[471]. Such a treaty could establish clear and enforceable obligations on states to ensure equitable access to health care resources, provide timely medical treatment, and protect vulnerable populations. This idea has recently acquired practical expression in the Pandemic

[466] Pawelczyk, *supra* note 361, at 611-12.
[467] CESCR, *supra* note 315, at para. 63.
[468] Ibid.
[469] I. Domenici and P. A. Villarreal, 'The Fragmented Nature of Pandemic Decision-Making: A Comparative and Multilevel Legal Analysis', (2022) 29(1) *European Journal of Health Law* 1, at 1-5.
[470] Meier, *supra* note 310, at 796-8.
[471] L. O. Gostin, B. M. Meier and B. Stocking, 'Developing an Innovative Pandemic Treaty to Advance Global Health Security', (2021) 49(3) *The Journal of Law Medicine & Ethics* 503, at 503-8.

Agreement,[472] adopted in 2025 under the auspices of the WHO, which seeks to establish a legal framework for pandemic prevention, preparedness and response. The Agreement has been welcomed as a historic milestone[473] in global health law, yet early scholarly assessments reveal a more nuanced picture. While commentators have praised its potential to strengthen preparedness and embed principles of solidarity into international law, significant doubts persist regarding its enforceability, the adequacy of its financing mechanisms, and the political will of states to implement its commitments.[474] In this respect, the Pandemic Agreement illustrates both the promise and the limitations of treaty-making in global health: it responds to long-standing calls for stronger legal instruments, but it does not, in itself, resolve the structural problems of compliance and accountability. Accordingly, the development of complementary tools (such as indicators) remains crucial if the Agreement's commitments are to be effectively translated into operational standards capable of guiding state conduct and facilitating meaningful monitoring.

It is precisely against this backdrop that this kind of tools become indispensable for the WHO to sustain its role as a central actor in the global health governance landscape, enabling it to compensate for structural limitations. In the absence of enforcement mechanisms, WHO has sought to exercise influence through systematic data collection, coordination, and standard setting. Indicators played an important role in this effort, particularly within the COVID-19 Strategic Preparedness and Response Plan (SPRP)[475] and its accompanying operational plan.[476] These instruments introduced a set of Key Performance Indicators (KPIs) designed to enable monitoring and evaluation of the global response. WHO maintained a global indicator platform and reporting structures that served not only to support planning but also to provide real-time evidence for tracking state's performance and decision-making in the pandemic context.[477]

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[472] WHO, *Pandemic Prevention, Preparedness and Response Agreement (Pandemic Agreement), adopted by the Seventy-eighth World Health Assembly,* WHA78.1 (2025),

[473] Lancet Editorial, 'The Pandemic Treaty: A Milestone, but with Persistent Concerns', (2025) 405(10489) *The Lancet* 1555, at 1555.

[474] P. A. Villarreal, A. Gross and A. Phelan, 'The Proposed Pandemic Agreement: A Pivotal Moment for Global Health Law', (2025) *The Journal of Law, Medicine & Ethics* 1, at 2-4 See also T. K. Deol et al., 'Adoption of Pandemic Treaty Is Historic: Compliance and Accountability Must Now Follow', (2025) 5(8) *PLOS Global Public Health* e0004969. *WHO: New Pandemic Treaty a Landmark, but Flawed*, available at www.hrw.org/news/2025/05/23/who-new-pandemic-treaty-landmark-flawed.

[475] WHO, *COVID-19 Strategic Preparedness and Response Plan* (2021).

[476] Ibid., at 2.

[477] Ibid., at 19.

Indicators also functioned as a means of directing technical and financial support.[478] Access to timely and reliable country-level data allowed WHO to identify where the assistance was most urgently required and to coordinate global and regional interventions accordingly.[479] The framework was revised regularly to capture evolving disparities in capacity and risks within states, thereby refining the targeting of support and reducing inefficiencies.[480]

Within the SPRP itself, indicators were embedded in the very architecture of the response. They formed a core component of the first pillar (coordination, planning, financing, and monitoring) and were also significant to other pillars, including those on surveillance and vaccination.[481] Monitoring was not conceived as an ancillary activity but as a foundational element of public health decision-making, ensuring that course corrections could be made on the basis of systematically collected evidence.[482] This approach extended to specific domains such as vaccine deployment, where additional KPIs relating to coverage, distribution equity, and uptake informed the allocation of doses and the provision of technical assistance to states.[483]

Taken together, the SPRP illustrates how WHO sought to compensate for its lack of enforcement powers by embedding indicators into the very architecture of its pandemic response. In a moment of global crisis, the Organisation could not afford to remain passive; it therefore turned to measurable information as a means of exercising influence. While indicators did not resolve the deeper structural weaknesses of global health governance, they provided a means through which WHO could translate legal commitments into concrete actions.

4.2. Second lesson:

Global health inequalities hinder the ability to achieve universal health care

The second lesson emerging from the COVID-19 pandemic concerns the persistence of deep global inequalities in the protection of the right to health and the difficulties these pose for achieving universal health care. As General Comment No. 14 suggests, the right to health cannot be fully realised without international assistance and cooperation, particularly for low-

[478] Ibid., at 13.
[479] Ibid., at 19.
[480] Ibid., at 28.
[481] Ibid., at 19.
[482] Ibid.
[483] Ibid., at 12.

income states that lack the financial and institutional resources to secure adequate health care for their populations.[484] The pandemic revealed the limited extent to which this principle has been implemented in practice. High-income states were able to secure large quantities of vaccines and medical supplies through bilateral agreements, while many low- and middle-income states experienced significant delays and shortages. Although the COVAX initiative was intended to promote vaccine equity, it was widely criticised for failing to meet its own distribution targets and for allowing wealthier participants to retain disproportionate access.[485] These developments reinforced the impression that the commitment to international solidarity, though well established in legal texts, has remained largely ineffective when most needed.[486]

The ICESCR does not merely recognise the progressive realisation of economic, social and cultural rights; it also requires states to take steps, individually and through international assistance and cooperation, to give effect to these rights. Yet this dimension of international cooperation has rarely been enforced. In practice, wealthier states have frequently invoked domestic priorities to justify withholding support, even in circumstances where assistance would have been crucial to preventing large-scale health crises elsewhere. The pandemic thus raises important questions about how the principle of cooperation can be made more concrete and how accountability for its neglect might be strengthened. Proposals such as the creation of a global health solidarity fund, financed by wealthier states and international organisations, exemplify attempts to move beyond temporary or voluntary initiatives towards more structured mechanisms of support, though their feasibility depends on political acceptance and effective institutional design.

Against this background, indicators can be conceived as instruments for rendering the obligations of international assistance more operationally determinate.[487] By articulating structured criteria for assessing how resources are mobilised and distributed in accordance with international commitments,[488] indicators create a basis for tracing whether assistance reaches intended beneficiaries and for exposing disparities between populations or states that receive

[484] CESCR, *supra* note 315, at paras. 38, 40, 45.
[485] M. Tatar et al., 'International COVID-19 Vaccine Inequality amid the Pandemic: Perpetuating a Global Crisis?', (2021) 11 *Journal of Global Health* 1, at 1.
[486] *Reshaping Global Health Law in the Wake of COVID-19 to Uphold Human Rights*, available at www.hhrjournal.org/2021/06/reshaping-global-health-law-in-the-wake-of-covid-19-to-uphold-human-rights/.
[487] S. Gruskin, 'Using Indicators to Determine the Contribution of Human Rights to Public Health Efforts', (2009) 87(9) *Bulletin of the World Health Organization* 714, at 715.
[488] Ibid.

support and those that remain excluded.[489] Such data may therefore illuminate the boundary between genuine capacity constraints and situations where support is withheld despite the availability of resources. As shown in Section 4.1, the SPRP incorporated indicators to guide the allocation of technical and financial support during the pandemic, with the stated aim of directing assistance to areas of greatest need and of systematically addressing disparities in capacity. A comparable rationale informed the design of the COVAX facility, which sought to structure vaccine distribution through the use of indicators.[490] Although the shortcomings of COVAX exposed the political and structural barriers that undermined the effectiveness of this approach, the attempt nonetheless illustrates the potential of indicators to translate the principle of international assistance into concrete operational criteria.[491]

4.3. Third lesson:

The standards for the right to health are too fluid

The third lesson to be drawn from the pandemic is that the normative standards of the right to health remain insufficiently determinate to provide consistent guidance for state conduct. Although the right is prescribed in the ICESCR and other international instruments, and has been further elaborated through the AAAQ framework, its substantive contours remain ambiguous. Categories such as availability, accessibility, acceptability and quality set out the dimensions of this right in general terms, but they do not on their own establish what states are concretely obliged to secure in specific contexts. As the pandemic revealed, the problem was not merely variation in interpretation between states but a more fundamental uncertainty as to what the right to health requires in practice, and how competing claims should be reconciled.

This indeterminacy undermines practical enforceability of the right to health. Standards expressed in broad language provide valuable flexibility, but they also risk being invoked in contradictory ways without a clear basis for evaluation.[492] Without more detailed guidance, it becomes difficult to assess whether state conduct is consistent with international

[489] UN OHCHR, *The Right to Health. Factsheet No. 31* (2008), 24-5.
[490] WHO, *COVID-19 Vaccine Allocation - Final Working Version* (2020).
[491] Ibid., at 31-2.
[492] For an example of how human rights can contribute to the protection of global health see J. Harrington, 'Indicators, Security and Sovereignty during COVID-19 in the Global South', (2021) 17(2) *International Journal of Law in Context* 249. See also Orzeszyna et al., *supra* note 425, at 64.

obligations or whether appeals to resource limitations and progressive realisation mask avoidable shortcomings.[493]

One possible way of addressing this problem has been the use of indicators, which aim to render abstract commitments more concrete by providing measurable points of reference. Such tools do not replace the legal framework, but they provide structured criteria that make the content of the right more transparent and allow for systematic monitoring of implementation. Indicators can also enhance comparability and transparency across jurisdictions. By providing a common set of evaluative criteria, they make it easier to identify gaps in national health systems and to distinguish between genuine capacity constraints and failures of prioritisation. Importantly, they can illuminate not only immediate crisis responses, such as the provision of oxygen therapy or critical care, but also longer-term obligations relating to the social determinants of health, including housing, education, and environmental conditions. In this sense, indicators operate at the intersection of law and policy: they retain their foundation in the legal duty to realise the right to health, but they give that duty a form that can be assessed empirically and debated publicly.

Yet this promise is not without limits. Indicators cannot eliminate the underlying indeterminacy of the right; they merely shift it to the level of technical design and selection. A hospital bed ratio, for instance, may capture one aspect of availability, but it leaves out other equally relevant dimensions such as staffing, equipment, or regional disparities. Similarly, aggregate data on service coverage may conceal systematic exclusion of marginalised groups. In this sense, the move from standards to indicators risks reproducing ambiguity in quantified form, while also introducing vulnerabilities to oversimplification.

By making obligations more visible and assessable, they contribute to transforming the right from a broadly formulated standard into a framework with clearer legal effect.[494] Their potential as (*quasi*-)legal instruments relies on several conditions that will be elaborated in the following chapters.

[493] See also P. Pisarek, 'Kryteria oceny efektywności ochrony wybranych praw człowieka II generacji w Polsce', in J. Jaskiernia and K. Spryszak (eds.), *Efektywność krajowych i międzynarodowych systemów praw człowieka drugiej generacji* (2024), 25 at 35-6.
[494] Orzeszyna et al., *supra* note 425, at 67-8.

Chapter IV

The potential of indicators as tools in human rights law

International human rights law is characterised by a persistent tension between normative ambition and interpretive openness.[495] While treaties set out obligations, their textual generality often requires further specification to become operational. This need for clarification becomes particularly evident when monitoring compliance or designing state policies intended to give effect to international commitments. As discussed in the previous chapters, legal provisions always rely on language which, though valuable for flexibility, risks generating uncertainty regarding the precise scope and content of state duties. The operationalisation of these duties requires tools capable of translating normative statements into measurable standards of conduct. One of the most prominent candidates to fulfil this function are human rights indicators.

In the field of human rights, indicators are regarded as instruments capable of converting abstract legal norms into empirically assessable elements, thereby allowing for monitoring, evaluation, and precise attribution of responsibility. At the same time, indicators are not neutral instruments. Their use has raised concerns about reductionism and the marginalisation of experiential and context-specific dimensions, which are often overlooked in technical assessments yet may prove decisive for the protection of individual rights.

This chapter aims to explore the potential of indicators to clarify state obligations and monitor implementation. It does so by examining a broad range of issues, including the evolution of indicators in human rights governance (Section 1), their definitional complexity (Sections 2-3), their applicability across both civil and political rights, as well as economic, social, and cultural rights (Section 4), and the challenges of distinguishing them from related tools such as benchmarks and indices (Section 5). The following sections analyse the process of indicator construction (Section 6), debates surrounding their potential universality (Section 7), typological classifications (Section 8), and the various data sources used in their

[495] J. Tobin, 'Seeking to Persuade: A Constructive Approach to Human Rights Treaty Interpretation', (2010) 23 *Harvard Human Rights Journal* 1, at 1, 4, 19.

development and application (Section 9) – before turning to key methodological issues such as disaggregation (Section 10).

The considerations developed in this chapter ultimately aim to clarify the place of indicators within human-rights law, treating them not as neutral statistical tools but as instruments whose legal meaning depends on their legal anchoring and rigorous methodology employed during their design and use. The analysis seeks to delineate the conditions under which indicators can genuinely enhance the clarity and enforceability of human rights obligations, while remaining alert to the risks of the marginalisation of lived experiences.

1. The rise of indicators

In his preliminary report to the Commission on Human Rights, the UN Special Rapporteur on the right to the highest attainable standard of health observed: "The international right to health is subject to progressive realization. Inescapably, this means that what is expected of a State will vary over time. With a view to monitoring its progress, a state needs a device to measure this variable dimension of the right to health. [The Committee on Economic, Social and Cultural Rights – M.B.] suggests that the most appropriate device is the combined application of national right to health indicators and benchmarks. Thus, a State selects appropriate right to health indicators that will help it monitor different dimensions of the right to health. Each indicator will require disaggregation […]. Then the State sets appropriate national targets – or benchmarks – in relation to each disaggregated indicator. It may use these national indicators and benchmarks to monitor its progress over time, enabling it to recognize when policy adjustments are required. Of course, no matter how sophisticated they might be, right to health indicators and benchmarks will never give a complete picture of the enjoyment of the right to health in a specific jurisdiction. At best, they provide useful background indications regarding the right to health in a particular national context."[496] It appears that the subsequent practice of international bodies confirms this proposition, as will be demonstrated below.

Particularly within the realm of economic, social and cultural rights, indicators have gained the attention of stakeholders as a potential means of addressing the marginalisation these

[496] Hunt, *supra* note 296, at 36.

rights have historically faced.[497] Over recent decades, this shift has paralleled efforts to strengthen the conceptual framework for understanding and implementing economic, social, and cultural rights.[498] Importantly, the application of indicators has extended beyond economic, social, and cultural rights to encompass civil and political rights.[499]

Notably, indicators as tools for human rights were emphasised in the early 1990s when the UN Special Rapporteur on the Realization of Economic, Social, and Cultural Rights first proposed their use for measuring progress in fulfilling these rights.[500] Within the UN treaty body system, the use of indicators (initially developed in an *ad hoc* manner), was shaped by the evolving working methods and interpretations of treaty provisions. For example, the CESCR underscored the importance of indicators in its General Comment No. 13 on the right to education, recommending that state parties adopt national education strategies that include monitoring through indicators and benchmarks.[501]

Efforts to systematise the development and application of indicators have expanded over time. Several noteworthy projects have emerged in the field, such as the Social and Economic Rights Fulfilment (SERF) Index[502], Todd Landman's framework[503] for categorizing rights into principle, practice, and policy dimensions, and initiatives aimed at constructing indicators for the right to health or the Human Rights Measurement Initiative (HRMI),[504] which focuses on providing state-level human rights data to support policy-making. These initiatives have been developed outside the framework of state authority or intergovernmental mandate, which in itself illustrates the decentralisation in the development of indicators. However, the most comprehensive and influential initiative has been undertaken by the OHCHR.

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[497] J. V. Welling, 'International Indicators and Economic, Social, and Cultural Rights', (2008) 30 *Human Rights Quarterly* 933, at 933. For the community's marginalization in the context of economic, social and cultural rights see P. Pearson et al., *Marginalised Communities and Economic, Social and Cultural Rights in Scotland: A Literature Review* (2022).

[498] Ibid., at 936.

[499] See for example UN OHCHR, *supra* note 299.

[500] UN General Assembly, World Conference on Human Rights, *Report of the Secretariat: Report of the Seminar on Appropriate Indicators to Measure Achievement in the Progressive Realization of Economic, Social and Cultural Rights,* UN Doc. A/CONF.157/PC/73 (1993).

[501] UN CESCR, *General Comment No. 13: The Right to Education (Art. 13 of the Covenant)*, UN Doc. E/C.12/1999/10 (1999), para. 52.

[502] See *SERF index*, available at www.serfindex.uconn.edu/about-us/.

[503] See T. Landman, 'Measuring Human Rights: Principle, Practice and Policy', (2004) 26 *Human Rights Quarterly* 906.

[504] See *HRMI*, available at www.humanrightsmeasurement.org/what-we-do/.

Launched in 2005 and culminating in the publication of the Human Rights Indicators: A Guide to Measurement and Implementation in 2012, the OHCHR-influenced project established a standardized framework for developing and applying indicators in human rights law.[505] The document was prepared to establish a coherent framework for the development and use of indicators in the field of human rights.[506]

The framework is intended to reach "all those who share a commitment to the promotion of human rights and those who are mandated, directly or indirectly, to address human rights issues in the course of their day-to-day work."[507] It introduced a core set of indicators alongside a methodology designed to guide their creation and use. The document prioritises quantitative indicators over qualitative ones,[508] emphasizing their verifiability and ease of comparison across time and populations.[509] Qualitative indicators, such as those derived from expert judgements, are considered less reliable and are often converted into numerical formats to enhance their utility.[510] Further, to ensure a systematic approach, the framework includes several key features. It links right-related indicators directly to the normative content of specific right by identifying attributes for this right. For instance, the right to a fair trial is broken down into components such as "access to and equality before courts and tribunals," "public hearing by competent and independent courts," "presumption of innocence and guarantees in the determination of criminal charges," "special protection for children," and "review by a higher court."[511] Such method facilitates the selection and measurement of indicators that concretise each right's normative dimensions.[512] Finally, the framework adopts the commonly used structure-process-outcome model.[513]

By establishing a standardized approach, the OHCHR framework marked a significant step towards integrating indicators into the legal architecture of human rights, providing a methodological reference for treaty bodies and monitoring mechanisms.[514] This development

[505] UN OHCHR, *supra* note 299.
[506] Ibid., at III.
[507] Ibid., at 4.
[508] For an analysis of the distinction between quantitative and qualitative indicators, see Section 9 below.
[509] UN OHCHR, *supra* note 299, at 17.
[510] Ibid., at 67-8.
[511] Ibid., at 98.
[512] D. McGrogan, 'Human Rights Indicators and the Sovereignty of Technique', (2016) 27 *European Journal of International Law* 385, at 389.
[513] UN OHCHR, *supra* note 299, at 34-8.
[514] McGrogan, *supra* note 512, at 390. See also Australian Human Rights Commission, *Human Rights Indicators* (n.d.). K. Starl et al., *Human Rights Indicators in the Context of the European Union* (2014).

reflects the growing reliance on quantitative measures to assess state performance and monitor compliance with international obligations. However, the quantitative assessment of human rights has faced criticism since its early stages, and as the use of indicators has gained traction, so too have concerns surrounding their application. Notably, most academic discussions on the topic highlight significant challenges, particularly regarding the reliability of statistical methods and their capacity to disaggregate data effectively.[515] This topic will be examined in detail in following sections.

2. The notion of indicators in human rights law

The concept of an indicator continues to lack a universally agreed definition. The significance of indicators appears to lie not solely in their definition or typological classification, but to emerge through their practical deployment within institutional processes, where their function and legal importance are shaped by their application. However, two distinct definitions (one from a non-governmental organisation and another from the UN) may provide a clarification. According to the NGO Redefining Progress, an indicator is "a set of statistics that can serve as a proxy or metaphor for phenomena that are not directly measurable. However, the term is often used less precisely to mean any data pertaining to social conditions."[516] The UN Population Fund, on the other hand, clarifies that "the definition and qualities of an indicator have long been the subject of debate. An indicator is a variable, or measurement, which may convey both a direct and indirect message. So long as it can be consistently measured, it can be based on either quantitative or qualitative information. An indicator is generally expressed as a single figure, even when it combines information from a number of different sources. Presentations of more complex arrays of inter-related figures are usually referred to as statistical tables or tabulations, which in many cases are needed to supplement the summary information contained in indicators."[517]

The absence of a universally accepted and consistent definition underscores the dynamic nature of indicators as tools of global governance. This also explains why they are

[515] See *Questioning the Numbers: Sally Merry Challenges the Shorthand Truth of Global Indicators*, available at www.law.nyu.edu/news/ideas/questioning-numbers-indicators-sally-merry-seductions-quantification.
[516] M. Green, 'What We Talk About When We Talk About Indicators: Current Approaches to Human Rights Measurement', (2001) 23 *Human Rights Quarterly* 1062, at 1076.
[517] Ibid., at 1076-7.

subject to varying conceptualisations. Sally Engle Merry views indicators as "audit technologies" that reframe social phenomena into ostensibly neutral, numerical terms, often stripping them of their context, and conceptualises them as instruments for new forms of governance and power.[518] She defines indicators as "statistical measures that are used to consolidate complex data into a simple number or rank that is meaningful to policy makers and the public. They tend to ignore individual specificity and context in favour of superficial but standardized knowledge. An indicator presents clearly the most important features relevant to informed decision making about one issue or question."[519] By contrast, Kevin E. Davis, Benedict Kingsbury and Sally Engle Merry jointly define an indicator as "a named collection of rank-ordered data that purports to represent the past or projected performance of different units. The data are generated through a process that simplifies raw data about a complex social phenomenon. The data, in this simplified and processed form, are capable of being used to compare particular units of analysis (such as states or institutions or corporations), synchronically or over time, and to evaluate their performance by reference to one or more standards."[520] This definition is particularly significant as it captures the dual nature of indicators: both as technical instruments for data organisation and as legally relevant assertions that shape the behaviour of different actors.

As discussing all existing definitions would not contribute significantly to the objectives of this work, they will not be cited or examined in detail. Nevertheless, it should be noted that all these definitions share one common feature: they present indicators as windows onto a broader reality or as inherently metaphorical.[521]

Notably, bodies using indicators tend to adopt their own definitions, aligned with the purposes for which the indicators are employed. As a result, indicators typically have functional rather than normative definitions. This pragmatic approach reflects the adaptability of indicators to the specific needs of the organisations or frameworks within which they are used. For example, the World Bank offers its own understanding of indicators, emphasising their practical utility over theoretical precision. According to the World Bank, indicators are tools designed to measure progress, facilitate comparison, and inform decision-making.[522] Rather than adhering

[518] S. E. Merry, 'Measuring the World', (2011) 52 *Current Anthropology* 83, at 88.
[519] Ibid., at 86.
[520] Davis et al., *supra* note 301, at 73-4.
[521] E. Andersen, H. O. Sano and the DIHR, *Human Rights Indicators at Program and Project Level - Guidelines for Defining Indicators, Monitoring and Evaluation* (2006), 10.
[522] McInerney-Lankford and Sano, *supra* note 302, at 15.

to a single definition, the World Bank adopts a functional approach, focusing on how indicators serve its operational objectives. These objectives align with the purposes of the institution, which include fostering economic development and promoting sustainable growth.[523]

Moreover, the World Bank advocates for the use of indicators as indispensable tools in development practice, arguing that they enhance accountability, improve transparency, and create a common language for evaluating progress.[524] Indicators such as the percentage of providers of core public services,[525] homicide rates,[526] or child stunting rates[527] serve not only as measures of development but also as signals for identifying areas requiring intervention. This emphasis reflects the World Bank's broader strategy of promoting evidence-based policymaking and fostering trust among stakeholders, donors, and civil society. By emphasising their relevance and adaptability, the World Bank demonstrates how indicators may be tailored to advance specific goals, persuade stakeholders to act, and provide a foundation for future development practices.

While indicators are functionally flexible, their frequent variation in definition and operationalisation across institutional contexts calls into question their comparability and universal applicability. If each body or framework defines indicators differently according to its needs, they can hardly be standardised across contexts or used to draw broader conclusions. As tools of governance, they are not static; their definitions and applications are shaped by the changing demands of societal progress and the priorities of their creators. This dynamism ensures that indicators remain relevant but also highlights the need for scrutiny of their design and application. Recognising that indicators are defined by their function seems crucial, as scholars and practitioners can better assess their strengths, limitations, and implications for human rights and governance practices.

Indicators are thus inherently pragmatic tools, being defined and shaped by the purposes they are intended to serve. The absence of a universal definition for indicators does not diminish the utility of indicators. Rather, it underscores their versality. In this study,

[523] See Art. 1 of 1944 The International Bank for Reconstruction and Development Articles of Agreement, 2 UNTS 134.
[524] McInerney-Lankford and Sano, *supra* note 302, at 16-17.
[525] Ibid., at 71.
[526] Ibid., at 69.
[527] Ibid., at 66.

indicators are identified as empirically grounded instruments of global governance, used to inform and assess performance linked to health-related human rights.

3. Typology of indicators

Indicators are usually classified into three interrelated categories: structural, process, and outcome indicators.[528] These three types of indicators are conceptually distinct yet operationally complementary, forming an interdependent system for policymaking, clarifying human rights obligations, and ensuring compliance with human rights commitments. Structural indicators primarily assess the formal legal and institutional commitments undertaken by a state, such as the ratification of international treaties or the constitutional guarantees of rights (3.1).[529] Process indicators examine the actions, policies, and interventions undertaken by states to implement their commitments and thus provide insight into state conduct and effort (3.2).[530] Outcome indicators, by contrast, focus on the tangible results of these actions and serve as proxies for the actual enjoyment of rights by individuals and groups within a state (3.3).[531]

The interplay between these types of indicators allows for triangulation and contextual interpretation, as no single type of indicator can independently provide a sufficient account of the realisation of human rights (3.4).[532] Structural indicators may reveal a state's intentions but fail to capture implementation, whereas outcome indicators may reflect rights violations or deprivations without attributing causality to state action or inaction.[533] The following parts examine each category of indicator in detail, with a view to evaluating their utility and practical limitations in assessing compliance with human rights obligations.

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[528] P. Hunt, *Interim Report of the Special Rapporteur of the Commission on Human Rights on the Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health*, UN Doc. A/58/427 (2003), para. 22.
[529] Ibid., at para. 18.
[530] Ibid., at paras. 22-5.
[531] G. de Beco, 'Human Rights Indicators for Assessing State Compliance with International Human Rights', (2008) 77 *Nordic Journal of International Law* 23, at 44.
[532] S. Walker, 'Challenges of Human Rights Measurement' in B. A. Andreassen, S. McInerney-Lankford and H. O. Sano (eds), *Research Methods in Human Rights* (2017), 306 at 326.
[533] de Beco, *supra* note 531, at 46.

3.1. Structural indicators

Structural indicators serve as basic tools for assessing state's *de jure* commitment to international human rights obligations, reflecting its formal adoption of legal and policy frameworks necessary for the implementation of rights.[534] These indicators primarily assess whether a state has ratified relevant international and regional human rights treaties, incorporated their provisions into domestic legislation, and established the requisite institutional mechanisms for enforcement and oversight.[535] By focusing on formal legal foundations, structural indicators can provide an assessment of the enabling environment that a state constructs to support the realisation of human rights.[536] Examples of such indicators include the ratification of core instruments such as the International Covenant on Civil and Political Rights (ICCPR) and the CEDAW.[537]

It appears crucial to investigate the extent to which a state has taken concrete steps to operationalise international human rights standards, thereby transforming them from abstract legal norms into functioning domestic practices. Accordingly, in addition to treaty ratification and legal incorporation, structural indicators may encompass the establishment of national human rights institutions, ombudsperson offices, anti-discrimination bodies, and national action plans relating to specific rights domains.[538]

However, the utility of structural indicators is subject to certain limitations. First, their reliance on formal legal texts and institutional declarations renders them useful for capturing the existence of legal and institutional commitments, yet they offer limited insight into whether such commitments translate into effective protection in practice. A state may formally adopt a treaty or establish an institution without allocating adequate resources, independence, or political support to ensure that these commitments are operational.[539] Moreover, structural indicators are frequently binary (e.g. treaty ratification: yes or no), which, while facilitating comparability, sacrifices the granularity necessary for meaningful evaluation. This binary logic

[534] Ibid., at 42.
[535] Hunt, *supra* note 528, at para. 19.
[536] UN OHCHR, *supra* note 297, at para. 17.
[537] P. Hunt, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: note by the Secretary-General,* UN Doc. A/59/422, 17-22.
[538] Hunt, *supra* note 528, at para. 20.

obscures differences in the quality of ratification or the practical capacity of the institutions established to achieve their intended objectives.

This gap between legal form and substantive function is well documented in empirical studies of human rights practice, which demonstrate that ratification does not necessarily correlate with compliance.[540] For example, states with high formal commitments may continue to perpetrate systemic violations, particularly where judicial enforcement is weak, civil society is constrained, or corruption undermines institutional integrity.[541] States may ratify treaties or establish institutions as part of reputational management strategies, seeking to enhance their international standing without implementing substantive change. Despite these limitations, structural indicators remain indispensable for certain purposes. First, they provide the legal and institutional reference points necessary for assessing the formal conditions under which rights can be claimed and adjudicated.[542] Second, they are relatively easy to collect and verify, given that their sources (such as treaty databases, constitutional texts, institutional charters) are often publicly available.[543] They function as a preliminary framework that underpins the development of more elaborate monitoring regimes, insofar as they reflect basic legal assumptions.

In conclusion, structural indicators must be considered alongside process and outcome measures in order to understand not only what a state has promised, but also whether and how these promises are translated into the effective fulfilment of rights. They provide a necessary, albeit insufficient, basis for assessing compliance with human rights obligations.

3.2. Process indicators

Process indicators are designed to assess measures and activities undertaken by states to implement their human rights obligations, focusing not on legal commitments or final outcomes, but rather on the means employed to give effect to normative standards.[544] They thus offer critical insight into the conduct of duty-bearers and serve as an essential tool for evaluating

[540] O. A. Hathaway, 'The Promise and Limits of the International Law of Torture', in S. Levinson (ed.), *Torture: A Collection* (2004), 199 at 207-9.
[541] E. M. Hafner-Burton, *Making Human Rights a Reality* (2013), 73
[542] de Beco, *supra* note 531, at 42.
[543] Ibid.
[544] Ibid., at 43.

whether a state is taking appropriate steps, within its available resources, to progressively realise rights.[545]

In contrast to structural indicators, which emphasise legal infrastructure, and outcome indicators, which focus on end results, process indicators examine the concrete efforts made by governments to operationalise rights through policies, programmes, and practices.[546] This includes the allocation of public budgets, the actual implementation of legislation and administrative guidelines, the training of relevant personnel, and the establishment of participatory and accountability mechanisms.[547] Examples of process indicators include the coverage of immunisation programmes, the proportion of births attended by skilled health personnel, or the proportion of law enforcement personnel trained in human rights.[548]

One of the advantages of process indicators is their capacity to differentiate between inability and unwillingness to comply with human rights norms. A low outcome, such as high infant mortality, may result either from a lack of capacity or from a failure to act; process indicators help to disentangle these possibilities by revealing the nature and quality of state interventions.[549] This distinction is particularly important in the context of economic, social and cultural rights, where obligations are subject to progressive realisation and conditioned by available resources, as stipulated in Article 2(1) of the ICESCR.

Nevertheless, the utility of process indicators is constrained by several methodological and epistemological challenges. First, they are often based on administrative data, which may be incomplete, unreliable, or selectively disclosed by states.[550] Administrative data alone are insufficient for a comprehensive appraisal of the human rights situation in any given context. Such data often fail to encompass the full spectrum of issues pertinent to the fulfilment and enjoyment of human rights. Moreover, their scope is typically restricted to individuals interacting with public service systems, thereby excluding significant portions of the

[545] Hunt, *supra* note 528, at para. 26.
[546] Hunt, *supra* note 537, at para. 75.
[547] K. Shields, 'Methods of Monitoring the Right to Food', in B. A. Andreassen, S. McInerney-Lankford and H. O. Sano (eds), *Research Methods in Human Rights* (2017), 333 at 348. Hunt, *supra* note 537, at paras. 74-5.
[548] de Beco, *supra* note 531, at 43. Hunt, *supra* note 537, at para. 74.
[549] UN OHCHR, *supra* note 297, at para. 20.
[550] G. de Beco, 'Human Rights Indicators: From Theoretical Debate to Practical Application', (2013) 5 *Journal of Human Rights Practice* 380, at 393–4.

population. The reliability of such data is further compromised by the potential for various forms of bias, including intentional distortion or misrepresentation.[551]

Moreover, there is a risk that process indicators are manipulated to signal compliance while masking underlying violations or policy failures. This is especially problematic when international funding or reputational incentives depend on the reporting of such indicators, encouraging states to overstate their efforts or selectively report certain type of measures.[552] Additionally, process indicators need to be disaggregated by gender, age, disability, ethnicity and other grounds. Such disaggregation is essential not only for identifying hidden patterns of discrimination and inequality, but also for enhancing both equity and accountability in rights implementation.[553] As the Paul Hunt has noted, only by using disaggregated indicators can states effectively evaluate which policies are working, where disparities persist, and how to adjust interventions accordingly.[554] Furthermore, the selection and use of process indicators must be guided by empirical relevance. Indicators that do not demonstrate adequate sensitivity to context or that cannot reliably measure progress lose their utility as monitoring tools.[555]

In sum, process indicators serve as a bridge between normative commitments and empirical outcomes, translating abstract rights into observable patterns of state conduct. Their ability to capture state efforts, however, demands caution. Yet their interpretive power is contingent upon transparency and integration with other types of indicators.

3.3. Outcome indicators

Outcome indicators focus on the actual enjoyment of human rights by individuals and groups within a society and are used to measure the tangible results of state actions or omissions in fulfilling their international human rights obligations.[556] Unlike structural and process indicators, which address commitments and efforts respectively, outcome indicators assess whether these have translated into real improvements in the lived experience of rights-holders.[557]

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[551] UN OHCHR, *supra* note 299, at 58.
[552] Merry, *supra* note 247, at 150.
[553] de Beco, *supra* note 531, at 30.
[554] Hunt, *supra* note 537, at para. 79.
[555] UN OHCHR, *supra* note 297, at para. 20.
[556] M. Satterthwaite and A. Rosga, *The Trust in Indicators: Measuring Human Rights* (2008), 43.
[557] de Beco, *supra* note 531, at 44.

Outcome indicators, moreover, are typically associated with an enjoyment-based approach to human rights, insofar as they prioritise the empirical and material fulfilment of rights over their formal legal recognition or administrative articulation.[558] This approach is relevant in the context of economic, social and cultural rights, where the framework established by the ICESCR combines the principle of progressive realisation with the requirement of measurable, continuous advancement. Outcome indicators, by capturing tangible improvements in the actual enjoyment of rights, may serve as tools for assessing compliance with this standard. Typical outcome indicators related to the right to health include quantitative measures such as the proportion of low-birth-weight live births, maternal and infant mortality rates, or the proportion of births attended by skilled health personnel.[559] In the realm of civil and political rights, outcome indicators may include the number of reported incidents of torture, enforced disappearances, or the percentage of eligible voters participating in elections.[560]

Despite their apparent clarity, outcome indicators face limitations. First, they are not inherently indicative of state compliance or non-compliance with its legal obligations.[561] For example, a high maternal mortality rate does not automatically entail a breach of Article 12 of the ICESCR (the right to health), unless it can be shown that the state failed to take adequate measures within its available resources to address the problem.[562] This illustrates that outcome indicators, while generally useful and illustrative, do not in themselves establish causality or intent.

Second, outcome indicators in isolation may obscure causal dynamics and misattribute responsibility. They are sensitive to factors beyond the control of the state, including natural disasters, global economic downturns, or armed conflict. As a result, their interpretation must be situated within a broader analytical framework that accounts for contextual and structural conditions.

In conclusion, outcome indicators contribute to the assessment of state compliance with international human rights obligations by reflecting the actual enjoyment of rights by individuals. Yet, when used in isolation, they may offer a partial or misleading account.

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[558] Ibid.
[559] Hunt, *supra* note 537, at para. 74.
[560] de Beco, *supra* note 531, at 44.
[561] Hunt, *supra* note 537, at paras. 17-26.
[562] Hunt, *supra* note 528, at paras. 28-9.

3.4. Triad of structural, process, and outcome indicators

In summary, structural indicators establish the legal and institutional foundations for rights implementation; process indicators evaluate the concrete measures undertaken to operationalise these commitments; and outcome indicators measure the actual impact of those measures on the lived experiences of rights-holders. A meaningful evaluation of a state's compliance with its international human rights obligations requires the integration of structural, process and outcome indicators into a coherent and interdependent analytical framework.[563] Collectively, they reveal not only theoretical (*de jure*) compliance with international human rights law but also its practical (*de facto*) observance. This tripartite model bridges the gap between legal obligations and empirical realities and provides a layered understanding of how rights are implemented in practice.

This approach has been endorsed by the OHCHR, which promotes the tripartite indicator framework as a reference standard for treaty body reporting and rights-based monitoring.[564] In practice, this model is employed by a range of prominent institutions, including the World Bank,[565] the WHO,[566] the UN Development Programme (UNDP)[567], and the European Union Agency for Fundamental Rights (FRA),[568] each of which utilises the tripartite typology to inform monitoring and evaluation practices.

However, combining indicators raises methodological challenges.[569] One unresolved issue concerns the determination of the relative weight to be accorded to each category of indicator.[570] The central question is whether outcome indicators should be accorded primacy as the principal measure of rights realisation, or whether greater weight should be given to structural and process indicators, insofar as they may reflect state effort and thus compensate

[563] UN OHCHR, *supra* note 299, at 85, 87.
[564] Ibid., at 19.
[565] McInerney-Lankford and Sano, *supra* note 302, at 18.
[566] WHO, *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies* (2010), 67, 80.
[567] T. Landman et al., *Indicators for Human Rights Based Approaches to Development in UNDP Programming: A Users' Guide* (2006), 22.
[568] FRA, *Implementing the UN Convention on the Rights of Persons with Disabilities: Human Rights Indicators - Guidance for Independent National Monitoring Frameworks* (2023), 17-25.
[569] See Landman, *supra* note 503, at 923.
[570] Ibid., at 910.

for potentially poor outcomes.[571] A further concern lies in ensuring that indicators are selected, interpreted and applied in a transparent manner. The reliability of indicators depends not only on methodological soundness but also on their responsiveness to local realities and to the perspectives of those directly affected.[572] This is crucial in contexts where certain rights-holders, such as indigenous peoples or persons with disabilities, are systematically marginalised within official data systems.[573] The following Section 10 will examine this problem in greater detail.

Accordingly, the structural-process-outcome model not only facilitates a complex assessment of compliance but also prompts a reconsideration of whether the underlying methodology is, or should be, sensitive to the specificities of different categories of rights. This raises a doctrinal and practical question: to what extent does the measurement of civil and political rights differ from that of economic, social and cultural rights, and does the persistence of this distinction retain analytical value within contemporary monitoring practice? The next section addresses these issues by examining the extent to which the tripartite typology accommodates, transcends, or renders obsolete such divisions.

4. Indicators across different categories of rights

In the discourse on human rights measurement, a traditional view has distinguished civil and political rights from economic, social, and cultural rights by characterizing the former as essentially 'negative' rights, requiring state abstention, and the latter as 'positive' rights, demanding affirmative state action.[574] Building on this distinction, a stereotypical assumption

[571] S. Fukuda-Parr, 'Indicators of Human Development and Human Rights – Overlaps, Differences ... and What about the Human Development Index?', (2001) 18 *Statistical Journal of the UN Economic Commission for Europe* 239, at 239–48.

[572] B. Feiring and S. König-Reis, *Indicators and Data for Human Rights and Sustainable Development: A Practical Approach to Leaving No One Behind* (2019), 11, 16.

[573] See *Poor People Living with Disabilities Are Counting on Better Data for Better Lives* (2025), available at www.theguardian.com/global-development/2015/dec/03/international-day-persons-disabilities-poor-people-disabilities-better-data-better-lives.

[574] The division between positive and negative human rights, formerly fundamental to legal and moral philosophy, is now barely preserved. The pivotal moment occurred in 1980 with the release of Henry Shue's Basic Rights: Subsistence, Affluence, and United States Foreign Policy. In this foundational text, Shue asserted that states must fulfil both obligations of actions as well as inaction to effectively uphold human rights, undermining a binary classification of rights as entirely positive or negative. See H. Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy: 40th Anniversary Edition* (2020).

emerged that the indicators required to monitor civil and political rights[575] should differ fundamentally from those used for economic, social, and cultural rights, as the former are typically associated with obligations of immediate implementation, whereas the latter are subject to the principle of progressive realisation under Article 2(1) of the ICESCR, albeit with certain core obligations taking effect immediately.[576] Accordingly, the implementation of civil and political rights was considered to rely primarily on governmental restraint (for example, respecting freedom of speech by refraining from censorship), whereas the fulfilment of economic and social rights depended on proactive measures by the state (for instance, providing public education or healthcare).[577]

If such a dichotomy were extended into the domain of measurement, one might expect indicators for civil and political rights to focus on the occurrence of violations or the existence of legal and institutional safeguards, in line with the understanding that these rights primarily entail obligations of non-interference.[578] Conversely, indicators for economic, social, and cultural rights would be expected to draw on socio-economic data, such as literacy rates, health outcomes, or levels of social spending, reflecting their association with progressive realisation.[579] A closer examination, however, reveals that this dichotomy is not reflected either in measurement practice or in the relevant literature.[580] A given civil or political right (e.g. the right to life) can be monitored through structural indicators (e.g. date of entry into force and coverage of domestic laws implementing the right to life, time frame and coverage of national policy on health and nutrition), process indicators (e.g. proportion of formal investigations of law enforcement officials resulting in disciplinary actions or prosecution during the reporting period, proportion of the targeted population covered by public nutrition supplement programmes), and outcome indicators (e.g. number of homicides and life-threatening crimes per 100,000 population, prevalence of and death rates associated with communicable and non-communicable diseases).[581]

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[575] In contemporary political philosophy, the first generation of human rights is often regarded as anachronistic, in the sense that it requires supplementation by rights of later generations, and as tailored to the liberal worldview of the nineteenth century; see Bała and Wielomski, *supra* note 54, at 79. See also Tabaszewski, *supra* note 312, at 36, 64.

[576] Green, *supra* note 516, at 1091.

[577] Orzeszyna et al., *supra* note 425, at 60-1.

[578] Green, *supra* note 516, at 1092.

[579] Ibid.

[580] Ibid.

[581] UN OHCHR, *Report on Indicators for Promoting and Monitoring the Implementation of Human Rights*, UN Doc. HRI/MC/2008/3 (2008), 22.

Likewise, the classification of indicators into structural, process, and outcome categories provides a widely used method for assessing the implementation of economic and social rights. Taking the right to education as an example, structural indicators might include whether the state has ratified relevant international treaties, the date of their entry into force, and the extent to which the right is enshrined in the national constitution or other superior legal instruments. Process indicators may include the proportion of complaints concerning the right to education investigated by national human rights institutions and the effectiveness of governmental responses, as well as the average salary of schoolteachers expressed as a percentage of the statutory minimum wage. Finally, outcome indicators might include the ratio of girls to boys in primary education by grade level, or the proportion of women and members of targeted groups holding a professional or university degree.[582] In other words, the process of setting indicators does not inherently differ between civil and political rights and economic, social and cultural rights, even if the substantive content and contextual focus of specific indicators may vary.

Consequently, rather than adhering to dichotomies, practice reflects the absence of any distinct or exclusive set of rules for developing indicators tailored specifically to either civil and political or economic, social, and cultural rights. While some differences in emphasis and contextual relevance may persist, there is no separate catalogue of norms governing indicator formulation for each category. Instead, indicators are generally grounded in common principles and objectives. Their use should always reflect the integrated and interdependent nature of all human rights. This convergence in measurement practice may invite a cautious reconsideration of whether long-standing distinctions between categories of rights remain relevant within contemporary human rights monitoring.[583] At the same time, it exposes another challenge: distinguishing human rights indicators from development indicators that may rely on similar datasets yet rest on different normative premises and serve different functions. The next section examines this distinction, considering both the conceptual and practical implications of adapting development indicators for human rights monitoring.

[582] UN OHCHR, *supra* note 299, at 105.

[583] See P. Alston, 'Putting Economic, Social, and Cultural Rights Back on the Agenda of the United States', (2009) 22 *Center for Human Rights and Global Justice Working Paper* 1.

5. Human rights indicators and development indicators

The increasing[584] use of indicators in human rights monitoring raises questions about how they differ from development indicators,[585] particularly in the context of economic, social and cultural rights.[586] Although both types of indicators may, at times, draw on similar datasets and measure overlapping aspects of reality (such as access to health care, education, or adequate housing) their foundations and functions differ.[587] Human rights indicators are, by definition, anchored in legal obligations and serve the specific function of assessing the extent to which duty-bearers fulfil those obligations.[588] In contrast, development indicators are typically goal-oriented and operate within broader planning and evaluation frameworks that may lack legal clarity or enforceability,[589] although they may also be anchored in legal commitments. This section examines the implications of these differences, with particular attention to the challenges of repurposing development indicators for use in human rights assessments.

A defining feature of human rights indicators lies in their normative foundation: they are derived from specific legal obligations, as articulated in international human rights treaties and further clarified through general comments and interpretive statements issued by treaty-monitoring bodies[590]. In contrast, development indicators are typically developed by international financial institutions or development agencies, based primarily on considerations of statistical measurability and policy relevance rather than direct derivation from legal norms.[591] For instance, an indicator measuring school enrolment rates becomes a human rights indicator only when it is clearly linked to the state's obligation under Article 13 of the ICESCR and interpreted in light of General Comment No. 13.[592] A similar pattern can be observed with

[584] UN OHCHR, *supra* note 299, at III.
[585] This distinction is functional rather than substantive. An identical indicator may operate within a development framework or within a human rights framework depending on its normative anchoring and the purpose for which it is deployed.
[586] Green, *supra* note 516, at 1089-90.
[587] Ibid., at 1089.
[588] de Beco, *supra* note 531, at, at 27.
[589] Green, *supra* note 516, at 1090.
[590] de Beco, *supra* note 531, at 28. F. López-Bermúdez, 'Creating and Applying Human Rights Indicators', in D. Shelton (ed.), *The Oxford Handbook of International Human Rights Law* (2013), 873 at 885.
[591] Green, *supra* note 516, at 1090.
[592] S. Kalantry, J. E. Getgen and S. A. Koh, 'Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR', (2010) 32(2) *Cornell Law Faculty Publications* 254, at 254. G. de Beco, P. Hyll-Larsen and M. Ron Balsera, *The Right to Education: Human Rights Indicators and the Right to Education of Roma Children in Slovakia*, 2010/ED/EFA/MRT/PI/19 (2009), 9. De Beco, *supra* note 531, at 29.

indicators such as maternal mortality ratios or vaccination coverage rates: although created for policy planning, they are now routinely cited by the CESCR as process indicators for the right to health when reinterpreted in light of Article 12 of the ICESCR and General Comment No. 14.[593] Without such normative anchoring, the indicator merely describes a social fact without capturing the state's obligation to ensure free and compulsory primary education.[594]

This distinction, however, is not always clearly maintained in practice. As Maria Green observes, much of the statistical infrastructure used by human rights bodies, including data from the UNDP, the World Bank, or the WHO, originates in the development field and was not designed with legal obligations in mind.[595] Even UN human rights treaty bodies, such as the CESCR, routinely cite development indicators in their concluding observations, thereby blurring the line between descriptive and normative measurement.[596] In doing so, they often seek to fill evidentiary gaps, particularly in contexts where data generated specifically for human rights monitoring are unavailable or insufficient. In this respect, some commentators have argued for convergence between the two domains, emphasizing complementarity rather than opposition[597]. Nonetheless, if development indicators are to serve human rights purposes, they must be carefully reinterpreted in light of legal standards so that their content reflects normative obligations rather than mere policy preferences.[598]

A further difference concerns the issue of non-discrimination. While development indicators often present aggregate outcomes, they rarely address disparities in access or outcomes between groups.[599] Human rights indicators, by contrast, must incorporate disaggregated data along prohibited grounds of discrimination, including sex, age, disability, ethnicity, or socio-economic status.[600] A literacy rate, for instance, may reflect educational development, but it cannot serve as a human rights indicator unless it also reveals whether women, minorities, or rural populations are disproportionately excluded from educational

[593] UN OHCHR, *supra* note 299, at 90.
[594] See *Indicators of Education Systems Programme (INES)*, available at www.oecd.org/en/about/programmes/ines.html#about.
[595] Green, *supra* note 516, at 1089.
[596]See UN CESCR, *UN Committee on Economic, Social and Cultural Rights: Concluding Observations: Canada*, E/C.12/1/Add.31, (1998). UN CESCR, *UN Committee on Economic, Social and Cultural Rights: Concluding Observations, Canada*, E/C.12/CAN/CO/4; E/C.12/CAN/CO/5 (2006). UN CESCR, *UN Committee on Economic, Social and Cultural Rights: Concluding Observations: Germany*, E/C.12/DEU/CO/6 (2018).
[597] T. B. Jabine and R. P. Claude, *Human Rights and Statistics: Getting the Record Straight* (1992), 12.
[598] de Beco, *supra* note 531, at 29.
[599] Ibid.
[600] UN OHCHR, *supra* note 297, at para. 21.

opportunities.[601] Thus, a core function of human rights indicators is not merely to quantify outcomes but to reveal patterns of structural exclusion and thereby operationalize the principle of equality.[602]

Nonetheless, development indicators can sometimes function as complementary tools in a human rights context, provided they are reinterpreted in light of human rights standards.[603] For example, budget allocations to maternal health may be treated as a development indicator, but if analysed through the lens of Article 12 of the ICESCR and General Comment No. 14, they can also serve as process indicators for the right to health.[604] In this sense, what distinguishes human rights indicators from development indicators is not necessarily the type of data they rely on but rather the normative framework within which they are interpreted and the function they are intended to serve. Thus, indicators originating in the development field can serve as human rights indicators when they are reinterpreted in light of legal standards, disaggregated to reveal inequality and developed or reviewed in consultation with affected populations or independent experts so as to ensure transparency.

6. Differentiating tools: indicators, benchmarks, and indices

As the practice of human rights monitoring becomes increasingly reliant on diverse tools, it is necessary to distinguish 'indicators' from adjacent and often conflated concepts such as benchmarks and indices. Although these categories share certain features, their meaning and functions within human rights governance differ.

At first glance, the distinction between indicators and benchmarks appears analytically robust. Benchmarks are commonly described as prescriptive in nature: they denote specific objectives or intended outcomes that a state undertakes to achieve in fulfilling its human rights obligations.[605] They concretize treaty norms in a time-bound and context-sensitive manner,

[601] de Beco, *supra* note 531, at 29.
[602] UN OHCHR, *supra* note 299, at 39.
[603] T. Landman, 'The Scope on Human Rights: From Background Concepts to Indicators', (2005) 2 *Revista Iberoamericana De Derechos Humanos* 109, at 134-6.
[604] López-Bermúdez, *supra* note 590, at 885.
[605] G. de Beco, *supra* note 531, at 47.

functioning as legal yardsticks for evaluating progress.[606] As Maria Green notes, "Benchmarks can be defined as goals or targets that are specific to the individual circumstances of each country. As opposed to human rights indicators, which measure human rights observation or enjoyment in absolute terms, human rights benchmarks measure performance relative to individually defined standards."[607] Therefore, indicators assume a primarily (though not exclusively) diagnostic role: they assess the prevailing state of rights enjoyment or institutional compliance, thus providing empirical baselines upon which benchmarks are subsequently constructed.

However, building on the theoretical insights of Kevin E. Davis, Benedict Kingsbury and Sally Engle Merry (as it will be discussed in Chapter V), this dichotomy proves to be more porous than it initially appears. Indicators are rarely purely descriptive or neutral, in the sense of being free from any hidden agenda. The selection and construction of indicators always reflect underlying assumptions about what should be measured and why to measure it. These decisions rest on implicit judgments regarding which aspects of reality deserve attention and how performance should be evaluated. As a result, indicators tend not only to describe existing conditions but also to suggest how they ought to look, thereby exerting prescriptive influence even in the absence of explicit legal mandates. This view is reinforced by the UN OHCHR, who acknowledges that "human rights indicators can serve multiple purposes at the national level: (a) They set objective benchmarks against which human rights can be monitored, […]"[608] thereby recognizing that indicators often perform benchmark-like functions even absent formal designation.

Consequently, the relationship between indicators and benchmarks should be understood as fluid and iterative rather than strictly dichotomous.[609] While indicators can

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[606] See for example Corporate Human Rights Benchmark, *Corporate Human Rights Benchmark 2023 Insights Report* (2023). This initiative is part of the broader work of the World Benchmarking Alliance, which evaluates the performance of leading global corporations in meeting their human rights responsibilities, as articulated in the UN Guiding Principles on Business and Human Rights. The overarching goal of this benchmarking process is to incentivize corporate accountability by creating transparency, encouraging competition in responsible business conduct, and enabling stakeholders (including investors, regulators, and civil society) to compare corporate performance and exert informed pressure for improvement.

[607] Green, *supra* note 516, at 1080.

[608] UN OHCHR, *Monitoring Economic, Social and Cultural Rights. Manual on monitoring* (2015), 9.

[609] A useful illustration can be found in the work of the WHO during the COVID-19 pandemic. The Strategic Preparedness and Response Plan included different indicators that did not merely describe the situation on the ground; they also helped establish expectations as to what constituted an adequate response, effectively shaping the evolving benchmarks against which state performance was judged. See WHO, *infra* note 858.

inform the construction of benchmarks, they also embody legal assumptions that shape how compliance is defined and assessed. In this sense, indicators do not merely inform the process of norm-setting; they participate in it. Rather than treating indicators and benchmarks as categorically distinct, it is more accurate to regard them as interdependent and overlapping categories of global governance tools.

A second distinction concerns the difference between indicators and indices. Indicators are typically used to measure specific aspects of a given situation, often in isolation and without necessarily facilitating direct cross-national comparison. Indices, by contrast, are constructed for the purpose of comparison; they combine multiple indicators into a single score intended to rank or classify, for example, states or regions.[610] This comparative function gives indices their appeal, particularly for international actors seeking to summarise complex realities in a form conducive to global benchmarking. Their value lies in simplification and communicability.[611] For example, the Human Development Index (HDI) compresses diverse data points into digestible numerical scores. However, this very act of compression introduces a range of methodological and legal concerns. As Robert Justin Goldstein cautions, indices may convey a "false precision" that obscures the qualitative complexity of human rights realities. Small differences in composite scores may carry undue interpretive weight despite being statistically insignificant or methodologically unstable.[612] Indices are also susceptible to ideological bias. The choice of constituent indicators, their respective weights, and aggregation techniques are often opaque and contingent upon the legal or policy priorities of the compilers. The Freedom House index, for instance, has been criticized for underreporting rights violations in non-communist regimes while overstating those in others.[613] As such, indices, unlike indicators, are not merely tools of measurement but also of narrative construction, often with implicit geopolitical or ideological valences. While they are sometimes endorsed for their comparative utility, particularly by UN programs such as the UN Development Assistance Framework Guidance (UNDAF), their limitations, as outlined above, warrant attention.

In sum, distinguishing indicators from benchmarks and indices is not merely a taxonomic task. Generally, indicators serve as tools of observation and interpretation,

[610] Jabine and Claude, *supra* note 597, at 28.
[611] Green, *supra* note 516, at 1082.
[612] R. J. Goldstein, 'The Limitations of Using Quantitative Data in Studying Human Rights Abuses', (1986) 8 *Human Rights Quarterly* 607, at 626-7.
[613] Ibid., at 620-1.

benchmarks as tools of evaluation, and indices as tools of comparison. Yet these distinctions are not always rigid in practice. Depending on how they are operationalized, certain instruments may acquire the functional characteristics of others; indicators may embody evaluative functions akin to benchmarks, and benchmarks may be constructed from aggregated indicators resembling indices. This functional permeability underscores the necessity of critically examining not only what indicators are but also how they are constructed, selected, and applied in practice. The following section turns to this methodological dimension, examining the principal approaches to indicator development and use within the human rights field.

7. Constructing indicators

Having clarified the distinctions in meaning and use between indicators and related tools such as benchmarks and indices, the analysis now turns to the process through which indicators are operationalized in human rights practice. This section examines the methodological and legal steps involved in this translation, beginning with the anchoring of indicators in treaty-based obligations, the identification of legally salient attributes, and typological differentiation. It further considers the role of cross-cutting human rights norms and the epistemic assumptions embedded in decisions concerning quantification. The aim is to illuminate the layered process through which indicators emerge not only as monitoring tools but also as mechanisms that shape the meaning of human rights standards.

As illustrated by international practice, the process of constructing legally relevant indicators begins with the foundational requirement of anchoring any proposed quantification in the legal content of the right in question, as established in relevant treaty provisions and elaborated by treaty bodies through general comments and jurisprudence.[614] This step is crucial to preserving human rights standards and avoiding the dilution of their legal relevance through decontextualized measurement practices.[615] Given that treaty provisions are often formulated in general terms, an intermediate stage is required: the identification of a finite set of key attributes that encapsulate the core legal components of a given right.[616] On the one hand, these attributes render the content of rights more tangible and operational by categorizing abstract

[614] UN OHCHR, *supra* note 297, at para. 13. De Beco, *supra* note 531, at 27.
[615] McGrogan, *supra* note 512, at 388.
[616] UN OHCHR, *supra* note 297, at para. 14. McGrogan, *supra* note 512, at 389.

norms into concrete dimensions.[617] On the other hand, they provide a structured template for selecting indicators, thereby reducing conceptual ambiguity in the monitoring process.[618] For instance, the right to life, as derived from Article 6 of the ICCPR and General Comment No. 6, has been disaggregated into attributes such as arbitrary deprivation of life, disappearances, health and nutrition, and the death penalty.[619] Although analytically derived from the right as a whole, each attribute lends itself to distinct forms of data collection and policy monitoring, for example: legal safeguards against extrajudicial killings (arbitrary deprivation of life), mechanisms for tracing the disappeared (disappearances), public health expenditures and outcomes (health and nutrition), or moratoria on capital punishment (death penalty).

Yet the identification of attributes alone does not suffice. In order to assess the implementation of each attribute in empirical terms, it is necessary to articulate corresponding indicators that reflect different dimensions of state action and responsibility. As noted in Section 3, these indicators typically fall into one of three categories – structural, process, and outcome indicators – each capturing a specific aspect of the realization of human rights.[620] This threefold typology of indicators aims to bridge the conceptual gap between legal obligations and empirical measurement by linking the intent, efforts, and results of human rights implementation within a single framework.[621] However, this linkage does not presuppose a strict causal relationship, as the realization of one right often depends on the fulfilment of others, given the indivisibility and interdependence of human rights.[622]

Another step in the operationalization process is to incorporate general human rights principles (such as non-discrimination, participation, accountability) into the way indicators are selected and designed.[623] This requires the use of disaggregated data by prohibited grounds of discrimination and an emphasis on access, not merely availability, of goods and services.[624] Indicators must measure not only whether rights are being fulfilled but also whether they are fulfilled equitably and inclusively.[625] Incorporating these cross-cutting principles complicates indicator design, but it is indispensable if the results are to reflect the structural and procedural

[617] UN OHCHR, *supra* note 297, at para. 14.
[618] de Beco, *supra* note 531, at 27.
[619] UN OHCHR, *supra* note 297, at para. 15. McGrogan, *supra* note 512, at 389.
[620] UN OHCHR, *supra* note 297, at para. 16. López-Bermúdez, *supra* note 590, at 885.
[621] UN OHCHR, *supra* note 297, at para. 20.
[622] Ibid., at para. 13.
[623] UN OHCHR, *supra* note 297, at para. 21. De Beco, *supra* note 531, at 27.
[624] UN OHCHR, *supra* note 297, at para. 21.
[625] Ibid., at para. 21.

dimensions of human rights obligations rather than solely outcomes.[626] For instance, an indicator measuring access to primary education cannot be limited to enrolment rates alone; it must be disaggregated by gender, ethnicity, disability, and geographic location to reveal whether certain groups face systemic exclusion, thereby addressing both non-discrimination and substantive equality.

Beyond these formal steps, the design of indicators is also shaped by implicit theoretical and political choices of their creators (usually so-called expert bodies), which often remain unexamined.[627] The decision to prioritize quantitative over qualitative indicators, for instance, is rooted in a preference for objectivity, verifiability, and cross-national comparability.[628] However, such preferences risk obscuring legal and contextual nuances, especially in domains where subjective experience and participatory processes are central to the right in question.[629] The predominance of statistical forms of knowledge may also marginalize local epistemologies and reduce rights-holders to mere data points.[630]

Notably, if indicators are used for the purpose of human rights protection, their development should be firmly grounded in the legal obligations undertaken by states under international human rights treaties. This requires linking each indicator to treaty provisions, general comments, and authoritative jurisprudence, as well as ensuring the institutional capacity for data collection, interpretation, and participatory validation.[631] Without such anchoring, there is a risk of reducing human rights to vague developmental aspirations rather than to enforceable legal standards of international law.[632]

8. Universality of indicators

An important question in the construction of indicators concerns their universality. Some scholars and practitioners advocate the establishment of universal indicators (common to all states) to enable cross-national comparison and benchmarking, which may enhance

[626] Ibid., at paras. 20-1.
[627] McInerney-Lankford and Sano, *supra* note 302, at 14.
[628] McGrogan, *supra* note 512, at 388.
[629] McInerney-Lankford and Sano, *supra* note 302, at 15. Green, *supra* note 516, at 1089.
[630] McInerney-Lankford and Sano, *supra* note 302, at 14-15. Green, *supra* note 516, at 1089-91.
[631] de Beco, *supra* note 531, at 27.
[632] Green, *supra* note 516, at 1091.

transparency and accountability through reputational incentives.[633] By making states' performance publicly visible and comparable, universal indicators could also generate reputational incentives that, over time, may encourage improved compliance with international human rights obligations. However, the imposition of externally designed tools may obscure local realities and reproduce power asymmetries, thereby undermining the credibility of the monitoring process.[634] Thus, the risks of epistemic colonialism and measurement bias (particularly when indicators are detached from national contexts, which may be of paramount importance in case of the Global South), must be underscored.[635] This issue will be further examined in Chapter V.

Gauthier de Beco argues that the development of universal indicators is problematic, as such indicators fail to account for disparities in states' capacities and levels of development.[636] In his view, universal indicators would measure a state's level of development rather than its compliance with international obligations, thereby unfairly favouring wealthier nations.[637] Consequently, de Beco advocates a dual approach, combining universal indicators for immediate obligations with state-specific indicators calibrated to states' maximum available resources.

While de Beco's concerns regarding equity and context sensitivity are valid, his scepticism regarding the potential of universal indicators cannot be fully endorsed. By their nature, international human rights norms establish a uniform standard of rights performance.[638] Although the pace and means of realization may differ depending on national circumstances, the legal ideal remains constant. Therefore, universal indicators serve a crucial function: they articulate in concrete terms the legal ideals embedded in international human rights law, providing a clear point of reference. Acknowledging that some states will achieve these standards more readily than others does not negate the necessity of having a shared point of

[633] Merry, *supra* note 247, at 166, 205.
[634] Davis et al., *supra* note 301, at 72, 76-7, 81.
[635] Merry, *supra* note 247, at 4-5.
[636] de Beco, *supra* note 531, at 46.
[637] Ibid.
[638] Preamble to the UDHR states: "The General Assembly proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction." See also UN OHCHR, *supra* note 299, at 44.

reference; rather, it underscores the role of indicators in tracing the trajectory of realisation and identifying gaps in compliance.

This theoretical point is corroborated by developments in human rights monitoring practice. As AnnJanette Rosga and Margaret L. Satterthwaite observe, despite initial aspirations for participatory and context-specific indicator development, the OHCHR framework ultimately acknowledges the need for a core set of universally applicable indicators, that are complemented by context-specific measures.[639] The OHCHR envisages a model in which universal indicators provide a common evaluative baseline, ensuring coherence and comparability, while allowing additional flexibility to address particular national circumstances.[640] Thus, universal indicators not only exist in theory but are also incorporated into contemporary human rights monitoring practice. They remain important for preserving the legal universality of human rights standards while being pragmatically adapted to diverse implementation contexts.

9. Sources of data on human rights events

To measure human rights performance credibly, states must prioritise the systematic collection of data on human rights violations, a foundational step explicitly emphasised by treaty bodies as essential for implementing human rights obligations.[641] Such data can take various forms, namely quantitative and qualitative information. While quantitative data often requires contextual interpretation through qualitative insights, qualitative data gains robustness when substantiated by statistical analysis. Depending on its source, such data may be classified as objective, when grounded in observable facts, or subjective, when reflecting personal perceptions. Due to the lack of or difficulties in obtaining reliable human rights data, combining different types is essential for understanding of given situation. Such data can be grouped into three categories: events-based data (9.1), socio-economic data (9.2), and household and expert opinions (9.3), each differing in characteristics.[642]

[639] Satterthwaite and Rosga, *supra* note 556, at 48.
[640] UN OHCHR, *supra* note 299, at 44.
[641] Art. 40(1) of the ICCPR, Art. 18(1) of the CEDAW, Art. 16 of the ICESCR. See also CESCR, *supra* note 315, at para. 16. UN CESCR, *supra* note 501, at para. 37.
[642] de Beco, *supra* note 531, at 35.

9.1. Events-based data

Events-based data focuses on individual incidents and provides objective, qualitative insights, predominantly relating to civil and political rights.[643] It records details concerning what occurred, the persons affected, the actors responsible, and the circumstances surrounding the event.[644] Such data can be disaggregated into individual violations, enabling the identification of trends and patterns, rather than absolute magnitudes, in the protection of human rights within a given state.[645] One of the most widely used mechanisms for gathering events-based data is HURIDOCS, which employs so-called Event Standard Format[646] to record human rights-related occurrences, documenting particulars such as location, time, victims, and alleged perpetrators. Such data are collected by human rights documenters, often affiliated with NGOs or legal teams, through interviews, surveys, and direct observation. Priority is accorded to first-hand sources (victims, perpetrators, witnesses), as their testimonies possess greater evidentiary value than hearsay.[647] In addition to oral accounts, primary documents such as affidavits, letters, or transcripts are utilised when available.[648] These materials may originate from courts, archives, or investigative files. Secondary and tertiary sources, including news articles and bibliographies, serve primarily to contextualise or identify relevant information.[649]

Events-based analysis has been applied in various contexts to document and estimate the human impact of armed conflicts and other crises. For example, it has been used to trace the progression of the Rwandan genocide, to calculate civilian mortality rates before and after the invasion of Iraq in March 2003, and to estimate the total number of civilian deaths resulting from the war in Iraq.[650]

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[643] Ibid.
[644] Landman, *supra* note 603, at 128.
[645] Ibid., at 129.
[646] This approach to documentation relies on organizing information about human rights violations around the concept of 'events.' An event is understood as one or more actions, either acts of commission or omission, that lead to or constitute violations of human rights. These actions are analysed individually or in connection with related incidents to form a cohesive event. The methodology unfolds in two key phases. The first phase involves establishing a conceptual framework to determine how the information will be categorized and structured. The second phase focuses on gathering and completing the data for each identified category, ensuring a comprehensive and systematic documentation process. See J. Dueck et al., *HURIDOCS Events Standard Formats: A Tool for Documenting Human Rights Violations* (2001), 20.
[647] M. Guzman and B. Verstappen, *What Is Documentation* (2003), 16.
[648] Ibid.
[649] Ibid.
[650] Ibid., at 130.

Despite its utility, events-based data is often limited by its incompleteness, rendering it insufficient to provide a comprehensive picture of the human rights situation in a given state. It tends to highlight patterns rather than to provide a full account of the scale of violations. The available data may also be unreliable or misleading due to deliberate omissions or distortions. The absence of key information – such as unrecorded deaths, manipulated statistics, or suppressed documentation – can in itself indicate intentional efforts by state authorities to conceal human rights violations.[651]

9.2. Socio-economic data

Socio-economic data, also referred to as statistical data, is generally widely available and provides an overall depiction of living conditions within a state.[652] Unlike events-based data, it does not focus on individual violations but instead provides a general indication of the extent to which human rights are enjoyed across the population. This type of data, principally objective and quantitative, is particularly relevant to the analysis of economic, social, and cultural rights.[653]

Numerous international organisations, including the UN Educational, Scientific and Cultural Organization (UNESCO), the UNICEF, the ILO,[654] the FAO, the World Bank, and the WHO, collect statistical data as part of their respective mandates.[655] For example, the World Bank has compiled and disseminated an extensive range of socio-economic statistics, primarily sourced from national statistical systems.[656] It has also compiled data on governance and the rule of law, drawing on information obtained through expert analyses and household surveys.[657]

Statistical data is often collected to evaluate the level of a state's development. Its primary limitation lies in its design and purpose, as it is not specifically linked to human rights treaty standards or disaggregated into specific groups. Nevertheless, statistical data can be

[651] A. M. Clark and K. Sikkink, 'Information Effects and Human Rights Data: Is the Good News about Increased Human Rights Information Bad News for Human Rights Measures?', (2013) 35 *Human Rights Quarterly* 539, at 545, 550-4.
[652] de Beco, *supra* note 531, at 36.
[653] Ibid.
[654] On the significant role of the ILO in the context of the protection of the right to health, see S. Poździoch, *Prawo do ochrony zdrowia w standardach Międzynarodowej Organizacji Pracy* (2007), 63.
[655] See Merry, *supra* note 518, at 85.
[656] R. Malhotra and N. Fasel, *Quantitative Human Rights Indicators – A Survey of Major Initiatives* (2005), 15.
[657] Ibid.

valuable for human rights analysis when appropriately adapted. It can serve as a proxy for assessing the broader context in which indicators operate, thereby illuminating environments that are conducive to or that hinder the realisation of human rights. Moreover, it can reflect the extent to which governments implement policies that support the realisation of human rights.[658]

9.3. Household and expert opinions

Household perceptions and expert judgments constitute distinct yet complementary forms of qualitative and subjective data, each offering unique insights into the analysis of human rights compliance.

Household perceptions capture general public opinion, frequently expressed in narrative form.[659] While inherently subjective, these opinions can be aggregated and analysed to yield quantitative insights and may even attain a degree of objectivity when grounded in observable facts.[660] Household perceptions can serve to validate, challenge, or enrich findings derived from other data sources. For example, the Eurobarometer survey series, established by the European Commission, the European Parliament and other EU institutions and agencies collects data on public opinion across EU member states.[661] It explores a range of topics, including perceptions of democracy, governance, and socio-economic issues, some of which may indirectly relate to human rights. Although not specifically designed to measure human rights, Eurobarometer offers valuable insights into public attitudes that can complement analyses of human rights. For instance, its surveys often examine citizens' trust in institutions, concerns regarding equality and discrimination, and perceptions of political participation, all of which are pertinent to understanding the broader context in which rights are realised.[662] The potential of household perceptions as a data source is, however, limited by their reliance on sampled opinions and by the variability of public understandings of human rights across states.[663]

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[658] Landman, *supra* note 644, at 123, 134
[659] de Beco, *supra* note 531, at 37.
[660] Ibid.
[661] *Eurobarometer: About Eurobarometer*, available at www.europa.eu/eurobarometer/about/eurobarometer.
[662] See European Commission, *Gender Stereotypes – Violence against Women* (2024).
[663] Economic Commission for Latin America, *Recommendations for Measuring Perceptions in Household Surveys* (2024), 13.

Expert judgments, by contrast, provide insights from professionals and institutions with specialisation in human rights. Such evaluations, often originating from research centres, NGOs, or media outlets, represent the informed assessments of analysts and practitioners.[664] An example of an expert-driven report is the Global State of Democracy Reports published by the International Institute for Democracy and Electoral Assistance.[665] These reports are prepared exclusively by researchers and analysts, who evaluate global and regional democratic trends, including elements of human rights and governance.[666] They draw upon expert assessments, academic studies, and institutional analyses to provide comprehensive insights into the quality of democracy and its alignment with fundamental human rights principles. Similarly, reports issued by Amnesty International and Human Rights Watch exemplify expert opinions, as they provide information on human rights violations based on extensive field research and professional expertise.[667]

In sum, effective human rights monitoring depends not only on the careful selection of indicators, but also on the integration of multiple data sources – quantitative and qualitative as well as objective and subjective. Each type of data contributes distinct insights: events-based records reveal patterns of violations; socio-economic statistics expose structural conditions, while household perceptions and expert judgments provide contextual depth. However, the mere availability of data is not sufficient. Where data is incomplete or biased, the actual state of human rights compliance may remain obscured.

However, even if data is accessible, it may fail to capture the experiences of those most affected by discrimination or marginalisation. This underscores the importance of data disaggregation. The following section addresses this issue, examining how disaggregation enhances the visibility of inequality and facilitates a more accurate evaluation of state compliance with human rights obligations.

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[664] de Beco, *supra* note 531, at 38.

[665] *About International IDEA*, available at www.idea.int/about-us.

[666] International IDEA, *What We Offer* (n.d.), 1.

[667] See D. Cingranelli and D. L. Richards, 'Measuring Government Effort to Respect Economic and Social Human Rights: A Peer Benchmark', in L. Minkler and S. Hertel (eds.), *Economic Rights: Conceptual, Measurement, and Policy Issues* (2007), 214.

10. Disaggregation of data

A crucial dimension in rendering indicators an effective tool for the protection of human rights lies not only in determining what they measure but also in establishing how they measure it. One particularly significant methodological aspect in this regard is the disaggregation of data. The imperative to disaggregate data in the assessment and monitoring of human rights derives from the fundamental principle of non-discrimination. This principle, which permeates all branches of international human rights law, requires that both the formulation of public policy and its evaluation be sensitive to the differentiated impacts experienced by various social groups.[668] In this regard, disaggregated data functions as an instrument to uncover patterns of inequality and exclusion that would otherwise remain obscured by average numbers.[669] As exemplified by health indicators such as infant mortality rates, aggregated figures may conceal substantial disparities. For instance, while national data may indicate overall progress, mortality rates among children from the poorest quintiles frequently remain disproportionately high.[670] For this reason, disaggregated data collection is often politically sensitive, as governments may resist revealing the actual level of human rights enjoyment within their jurisdiction, particularly when such disclosure would expose patterns of systemic disadvantage for which they may bear legal or political responsibility.[671]

Disaggregation enables indicators to be more precisely aligned with the specific patterns of vulnerability and inequality affecting particular social groups within a given national context.[672] This is clearly illustrated by Paul Hunt's example concerning the proportion of births attended by skilled health personnel, a commonly used indicator in the domain of maternal health. As he demonstrated, at first glance a national average of 60% might suggest moderate coverage. However, when the same indicator is disaggregated by urban and rural areas, it may reveal that coverage is significantly higher in urban centres (e.g. 70%) than in rural ones (e.g. 50%). Further disaggregation by ethnicity within the rural subset may expose even starker disparities: while women from the dominant ethnic group may benefit from 70% coverage, women from minority ethnic groups may receive assistance in only 40% of births. This layered

[668] See A. Nowakowski, 'Cultural Rights', in G. McCann and F. Ó hAdhmaill (eds.), *International Human Rights, Social Policy and Global Development: Critical Perspectives* (2020), 117.
[669] UN OHCHR, *supra* note 299, at 68.
[670] Ibid.
[671] de Beco, *supra* note 531, at 29-30.
[672] Hunt, *supra* note 537, at para. 74.

disaggregation reveals the compounded vulnerability of rural women from ethnic minorities, which is otherwise masked by national averages.[673] Such insights are indispensable for targeted policy interventions aimed at addressing structural inequalities.

Consequently, disaggregation is not merely a matter of technical refinement, but it constitutes an element of the legal relevance of indicators. This is particularly evident in the case of the right to health, where the principle of equality and non-discrimination is central to defining the scope of state obligations. Many indicators in this domain, such as access to health care services, must be disaggregated by relevant grounds of potential discrimination, including gender, ethnicity, and socio-economic status. Without such differentiation, indicators fail to capture whether health services are equitably accessible to all segments of the population, thereby distorting the actual level of rights realisation.[674]

Nonetheless, the pursuit of disaggregated data may encounter significant methodological difficulties. The identification of certain categories within a specific society can be politically contested. While disaggregation by sex, age, or region is relatively straightforward, disaggregation by ethnicity involves both objective and subjective criteria that evolve over time and may not be uniformly understood or accepted by respondents.[675] This fluidity challenges the coherence of the categories used, thereby undermining the reliability of such data. Moreover, there is an inherent tension between the imperative to collect disaggregated data and the standards of privacy and data protection. It should be emphasised that data collection, particularly when linked to sensitive personal attributes, must adhere to rigorous confidentiality standards.[676] Furthermore, logistical and conceptual obstacles may arise in the process of data disaggregation. From a practical standpoint, the cost and complexity of disaggregation frequently constitute significant barriers to implementation. It requires increased sample sizes and multiple rounds of data collection, all of which place considerable strain on national statistical capacities.[677]

Ultimately, the decision to disaggregate, particularly on politically or socially sensitive grounds, rests with national authorities, as usually they possess or can potentially obtain the broadest access to relevant datasets. However, there is less legal leeway in relation to grounds

[673] Ibid.
[674] Hunt, *supra* note 528, at para. 12.
[675] UN OHCHR, *supra* note 297, at para. 27.
[676] Ibid.
[677] UN OHCHR, *supra* note 299, at 69.

such as sex, age, disability, or socio-economic status, which are widely recognised as prohibited grounds of discrimination.[678] Notably, the Convention on the Rights of Persons with Disabilities is particularly explicit in mandating disaggregated data collection to monitor state compliance.[679] This represents a shift towards a more prescriptive model of data collection in human rights law, where the production of disaggregated data is not merely encouraged but required.

In sum, the function of disaggregation extends beyond statistical differentiation to the essence of accountability, revealing inequalities that undermine the enjoyment of human rights. Without it, indicators risk reinforcing the invisibility of structurally marginalised groups and obscuring patterns of exclusion that require redress. The practice of disaggregation thus illustrates a broader methodological and legally relevant function of indicators in human rights law: their capacity to make visible the nuanced realities of rights enjoyment and to inform targeted interventions. Yet this is only one dimension of their utility. To fully appreciate the value of indicators in the human rights domain, one must also consider their operational capacity, namely their ability to serve as tools for accountability, policymaking, and compliance monitoring.

To conclude, the foregoing sections have shown that the potential of indicators to contribute meaningfully to human rights law is not inherent in their existence but emerges only when they capture the conditions in which human rights are exercised. The discussion has also underscored that their usefulness depends on the quality and appropriateness of the data on which they are built, together with the institutional safeguards that govern their application. Without these conditions, indicators can obscure rather than clarify the state of rights protection.

However, even when constructed with methodological care, indicators exist in a state of tension: between comparability and sensitivity to context, between stability over time and the need to capture differentiated impacts, between communicability and the risk of oversimplification. For these reasons, the next stage of the analysis turns to practical application of indicators. Chapter V will examine how indicators operate within institutional and procedural settings, exploring their role in shaping the human rights reality. It will consider how relationships between data producers, monitoring bodies and duty-bearers influence the ways

[678] Ibid., at 70.
[679] Ibid.

in which information is generated and interpreted, and how such processes affect the derivation of legally relevant findings. This inquiry will aim to clarify the criteria by which the legal relevance of indicators can be assessed in the context of their application.

Chapter V

Indicators as instruments of global governance

Global governance in the field of human rights increasingly relies on indicators, which functions range from the technical measurement of human rights performance to the structuring of actions aimed at implementing human rights norms. Although frequently presented as neutral tools for capturing social realities, their design and application influence the interpretation of rights and institutional responses to identified shortcomings. Their nature is not merely descriptive, since by determining what is measured and establishing thresholds for acceptable or inadequate performance, indicators actively participate in constructing the realities they claim to observe.

The discussion begins with an examination of the operational capacity of indicators, focusing on their potential to translate abstract human rights obligations into actionable standards (Section 1). Drawing on international monitoring practice, it considers how indicators are used to structure compliance assessment and to inform policymaking in ways that strengthen accountability. The analysis then turns to their limitations, scrutinising the epistemological assumptions, processes of simplification, and structural imbalances that shape indicator frameworks (Section 2). Particular attention is given to the ways in which quantification can obscure the complexity of social life, what sometimes perpetuates existing asymmetries rather than addresses the needs of affected individuals.

Jurisprudence of the ECtHR illustrates how indicators can contribute to judicial reasoning and to the interpretation of human rights provisions. Moreover, additional institutional examples from national administrations show how indicators can be integrated into policy planning or performance evaluation, thereby linking international norms with domestic

implementation. Building on this usage, the following Section 3 examines situations in which indicators have been employed as legally relevant instruments.

The argument advanced neither supports the uncritical acceptance of indicators nor advocates their complete rejection (Section 4). Rather, it calls for a reflective engagement with the processes through which indicators are constructed and applied. Such engagement requires awareness of their political effects and sensitivity to context-specific factors. This chapter provides both a conceptual and an empirical basis for assessing the governance functions of indicators, and it prepares the ground for the subsequent examination of their role in the WHO's response to COVID-19.

1. Operational capacity of indicators

As demonstrated in human rights monitoring practice, particularly within UN treaty bodies, the request for states to provide statistical evidence in their reports underscores the importance of indicators in assessing compliance and tracking changes in the field of human rights over time.[680] In the Human Development Report 2000: Human Rights and Human Development, it was asserted that "indicators are a powerful tool in the struggle for human rights. They make it possible for people and organisations – from grass-roots activists and civil society to governments and the United Nations – to identify important actors and hold them accountable for their actions."[681] The World Bank emphasises the value of indicators in summarising complex realities, measuring compliance with obligations, and evaluating institutional performance, thus linking normative standards with empirical evidence.[682] Importantly, indicators are not just passive descriptors but are actively used by institutions to structure planning and evaluation processes. Their value lies in this dual capacity: serving both as analytical instruments and as tools of governance.[683]

It seems that indicators serve not only to reflect social conditions, but also to shape responses that are normatively guided and contextually appropriate. AnnJanette Rosga and

[680] C. Naval et al., *Measuring Human Rights and Democratic Governance: Experiences and Lessons from Metagora* (2008), 23-4.
[681] UNDP, *Human Development Report* (2000), 89.
[682] McInerney-Lankford and Sano, *supra* note 302, at 25.
[683] Ibid.

Margaret L. Satterthwaite have articulated the functions of indicators in a particularly concise but substantive manner. According to them, indicators serve three principal purposes: to monitor state compliance with human rights obligations, to assess development outcomes from a human rights perspective, and to evaluate the effectiveness of rights-based programmes.[684] This formulation captures the prominent role indicators have acquired in contemporary human rights governance, not only as technical tools but also as significant instruments for both evaluation and strategic advancement of rights realisation.

Their functional versatility is particularly important in the field of human rights, where enforcement mechanisms are often diffuse, and evidence-based policy-making depends on reliable information.[685] Klaus Starl et al. have shown that indicators can strengthen accountability by making rights violations visible and traceable, as well as support political decision-making by revealing structural disparities and policy gaps.[686] In this sense, indicators operate not merely as datasets but as instruments of governance, structuring how problems are defined and prioritised.

Indicators are positioned within a broader strategy of operationalising treaty obligations. According to the OHCHR, indicators function as practical tools that help transform abstract legal commitments into actionable standards that are accessible to international actors.[687] Specific, normatively embedded indicators (as opposed to generic statistics) make it possible to assess whether legal standards are being meaningfully implemented. In addition, the process of selecting and using indicators contributes to clarifying the content of human rights obligations, thereby improving both interpretive precision and implementation.[688]

Paul Hunt noted that indicators function as operational tools in the field of human rights and serve several functions: they are helpful in (1) making better policies and monitoring progress; (2) identifying unintended impacts of laws, policies and practices; (3) showing which actors are having an impact on the realization of rights; (4) revealing whether the obligations of these actors are being met; (5) giving early warning of potential violations, prompting preventive action; (6) enhancing social consensus on difficult trade-offs to be made in the face

[684] Satterthwaite and Rosga, *supra* note 556, at 4.
[685] K. Starl et al., *supra* note 514, at 16.
[686] Ibid.
[687] UN OHCHR, *supra* note 299, at 2-6.
[688] Ibid.

of resource constraints; and (7) exposing issues that had been neglected or silenced.[689] Consequently, indicators can help states, and others, recognize when national and international policy adjustments are required.[690]

Each of these functions requires at least brief elaboration, both to illustrate its practical significance and to highlight the concerns it raises. First, indicators have proved to be particularly influential in supporting better policymaking and monitoring progress over time. By providing ostensibly objective information about social trends, they enable governments and other actors to identify problems and to design more effective interventions.[691] Yet indicators alone do not capture the full content of human rights, and without a careful political and contextual analysis they risk reproducing biases and steering attention in ways that are neither legally nor politically neutral.[692]

A second, equally important dimension concerns the use of indicators to diagnose unintended impacts of laws, policies and practices as diverse initiatives framed as neutral, or efficiency-enhancing may produce adverse side-effects[693] that may remain invisible without systematic measurement. In the health sector, for example, the introduction of user fees for basic services was widely justified as a means of mobilising additional resources and improving quality. Yet data collected by the World Bank and the WHO in Uganda showed that even small charges had a dramatic effect on access for the poorest segments of the population, leading to sharp declines in service utilisation.[694] When Uganda abolished user fees in 2001-2002, utilisation rates for primary health care surged almost immediately, particularly among women and children, and similar patterns were subsequently documented in other low-income states.[695] Indicators thus helped to reveal the distributive consequences of apparently neutral policies and prompt a re-evaluation of their human rights compatibility.

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[689] Hunt, *supra* note 528, at para. 7.

[690] T. Landman and E. Carvalho, *Measuring Human Rights* (2010), 4-6.

[691] UNDP, *supra* note 681, at 99, 141. This role can be briefly illustrated by the experience of Bolivia, where, following consultations with civil society, the government introduced indicator-based framework to track progress in areas such as the proportion of births attended by trained health personnel.

[692] Merry, *supra* note 247, at 20.

[693] See R. K. Merton, 'The Unanticipated Consequences of Purposive Social Action', (1936) 6 *American Sociological Review* 894.

[694] K. Deininger and P. Mpuga*, Economic and Welfare Effects of the Abolition of Health User Fees: Evidence from Uganda* (2004), 19. WHO, *The elimination of user fees in Uganda: impact on utilization and catastrophic health expenditures* (2005), 15-17.

[695] J. Nabyonga Orem et al., 'Abolition of user fees: the Uganda paradox', (2011) 26 *Health policy and planning* 41, at 49-50.

A third function concerns the ability of indicators to make visible which actors actually influence the realisation of rights. Many situations that undermine the enjoyment of human rights originate not in state action but in the conduct of different actors, whose influence becomes visible only through systematic data collection.[696] For example, household-level surveys may reveal persistent disparities in school attendance between boys and girls, not because of formal exclusionary laws but because parents undervalued the education of daughters.[697] Such data not only documents a pattern of discrimination but also points to the locus of responsibility outside the state apparatus. Nowadays, similar concerns may extend to multinational corporations and multilateral institutions whose decisions profoundly affect access to essential goods and services,[698] exposing the actual influence of such actors yet their ability to translate exposure into accountability depends on the availability of legal and institutional mechanisms beyond measurement itself.[699]

Another function of indicators is to enable an assessment of whether states are actually meeting their obligations. In practice, a tripartite structure of measurement was created.[700] Structural indicators monitor the existence of formal legal commitments, such as treaty ratifications or the adoption of national policies.[701] Process indicators capture the concrete efforts undertaken to implement those commitments, including staff training, budgetary allocations or the establishment of institutional mechanisms.[702] Outcome indicators, by contrast, reflect the actual level of enjoyment of rights by individuals and groups.[703] Properly combined, these indicators can provide a picture of compliance. At the same time, they risk conveying an impression of precision that masks deep methodological and normative choices about what counts as compliance and about how to weigh effort against results, especially where data are incomplete or selectively reported.[704]

Indicators can facilitate social consensus on national priorities under conditions of limited resources. By establishing targets and tracking progress over time, they help make the

[696] UNDP, *supra* note 681, at 10.
[697] Ibid., at 92.
[698] Ibid., at 82. See also Tabaszewski, *supra* note 312, at 41.
[699] See Pawelczyk, *supra* note 361, at 611.
[700] As discussed earlier in Section 3 of Chapter IV.
[701] See for example Kalantry et al., *supra* note 592, at 281.
[702] Ibid., at 282.
[703] Ibid., at 283-4.
[704] McGrogan, *supra* note 512, at 390.

processes of resource allocation more transparent and intelligible to citizens.[705] Budgetary analysis grounded in indicators can demystify how funds are distributed and reveal whether governments are actually directing resources towards priority social sectors, thus providing a basis for assessing compliance with the obligation to realise rights to the maximum of available resources.[706] Properly used, such indicators can support a debate on how resources should be allocated rather than entrenching technocratic decision-making. However, while measurement can inform choices, it does not resolve the underlying questions about what should count as a priority or at what pace progress should be achieved.[707]

Finally, indicators play a crucial role in advancing human rights by making the scale of problems visible and overcoming "barriers of disbelief."[708] They can expose hidden forms of discrimination, such as gender gaps in education that remain invisible in aggregated national averages. Moreover, the very absence of data can itself be a revealing indicator, pointing to the deliberate concealment of problems (for example, the suppression of information on radiation-related illnesses or the statistical underreporting of political victims).[709] However, reducing complex social phenomena to what can be counted risks overlooking issues that are harder to quantify, such as the human dignity.[710]

To conclude, while the operational capacity of indicators shows their ability to render human rights obligations more tangible, it also raises questions about the assumptions, methodologies, and power structures underlying their creation and use. To fully understand their governance role, it is necessary to examine the limitations that accompany their use. The following section turns to this inquiry, examining the epistemological and political limitations of indicators, and the risks entailed in their deployment as instruments conveying (at least to some extent) a veneer of normativity.[711]

[705] UNDP, *supra* note 681, at 99.
[706] Ibid., at 77.
[707] Ibid., at 23.
[708] Ibid., at 90.
[709] Ibid., at 94.
[710] McGrogan, *supra* note 512, at 401.
[711] As understood by E. Hey – see Section 3.4 of Chapter II.

2. Constraints of indicators

Quantification of reality through indicators is often regarded as a means of producing knowledge that appears objective and transparent. Thus, it should be perceived as relevant to policymaking.[712] Despite their appealing appearance, indicators have not remained immune to contestation. The transformation of complex phenomena into numerical form necessitates processes of standardisation and simplification, which inevitably involve interpretive and political choices at every stage.[713]

Indicators rely on the assumption that social realities can be disaggregated into measurable components. This process replaces contextual particularities with formal categories, derived from legal or bureaucratic frameworks. For example, measurements of gender-based violence typically rely on standardised legal definitions, ignoring the varying ways in which violence is conceptualised or experienced in different socio-cultural settings.[714] Likewise, cross-national comparisons of corruption may privilege perception-based data, treating subjective impressions as empirical fact, while overlooking structural and historical drivers of institutional distrust.[715] By privileging what can be counted, indicators obscure phenomena that escape formalisation (e.g. local knowledge, community customs, and lived experiences). As a result, the quantifiable becomes conflated with the meaningful, and policy interventions are shaped by what can be measured rather than by what matters.[716] Results produced by indicators are often seen as neutral facts, even though they are rarely questioned or treated as open to debate. It must be underscored, however, that indicators do not merely *describe* reality; they participate in its construction. Through processes of categorisation, selection of proxies, and ranking, they actively shape what is seen, what is ignored, and what is valued in governance discourses.[717]

It must be emphasized that indicators are not neutral measurement tools; they are embedded in the social, cultural, and political contexts within which they are designed and implemented. This broad understanding of indicators also requires critical attention to their

[712] Merry, *supra* note 247, at 3.
[713] Ibid., at 1-2.
[714] Ibid., at 27.
[715] Ibid., at 7.
[716] Ibid., at 19-21.
[717] Ibid., at 20.

epistemological and political implications, as emphasised by Kevin E. Davis, Benedict Kingsbury and Sally Engle Merry. Their analysis lays bare the structural features and political effects of indicators that are often obscured by their apparent technical neutrality. Four interrelated characteristics of indicators are particularly salient. First, the act of naming an indicator (e.g. rule of law index) constitutes a powerful assertion of authority: it not only presupposes the existence of a stable, measurable phenomenon, but may in fact produce the very reality it claims to represent.[718] Second, the logic of indicators introduces a ranking structure that exerts normative pressure. Indicators rarely describe in isolation; they compare, contrast, and rank entities in a manner that imposes a hierarchy of performance.[719] Third, indicators are useful to translate complex social phenomena into seemingly objective forms; however, this process of simplification entails significant epistemological risks.[720] Decisions made on the basis of indicators often rely more on the appearance of objectivity than on a critical interrogation of underlying data and assumptions. Fourth, indicators function as tools of evaluation, and in so doing, they embed and advance specific theories of governance,[721] what makes indicators deeply ideological. Criteria used in indicators often reflect specific ideas about what a good society should look like, but these ideas are usually not stated openly.

Their construction reflects particular institutional agendas and epistemic commitments, shaped by the professional environments of their creators, typically situated within established bureaucratic or financial structures. In many cases, indicators produced by global institutions are calibrated to serve operational mandates (whether related to economic growth, governance reform, or development promotion) thereby encoding within themselves institutional values that may diverge from the situated needs of the communities being evaluated.[722] The epistemological gap between the designers and the measured is particularly evident in areas such as human trafficking, where indicators may disproportionately focus on criminal justice outputs (prosecutions, convictions, arrests) while failing to account for structural drivers or community-based conceptions of harm.[723]

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[718] Davis et al., *supra* note 301, at 75.
[719] Ibid., at 76.
[720] Ibid., at 76-7.
[721] Ibid.
Merry, *supra* note 247, at 4-5.
[723] The United States State Department's annual Trafficking in Persons (TIP) Reports constitute a unilateral, indicator-based mechanism promoted as a foreign policy instrument. Developed from the earlier United States narcotics-control evaluation models, they embed a criminal-justice approach to trafficking, measuring progress mainly through prosecutions, convictions and sentences. Such output-oriented approach risk neglecting structural causes such as poverty, gendered inequalities, restrictive migration policies or servile labour traditions and may

The power to define and operationalize indicators is predominantly held by actors from the Global North.[724] Experts engaged in developing global indicators are usually cosmopolitan elites with advanced education, often originating from the Global North and trained in fields like political science, economics, or statistics.[725] States that have already developed extensive survey and statistical systems often provide the templates for subsequent global indicators. Because adapting and applying these templates requires specialist knowledge, a phenomenon of "expertise inertia"[726] emerges: insiders with the requisite skills and experience exert disproportionate influence over the construction of measurement systems, while resource-poor or inexperienced actors remain largely excluded from determining what is measured and how.[727] Consequently, local or vernacular knowledge often lacks influence or is excluded from global discussions. The United States State Department's annual Trafficking in Persons Reports exemplify this pattern. As an indicator-based mechanism promoted by a powerful sponsor, it presents a criminal-justice approach to trafficking and enforce compliance through rankings and the threat of sanctions, illustrating how measurement regimes can reflect the agendas of their architects rather than the full complexity of the issues they claim to address.[728]

Such dynamic constitutes a form of epistemic violence, silencing subaltern forms of knowledge through dominant systems of representation. As Gayatri Chakravorty Spivak observed, the subaltern cannot speak when the conditions of knowledge production are structured to exclude their voice.[729] In the context of indicators, this exclusion occurs not merely at the level of participation but at the level of ontology: what counts as knowable, what is deemed measurable, and who has the power to define social reality. Moreover, it must be acknowledged that the epistemic framework within which indicators operate is not ideologically neutral. It usually reflects what has been termed "epistemologies of the North", which systematically exclude indigenous, vernacular, and experiential knowledges of the

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incentivise governments to prioritise easily quantifiable actions over substantive change, as illustrated by India's low conviction rates for bonded labour despite other initiatives. Ethnographic research indicates that this framework overlooks the complex mix of coercion and constrained choice shaping women's entry into sex work, underscoring how indicators reflect the perspectives and interests of the agencies that design them rather than the full reality on the ground. See Merry, *supra* note 247, at 157-60.

[724] Merry, *supra* note 247, at 6.

[725] Ibid.

[726] Ibid.

[727] Ibid., at 77.

[728] See *supra* note 723.

[729] G. C. Spivak, 'Can the Subaltern Speak?', in C. Nelson and L. Grossberg (eds), *Marxism and the Interpretation of Culture* (1988), 271 at 287.

Global South.[730] The issue, therefore, is not merely the absence of inclusion, but the epistemological invalidation of alternative ontologies.

Sally Engle Merry advocates for more participatory approaches to indicator creation, where local knowledge and perspectives are integrated into the process.[731] However, the inclusion of local voices in indicator design does not automatically challenge the underlying power structures if it is merely consultative. As Boaventura de Sousa Santos reminds, genuine epistemic inclusion requires recognition of alternative systems of knowledge production as co-equal and legitimate, rather than as supplementary or anecdotal. Without such recognition, participation risks functioning as a technocratic ritual rather than enabling genuine transformation.[732]

In light of the foregoing, it must be insisted that indicators, despite their utility for governance and accountability, cannot be undeniably approached as neutral or objective. Their design and deployment should be subjected to epistemological analysis. Thus, the use of indicators must be examined as a social practice that carries symbolic and distributive consequences. For instance, the World Bank selectively grants or suspends eligibility for funding based on different indicators such as control of corruption or democratic governance. If a state falls below certain threshold, it may lose access to funding.[733] Consequently, indicators operate not merely as descriptive tools. They define problems, classify behaviours, and structure institutional responses. In doing so, they perform a powerful epistemic function: they bring into being specific configurations of knowledge and visibility. This performativity reveals that objectivity, far from representing a neutral epistemic condition, is in fact the outcome of institutional practices. It is produced through acts of formatting and scaling, what leads to concealing complexity.[734]

Such effects are enabled through processes of simplification and black-boxing, whereby the intricate and context-bound nature of social phenomena is rendered invisible. [735]

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[730] B. De Sousa Santos, *Epistemologies of the South* (2015), 237.
[731] Merry, *supra* note 247, at 25.
[732] De Sousa Santos, *supra* note 730, at 133, 207-235.
[733] See Global Partnership for Results-Based Approaches, *AN INTRODUCTION TO OUTCOME-BASED FINANCING. GPRBA's Outcomes Fund MDTF* (2020).
[734] W. N. Espeland, M. Sauder and W. Espeland, *Engines of Anxiety: Academic Rankings, Reputation, and Accountability* (2016), 7-8. See also M. Strathern, 'The Tyranny of Transparency', (2000) 26 *British Educational Research Journal* 309.
[735] B. Latour, *Pandora's Hope: Essays on the Reality of Science Studies* (1999), 304.

In its place emerge calculable representations, designed to travel across policy regimes and reporting systems.[736] These representations seem to derive their authority precisely from the fact that the normative and political assumptions embedded in their construction are obscured behind technical documents. As a result, the criteria for what counts as legitimate knowledge, what qualifies as measurable, and what becomes visible in governance frameworks are not outcomes of open deliberation, but of silent design choices; choices that remain largely shielded from public scrutiny.[737] The existence of indicators proves that governance is thereby exercised not only through formal rules, but also through the dissemination of norms encoded in measurement systems.[738] The resulting audit culture[739] subjects social phenomena to systems of comparison and calibration that are designed (and controlled) by actors with vested interests in shaping particular versions of reality.

However, despite those many critical concerns surrounding the epistemic foundations and performative effects of indicators, it would be reductive to dismiss them altogether.[740] Indicators, for all their limitations, offer a structured means of rendering social issues visible in domains where inaction often thrives on vagueness or denial. Indicators must be carefully constructed and contextually informed, so that they can support accountability, standardise reporting, enable cross-national comparison, and serve as entry points for legal or political mobilisation. It seems that their potential lies not in their presumed neutrality, but in their ability to provoke attention, and sustain dialogue about normative commitments. Yet this potential can only be realised if indicators are used with methodological humility and political reflexivity; not as instruments of technocratic closure, but as part of an ongoing process of knowledge production and governance. Recognising their limits is not a rejection of their value, but a condition for their responsible use.[741]

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[736] Ibid.

[737] Merry, *supra* note 247, at 207-10.

[738] N. Rose, 'Governing by Numbers: Figuring out Democracy', (1999) 16(7) *Accounting Organizations and Society* 673, at 673-4.

[739] Merry, *supra* note 247, at 9. C. Shore and S. Wright, 'Audit Culture and Anthropology: Neo-Liberalism in British Higher Education', (1999) 5 *Journal of the Royal Anthropological Institute* 557, at 558. Strathern, *supra* note 734, at 313.

[740] See Merry, *supra* note 247, at 25, 216.

[741] It appears justified to suggest that many of the criticisms identified by S. E. Merry do not pertain solely to indicators themselves but rather reflect broader structural features of the international system established for the protection of human rights. See also J. M. Bello y Villarino and R. Vijeyarasa, 'The Indicator Fad: How Quantifiable Measurement Can Work Hand-in-Hand with Human Rights - A Response to Sally Engle Merry's the Seductions of Quantification', (2018) 50(3) *New York University Journal of International Law & Politics* 985, at 1018.

The constraints outlined above directly influence the functions of indicators discussed in Section 1 and the conditions under which they can be realised. When governments are encouraged to use indicators to design better policies and monitor progress, the categories and proxies they employ should draw not only on existing templates but also on locally defined priorities. Otherwise, entire areas of experience risk being excluded from the dataset. An analogous pattern may limit the diagnostic potential of indicators: what counts as an 'unintended impact' is itself determined by the measurement frame, so outcomes that do not fit dominant categories remain invisible. Similarly, the accountability functions discussed earlier (making visible which actors influence the realisation of rights and whether they meet their obligations) are filtered through legal and bureaucratic definitions that privilege formal institutions and outputs over informal practices or structural drivers. Likewise, the promise of using indicators to foster social consensus is constrained if those indicators are externally defined and do not reflect the plural priorities of the affected communities. These examples show that the governance effects of indicators are inseparable from the practices and power asymmetries that shape them. Without recognising how the constraints analysed here influence the functions identified in Section 1, it is impossible to evaluate the actual capacity of indicators to advance human rights. In practice, indicators have been adopted in a variety of institutional contexts, where they inform decision-making. What follows, therefore, is an exploration of how indicators have been used by different actors, highlighting their role to support human rights standards.

3. Indicators in action

Indicators have been put into operation by a variety of actors, including domestic administrations and judicial bodies. This section examines how indicators are used in practice, not only to monitor compliance or evaluate outcomes, but also to influence the interpretation and implementation of human rights norms. The focus is placed on two distinct but complementary domains of practice: the judicial use of indicators by the ECtHR (3.1),[742] and the operationalisation of indicators within state systems, including their importance in national policymaking, administrative oversight, and treaty reporting (3.2). These case studies illustrate

[742] This section focuses on the ECtHR jurisprudence because a review of other regional courts did not reveal judgments in which indicators were used in a manner comparable to that of the ECtHR.

how indicators, despite their conceptual limitations and political ambiguities, can serve as legally relevant instruments. Whether used in adjudication or institutional governance, indicators contribute to shaping the legal meaning of rights and clarifying the modalities of state obligations. Their deployment across diverse contexts affirms that indicators are not merely tools for measurement but also mechanisms through which human rights are rendered actionable.

3.1 Indicators in the case law of the ECtHR

One of the significant developments in the operationalisation of indicators lies in their increasing use by a wide range of actors in the human rights ecosystem. The question arises as to whether judicial bodies (particularly international courts) may similarly draw on such instruments when interpreting and applying legal norms.

The practice of the ECtHR, specifically in the judgment in D.H. and Others v. the Czech Republic, provides an instructive example.[743] The Court's reasoning demonstrates that it is procedurally and conceptually possible to base legal conclusions on indicators, including those produced by civil society. While the Court did not employ the term "indicators", the statistical material on which it relied met the functional criteria of human rights indicators as defined by the OHCHR.[744] The following analysis suggests that in D.H. and Others v. the Czech Republic, the Court applied such indicators as part of its methodology. Moreover, the judgment illustrates that statistical material may acquire the character of a human rights indicator when used within a normative context; specifically, as a basis for assessing compliance with legal standards.

In the judgment mentioned, the Court considered the placement of Roma children into special schools intended for pupils with mental disabilities. The applicants alleged that this practice constituted racial discrimination, in breach of Article 14 of the ECHR, read in conjunction with Article 2 of Protocol No. 1 to the Convention. The case did not rest on allegations of direct discriminatory intent but was structured around a disparity in educational outcomes documented through statistical data. The key empirical element submitted to the Court was a result indicator: the proportion of Roma pupils assigned to special schools in

[743] *D.H. and Others v. the Czech Republic*, Judgment of 13 November 2007, ECtHR Case No. 57325/00.
[744] UN OHCHR, *supra* note 299, at 16.

Ostrava. According to data gathered by NGOs from school headmasters in 1999, Roma pupils represented 56% of the student body in such schools, while constituting only 2.26% of the general primary school population. Moreover, while 1.8% of non-Roma children were placed in these institutions, the corresponding figure for Roma children was 50.3%.[745] These figures were not merely acknowledged by the Court but were integrated into its legal assessment. The Court noted that the statistical data produced by the applicants, although limited in scope, were not without significance, and found that the disparity in placement was sufficiently marked to give rise to concerns under Article 14.[746] The Court held that where applicants are able to demonstrate disproportionate impact through "statistics which appear on critical examination to be reliable and significant," such evidence "will be sufficient to constitute the *prima facie* indication" of discrimination, thereby requiring the respondent government to provide justification.[747]

The state's defence rested on parental consent and psychological testing. The Court, however, identified irregularities in these practices. Some consent forms were backdated or pre-filled,[748] and the psychological assessments used were not adapted to the linguistic or cultural background of Roma children.[749] The Advisory Committee on the Framework Convention for the Protection of National Minorities had previously noted that Roma continued to constitute up to 70% of pupils in special schools despite reforms.[750] The Court concluded that the authorities had not succeeded in showing that the difference in treatment was objectively and reasonably justified.[751] It is also noteworthy that the statistical material was not collected by state bodies but by non-governmental organisations.[752] Nevertheless, the Court did not treat this as a barrier to admissibility or reliability.[753] This aspect is particularly relevant in contexts where states either do not collect disaggregated data or are legally prohibited from doing so.

Although D.H. and Others v. the Czech Republic remains the most elaborated example of the Court's engagement with human rights indicators, the judgment in S.M. v. Croatia

[745] *D.H. and Others v. the Czech Republic*, *supra* note 743, at paras. 18, 190.
[746] Ibid., at para. 195.
[747] Ibid., at para. 188.
[748] Ibid., at para. 20.
[749] Ibid., at paras. 40-1.
[750] Ibid., at para. 41.
[751] Ibid., at paras. 205-10.
[752] The Court used indicators associated with the Global Alliance for the Education of Young Children. Ibid., at para. 44.
[753] Ibid., at para. 190.

demonstrates a distinct but no less significant form of reliance on indicators. The case concerned an alleged failure by the Croatian authorities to fulfil their positive obligations under Article 4 of the ECHR in the context of human trafficking and forced prostitution. In its reasoning, the Court referred to legal framework developed by the ILO, which includes a set of eleven indicators of forced labour.[754] In its judgment, the Court cited the ILO's Special Action Programme to Combat Forced Labour, which identifies the following indicators: "(i) abuse of vulnerability; (ii) deception; (iii) restriction of movement; (iv) isolation; (v) physical and sexual violence; (vi) intimidation and threats; (vii) retention of identity documents; (viii) withholding of wages; (ix) debt bondage; (x) abusive working and living conditions; and (xi) excessive overtime." As noted by the ILO, the presence of one or more such indicators may suffice to establish the existence of forced labour, depending on the specific circumstances.[755] The Court further recalled that the ILO had clarified the conceptual threshold separating forced labour from general violations of labour standards. For example, the mere failure to pay the minimum wage does not, in itself, amount to forced labour.[756] Additionally, the Court cited ILO reports establishing the definitional relationship between trafficking and forced or compulsory labour under international law, including Convention No. 29 and the Palermo Protocol.[757] In particular, the ILO Committee of Experts had highlighted the role of 'exploitation' as the element linking trafficking with forced labour, including in contexts of sexual exploitation. The Court also made reference to the Operational Indicators of Trafficking in Human Beings, a set of indicators jointly developed by the European Commission and the ILO.[758] These indicators are organised by the three definitional components of trafficking (act, means, and purpose) and are classified by evidentiary strength as strong, medium, or weak. The case of S.M. v. Croatia illustrates the judicial application of indicators developed by the ILO to structure the legal meaning of forced labour as they informed the Court's understanding of the definitional boundaries of Article 4 of the ECHR in relation to international law and state practice.

In NIT S.R.L. v. the Republic of Moldova, the applicant complained under Article 10 of the ECHR that the withdrawal of its broadcasting licence by the Audiovisual Coordinating Council constituted an unlawful and disproportionate interference with its freedom of expression. In assessing whether the interference was compatible with the standards of a

[754] *S.M. v. Croatia*, Judgment of 25 June 2020, ECtHR Case No. 60561/14, para 143.
[755] Ibid.
[756] Ibid., at para. 144.
[757] Ibid., at paras 145-6.
[758] Ibid., at para. 146.

democratic society, the Court considered not only the specific facts of the revocation decision but also the broader regulatory and political context in which the Moldovan media operated. In this regard, the Court made explicit reference to a structured indicator framework developed in the 2009 report Independent Study on Indicators for Media Pluralism in the Member States – Towards a Risk-Based Approach, commissioned by the European Commission. The Court outlined the five dimensions of pluralism distinguished in that study: cultural, political, geographical, ownership/control, and types/genres of media. These dimensions were presented not merely as abstract categories but as part of a legal and analytical model for identifying structural risks to pluralism in democratic societies.[759] More specifically, the Court cited the study's elaboration of indicators associated with the domain of political pluralism.[760] These indicators are intended to assess the existence and effectiveness of safeguards ensuring both fair access for political actors and a well-informed public. The Court referred to the study's observation that an effective media pluralism policy requires both support for diverse political views and protection of editorial independence. Although the indicators were not treated as evidence in the case, they assisted the Court clarify the basic requirements of fair and accurate political reporting, including in privately owned media. Although the Court did not apply the media pluralism indicators directly to determine the lawfulness of the interference, they served to frame the systemic risks arising from concentrated regulatory control and political influence in the Moldovan media landscape. The Court considered, for example, the political composition and lack of independence of the broadcasting regulator,[761] and it placed these institutional facts in relation to the risk-based categories outlined in the indicator framework.

The examination of the Court's practice confirms that indicators can serve multiple analytical functions within judicial reasoning under the ECHR. Their application remains contingent on contextual relevance and methodological coherence. While the Court has drawn on indicators to illustrate patterns of harm and to clarify the scope of state obligations, this practice raises certain concerns.

First, indicators, though presented as objective and neutral measurement tools, are in fact instruments of governance that carry with them the concepts, priorities and institutional agendas of their creators. When indicator frameworks developed outside certain (e.g. Convention) system are introduced into judicial reasoning, a court does not simply gain an

[759] *NIT S.R.L. v. the Republic of Moldova*, Judgment of 5 April 2022. ECtHR Case No. 28470/122022, para. 107.
[760] Ibid., at para. 108.
[761] Ibid., at paras 209-11.

additional source of empirical information. It also imports simplified definitions and schematic proxies that structure how complex phenomena are named and ordered, thereby embedding into its jurisprudence methodological and normative choices made elsewhere.

Second, because indicators are designed to compress complexity into parsimonious data, their use in adjudication also carries a risk of selective and reductive reasoning. When used to express or operationalise legal standards, they privilege auditable outputs over contextualised evaluations of compliance, reinforcing a managerial language in which contested value judgements are recast as performance scores. This masks the underlying methodological and normative choices, especially where data are incomplete or selectively reported, and can produce inaccurate or just partial assessments of treaty obligations.

These observations do not amount to a rejection of indicators. They underscore the need for methodological reflexivity when importing externally developed measurement systems into human rights adjudication. Without such scrutiny, indicators can technocratise adjudication by reducing complex disputes to easily measurable categories and incorporating external policy agendas into the Court's internal interpretive framework.

3.2. Domestic use of indicators for providing compliance and planning

Indicators have been progressively incorporated into the practice of national administrations, going beyond their origin as instruments of international monitoring. This section examines how selected states have integrated indicators into their legal systems.

3.2.1. Indicators in national policy frameworks: cases of Ecuador, Kenya and Nepal

An explicit institutionalisation of indicators within a human rights-based development plan can be observed in Ecuador. Following the adoption of the 2008 Constitution, which enshrines social rights as directly justiciable and enforceable, the Ecuadorian Government initiated the integration of human rights into its national planning process.[762] Acting through the Secretariat for National Planning and Development and the Ministry of Justice, the state began developing a national human rights indicator system (SIDERECHOS), guided by the

[762] *Constitution of the Republic of Ecuador* (2008).

OHCHR framework.[763] This initiative aimed to translate constitutional and treaty-based obligations into measurable policy objectives, and to provide planning officials with a tool for conducting sectoral diagnostics and prioritising interventions.[764]

The development of SIDERECHOS was closely aligned with recommendations issued through the Universal Periodic Review (UPR) process, as well as by treaty bodies such as the UN Human Rights Committee (HRC) and the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW).[765] For instance, in implementing a UPR recommendation to improve detention conditions, the Government operationalised follow-up through specific indicators, such as the proportion of prison staff formally investigated for abuse, the frequency of detention-centre inspections, and prison-occupancy levels relative to capacity.[766]

In Kenya, the National Commission on Human Rights (KNCHR), in cooperation with OHCHR and several government bodies, initiated a sustained process to embed indicators within the national development agenda.[767] A key step in this process was a workshop held in 2009, which brought together state institutions, including the Ministry of Planning, the Ministry of Public Services, and the Kenya National Bureau of Statistics, as well as civil-society actors.[768] The outcome of this workshop was a shared recognition of the value of indicators in monitoring treaty compliance and in ensuring that human rights considerations were incorporated into performance-evaluation systems.[769] Following this engagement, a working group was formed comprising the KNCHR, the Ministry of Justice, the Monitoring and Evaluation Directorate, and the Performance Secretariat.[770] The indicators developed included reference points for the right to health, the right to adequate housing, the right to participate in public affairs, and the right to liberty and security of the person.[771] The indicators were based on an interpretation of the right to health that reflected the structure and content of the AAAQ framework. This rights-based orientation was evident in the 2011 KNCHR report "Silenced

[763] UN OHCHR, *supra* note 299, at 113.
[764] *SiDerechos*, available at www.siderechos.cancilleria.gob.ec/app/web/inicio.do.
[765] See CMW, *Concluding Observations of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families*, CMW/C/ECU/CO/2 (2010).
[766] UN OHCHR, *supra* note 299, at 113.
[767] Ibid., at 119.
[768] Ibid.
[769] Kenya National Bureau of Statistics et al., *Kenya Demographic and Health Survey 2008-09* (2010), XIX.
[770] UN OHCHR, *supra* note 299, at 119.
[771] See *Mandate and Functions*, available at med.planning.go.ke/mandate-functions.

Minds", which used the OPERA framework (Outcome-Policy-Effort-Results-Assessment) to assess how Kenya was fulfilling its obligations in the area of mental health.[772]

Moreover, the Kenyan case is notable for the institutional mechanisms through which these indicators were implemented. Rather than remaining within the domain of reporting or advisory functions, the indicators were integrated into Kenya's national Performance Contracting system (a governance tool used to evaluate public institutions and civil servants).[773] Through this mechanism, ministries were required to achieve specific goals, including those related to the right to health. In practice, this meant that indicators had a tangible role in shaping the incentives of public authorities, thereby enhancing their potential legal and policy relevance. However, the functioning of this system revealed certain practical issues regarding the use of indicators. Subsequent evaluations by the KNCHR and civil society organisations highlighted significant disparities in data quality and availability across counties.[774] In particular, the data collected were rarely disaggregated by gender, income, or geographical region, thereby undermining the ability of indicators to reflect patterns of systemic inequality. Taken together, Kenya's experience illustrates both the potential and the limitations of using indicators as tools for realising the right to health. It demonstrates how indicators may attain legal relevance[775] when developed through normatively grounded processes and embedded within institutional frameworks. At the same time, it reveals that such frameworks must be accompanied by robust systems of independent data oversight if they are to contribute meaningfully to equality in the field of health care.

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[772] KNCHR, *Silenced Minds: The Systemic Neglect of the Mental Health System in Kenya: A Human Right Audit of the Mental Health System in Keny*a (2011), 9-10.

[773] See Republic of Kenya Ministry of Public Service, Performance and Delivery Management Office of the Cabinet Secretary, *PERFORMANCE GUIDLINES FINANCIAL YEAR 2024/2025 (21 ST CYCLE)* (2024).

[774] The Kenyan Section of the International Commission of Jurists, *A REVIEW OF THE LEGAL AND POLICY FRAMEWORKS ON THE RIGHT TO HEALTH IN KENYA* (2023), 13, 18, 60, 81, 86.

[775] "The State's compliance with its obligation to take appropriate measures to ensure progressive realisation should hence be assessed in the light of the resources - financial and others - made available for that purpose. This requires that clear performance indicators and targets are set on what constitutes the progressive realization of the right to health or health care to ensure tracking and monitoring of progress." Ibid., at 23. This observation is particularly significant from the perspective of the present dissertation, as it affirms the legal relevance of indicators in assessing a state's compliance with its obligations under the right to health. Rather than treating indicators as optional managerial tools, the source explicitly frames them as necessary elements for tracking the progressive realisation of health-related rights. It thus supports the central argument advanced here: that indicators can serve not only as instruments of policy evaluation but also as juridically relevant benchmarks for measuring compliance with binding legal obligations.

Nepal's trajectory is likewise rooted in collaboration between national authorities and the OHCHR. In 2008-2009, a series of workshops involving the Office of the Prime Minister and Council of Ministers, several line ministries, the National Human Rights Commission, and civil society organisations led to the development of indicators for use in the state's third National Human Rights Action Plan (NHRAP).[776] The initiative was built around two parallel processes: the identification of indicators for programming within the NHRAP and the establishment of five working groups tasked with contextualising indicators for economic, social, and cultural rights. The indicators developed were primarily structural and process-based, corresponding to the programming focus of the NHRAP.[777] Importantly, their design took into account existing planning instruments, such as the Three-Year Interim Development Plan, thereby facilitating alignment between human rights monitoring and broader national policy objectives.[778] However, the available sources do not allow for an assessment of the initiative's effectiveness or of whether, as in the Kenyan case, specific methodological problems were subsequently identified.

The Polish health-care system offers a pertinent domestic example of the institutionalisation of indicators within a regulatory framework. The Act on Quality in Health Care and Patient Safety establishes a nationwide system for measuring and improving the quality of medical services.[779] Under Articles 4 and 5 of the Act, the quality of health care must be assessed using a set of indicators divided into three domains: clinical (covering outcomes such as mortality within 30, 90 and 365 days after hospitalisation, rates of repeat admissions and the structure of procedures), consumer (capturing patient experiences of care), and managerial (addressing resource use, accreditation status and hospital-stay length).[780] Further, the National Health Fund is responsible for monitoring these indicators and, beginning in 2024, publishes the results for each provider in its public bulletin.[781] Moreover, under Articles 5(3)-(4) the values achieved on these indicators are linked to contractual settlements with providers, thereby giving them direct financial relevance. In parallel, the e-Health platform presents annual

[776] UN OHCHR, *supra* note 299, at 117.
[777] UN OHCHR, National Human Rights Commission of Nepal and the Government of Nepal, *Indicators for Monitoring Economic, Social and Cultural Rights in Nepal* (2011).
[778] Ibid., at 117.
[779] *The Act on Quality in Health Care and Patient Safety*, Journal of Laws item 1692 (2023).
[780] *Appendix 1 to Regulation of the Minister of Health on Health Care Quality Indicators*, Journal of Laws, item 1349 (2024).
[781] Art. 5(2) of the Act on Quality in Health Care and Patient Safety.

data sets on the realisation of these indicators at national and regional levels, thus embedding indicator-based evaluation in routine governance of the health-care system.[782]

This legislative framing makes explicit that the new system of health-care quality indicators in Poland is not conceived solely as a tool for internal oversight and patient safety but also as a lever for market positioning. As the explanatory memorandum to the Act underlines, the indicator framework is intended to "improve the efficiency and performance of providers" and, by aligning with EU cross-border health-care standards, to enhance the international competitiveness of Polish facilities.[783] In other words, indicators are presented simultaneously as instruments for standardisation and as reputational and economic assets designed to attract foreign patients and capital. While such a dual function may indeed stimulate improvements in service delivery, it also risks shifting attention towards those aspects of care that are easiest to quantify and showcase for competitive purposes, potentially at the expense of less visible dimensions of quality that remain harder to measure but are equally significant from a rights-based perspective.

3.2.2. Indicators in judicial and administrative oversight: the case of Mexico

Beginning in 2007, the OHCHR-Mexico launched a broad capacity-building initiative aimed at supporting state institutions in developing indicators to monitor compliance with international obligations and to assess the human rights impact of public policies.[784] One of the most significant outcomes of this process was the adoption of an indicator system by the Superior Tribunal of Justice of Mexico City.[785] These indicators were the result of an extensive participatory process involving judicial institutions, civil society, academics, and international organisations. The indicators address core dimensions of the right to a fair trial, including non-discrimination in access to justice, judicial conduct regarding the presumption of innocence, the use of pre-trial detention, and the protection of vulnerable groups such as children.[786] They

[782] *Monitorowanie jakości opieki zdrowotnej*, available at www.ezdrowie.gov.pl/portal/home/badania-i-dane/zdrowe-dane/monitorowanie/monitorowanie-jakosci.
[783] *Jakość w opiece zdrowotnej i bezpieczeństwo pacjenta*, IX.3260, available at www.orka.sejm.gov.pl/Druki9ka.nsf/0/F2416671B10E1F3DC12589B800417153/%24File/3260.pdf.
[784] Ibid., at 118.
[785] See M. Paspalanova et al., *Indicadores Sobre El Derecho a Un Juicio Justo Del Poder Judicial Del Distrito Federal* (2011).
[786] Ibid., at 31-2, 52, 129.

were not used merely for statistical reporting but were formally approved by the Judicial Council for internal use in assessing the Tribunal's performance in protecting and promoting human rights.[787] Their integration extends beyond technical benchmarking; rather, it reflects a broader process in which indicators become part of the normative infrastructure through which institutions define and evaluate their responsibilities.

3.2.3. Indicators as tools for international treaty reporting: the case of Guatemala

The case of Guatemala offers an example of the use of indicators in the context of international reporting under the treaty body system. In preparation for its periodic report to the CESCR, the Guatemalan government (under the coordination of the Presidential Commission on Human Rights) adopted the OHCHR framework and lists of illustrative indicators to assess its compliance with its obligations under the International Covenant on Economic, Social and Cultural Rights.[788] This reporting process was organised through an inter-institutional and participatory structure that included national entities such as the Human Rights Ombudsman, the National Secretariat for Planning, the National Council for People with Disabilities, and the Coordination Office for Mainstreaming Gender and Indigenous Peoples' Statistics, as well as international actors such as the UNDP and the United Nations Population Fund (UNFPA).[789]

Following an audit of the national statistical system, the government selected a set of indicators to report on three particular rights: the right to health, the right to education, and the right to food. The use of indicators in this context served not only to meet reporting obligations under the Covenant but also to enhance the transparency and responsiveness of the national statistical system.[790] The periodic report submitted by Guatemala acknowledged that indicators facilitated the dissemination of human rights information across institutions and constituencies and provided more objective basis for evaluating progress in the realisation of economic and social rights.[791] Demographic and health indicators have been deployed to monitor structural change, including declining fertility rates, rising life expectancy and a fourfold reduction of

[787] Ibid., at 19.
[788] UN OHCHR, *supra* note 299, at 105.
[789] Ibid.
[790] Ibid.
[791] UN, *Core document forming part of the reports of States parties. Guatemala*, HRI/CORE/GTM/2012 (2012), paras. 173-6.

under-five mortality over four decades, thereby evidencing the impact of public policies.[792] At the same time, the indicator system brought into view persisting deficits, such as the high and, in some years, increasing maternal mortality rate.[793] Epidemiological indicators documented both the contraction of communicable diseases (cholera, tuberculosis) and the growing prevalence of chronic non-communicable conditions, as well as projecting HIV trends while signalling underreporting linked to social stigma.[794] Disaggregated indicators made visible entrenched inequalities, notably the exceptionally high prevalence of chronic malnutrition among rural and indigenous populations and the low rate of contraceptive use, which correlates with poverty, limited education and restricted access to quality services.[795] Fiscal indicators, in turn, measured the allocation of public resources to health, recording a near doubling of expenditure as a share of GDP and allowing comparison with private outlays.[796] This case demonstrates that indicators can function as a bridge between domestic administrative data systems and the demands of international human rights law. Rather than producing parallel structures for compliance monitoring, Guatemala's approach embedded indicator development within existing institutional structures, thereby reinforcing both treaty reporting and domestic policy formulation. While the practice remains dependent on the availability of reliable data and institutional coordination, it illustrates the capacity of indicators to support structured, evidence-based dialogue between states and international monitoring bodies.

Despite differences in institutional capacity and political will, the examined examples support the view that, when properly institutionalised, indicators can function as legally relevant mechanisms. They contribute to clarifying the content of rights, structuring compliance, and facilitating accountability. Rather than remaining external tools of technocratic governance, indicators has become part of the way in which states interpret and implement their human rights obligations.

[792] Ibid., at para. 17.
[793] Ibid., at para. 50.
[794] Ibid., at paras. 41-2.
[795] Ibid., at paras. 39-40.
[796] Ibid., at paras. 38, 44-5.

4. Conclusion: towards a responsible use of human rights indicators

The preceding analysis has demonstrated that indicators can constitute a powerful tool for enhancing the visibility and enforceability of international human rights obligations. Their increasing integration into the practices of international organisations, domestic institutions, and judicial bodies reflects their importance in translating abstract legal commitments into operational standards.

At the same time, the use of indicators is not without risks. As has been shown, indicators may oversimplify complex realities and reproduce dominant epistemologies that marginalise local knowledge and experiences. The quantification of rights enjoyment tends to privilege that which is easily measurable, potentially neglecting aspects of dignity or contextual specificity that elude standardised metrics. The resulting technocratic rationality embedded in indicators may displace deliberative processes and entrench asymmetries of power, particularly between data producers and the communities assessed.

Yet these limitations do not invalidate the use of indicators; rather, they underscore the necessity of their responsible and reflexive deployment. This entails not only ensuring disaggregated data collection and inclusive stakeholder engagement but also embedding the monitoring process within institutions that are independent, adequately resourced, and mandated to interpret data through a human rights lens. Thus, indicator frameworks must be designed in accordance with cross-cutting human rights norms of participation, transparency, and accountability.

Moreover, the functional and epistemic plurality of indicators should be recognised as both a strength and a challenge. Their hybrid nature (as tools of diagnosis and governance) requires that their use be subjected to particular scrutiny. Indicators should be treated neither as ends in themselves nor as substitutes for political will or structural reform. They must instead be viewed as instruments that support, but do not replace, the legal and institutional mechanisms through which human rights are realised.

In sum, the utility of indicators does not lie in their presumed neutrality, but in their capacity to expose rights-related disparities and support legal and policy responses grounded in human rights obligations. Their effectiveness depends on methodological rigour and normative grounding. Only when indicators are developed and employed with an *awareness* of their

limitations can they fully realise their potential as tools for the realisation of human rights. This calls neither for their uncritical embrace nor for their wholesale rejection, but for a principled commitment to their justice-oriented application. The considerations developed above provide the conceptual and methodological backdrop for the following chapter, which examines how the WHO has employed indicators in practice. This shift to an institutional case study allows for an assessment of the extent to which indicators, when operationalised by WHO, shape not only monitoring and evaluation but also the implementation of health-related human rights obligations.

Chapter VI

Indicators in the WHO's practices during the COVID-19 pandemic

The COVID-19 pandemic exposed severe deficiencies in global health preparedness. As observed by the Independent Panel for Pandemic Preparedness and Response, many governments entered the COVID-19 crisis without comprehensive contingency frameworks and adequately resourced public health infrastructures, despite many rhetorical commitments and reform efforts.[797] These failures were not isolated incidents but indicated deeper structural problems in pandemic preparedness and global health governance system. According to states' self-assessments under the IHR, the global average score for so-called "core preparedness capacities" stood at just 64 out of 100 in the immediate pre-pandemic period – a figure indicating systemic underinvestment and insufficient readiness to combat the virus.[798] Moreover, only two-thirds of states declared that they had established legal and financial frameworks to support the prevention, detection, and effective management of health emergencies.[799] These results highlight not merely a lack of institutional capacity. The pandemic response suffered from weak accountability, inconsistent reporting, and investment choices that did not support preparedness.

In light of these shortcomings, the importance of reliable monitoring tools becomes evident. As global health governance increasingly depends on evidence-based assessments,[800] indicators emerge as not only diagnostic instruments but also leveraging factors capable of shaping how preparedness, response, and resource distribution are conceptualised and enacted. Their function is not confined to measurement; they operate as instruments through which institutional attention is channelled and interventions are prioritised. By doing so, they translate abstract human rights norms into concrete actions demanded by the circumstances. Against the backdrop of insufficient national healthcare capacities revealed at the onset of the pandemic,

[797] The Independent Panel for Pandemic Preparedness & Response and H. Clark, *COVID-19: Make It the Last Pandemic* (2021), at 18-19.
[798] *Average of 13 International Health Regulations Core Capacity Scores SPAR Version*, available at www.who.int/data/gho/data/indicators/indicator-details/GHO/-average-of-13-international-health-regulations-core-capacity-scores-spar-version.
[799] Ibid.
[800] See WHO, *Guide for Evidence-Informed Decision-Making* (2021), 6-14.

WHO sought to fill governance gaps mentioned by developing a range of indicator-based frameworks, which were disseminated through different types of documents during the COVID-19 response.

This chapter examines five key WHO documents issued during the pandemic in order to trace the diverse functions that indicators assumed in global health governance. The documents are not presented chronologically but rather arranged according to the degree of operational significance and institutional embedding that indicators acquired within them. The analysis begins with a narrowly targeted regional guidance document that sought to equip national authorities with tools to monitor health-care capacities under emergency conditions (Section 1). It then considers a methodological framework designed to help states build context-sensitive monitoring systems capable of capturing the pandemic's indirect effects (Section 2). Sections 3 and 4 examine cases where indicators moved beyond descriptive use and began to shape concrete decision-making: first at the regional level in Africa, and then at the global level in relation to vaccine allocation through the COVAX Facility. Section 5 turns to the most comprehensive framework, which sought to consolidate disparate monitoring practices into a unified global structure during the later stages of the pandemic.

Each document has been selected as the most illustrative example of a particular dimension of indicator use. This does not suggest that analogous instruments were absent in other parts of WHO's governance practice. Rather, the choice of specific regional or institutional contexts reflects the fact that the character and implications of indicator use can be most clearly (for the purposes of this dissertation) demonstrated based on the specific example. Together, these case studies provide a picture of the ways in which WHO employed indicators during the COVID-19 pandemic.

By situating these documents within their legal and institutional context, the chapter examines both the practical influence and the inherent limitations of indicators as tools of global health governance. The analysis suggests that indicators may contribute to specifying elements of international obligations, aligning national practices with common standards, and structuring the allocation of resources. At the same time, it points to persistent risks of reductionism and selective implementation, which limit the potential of indicators to improve institutional responsiveness, leading to ineffective addressing of inequities in the distribution of health resources. The analysis of each document begins with a descriptive overview, addressing the document's background and context, legal status, objectives, and application or reception in

practice. This is followed by an examination focusing on methodological soundness of the indicator framework presented, the tensions or limitations arising from their construction or use, and implications of their use for global health governance.

1. Monitoring health system capacity: "Indicators to Monitor Health-care Capacity and Utilization for Decision-making on COVID-19"

To understand the WHO's response to health-related challenges arising from the COVID-19 pandemic, this section begins with one of the earliest and most narrowly targeted applications of indicators during the crisis: the real-time measurement of national health-system capacity. Having established in the preceding chapters that indicators constitute important instruments through which the WHO translates its legal and institutional mandate into practice, the present analysis examines the manner in which this process was articulated during the initial phase of the pandemic. In November 2020, as several states in the Western Pacific Region faced rising hospital admissions, increasing ICU occupancy rates, shortages of ventilators, and significant staff absenteeism due to infection or quarantine, the WHO Regional Office for the Western Pacific (WHO Western Pacific) issued the document called "Indicators to Monitor Health-care Capacity and Utilization for Decision-making on COVID-19" (2020 Guidance).[801] The document aimed to support national and subnational health authorities at a time when many states were assembling fragmented data from disparate facilities and lacked standardised tools for assessing health-system capacity. In this sense, it exemplified how the Organisation, constrained by the limits of its formal authority, sought to exercise global health governance through the creation of data-based frameworks – a form of *governance through knowledge* consistent with its institutional orientation, as outlined in Chapter II.

From a legal-institutional perspective, the issuance of the 2020 Guidance falls within WHO's mandate under Article 2 of its Constitution, which authorises the Organisation to "act as the directing and co-ordinating authority on international health work" and "to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments."[802] Its adoption was further grounded in WHA resolution

[801] WHO Regional Office for the Western Pacific, *Indicators to Monitor Health-Care Capacity and Utilization for Decision-Making on COVID-19* (2020), at 1-2.
[802] Art. 2(a)(d) of the WHO Constitution.

WHA73.1, which called upon the Organisation to support member states in developing and implementing operational tools for monitoring and responding to the COVID-19 pandemic.[803] Acting pursuant to this mandate, the WHO Western Pacific issued the 2020 Guidance as a technical advisory instrument aimed at strengthening states' real-time monitoring capacities during the early stages of the pandemic. While the document carries no binding force, its legal relevance is reinforced by the fact that it operationalises commitments collectively endorsed by member states through the WHA resolution. This relevance is further supported by the substantive alignment of its indicators with human rights standards, particularly the right to health under the ICESCR, which already form part of states' international obligations, even if such alignment is not explicitly stated. Functionally, the 2020 Guidance can also be understood as contributing to the implementation of the IHR.[804] Although presented as a technical tool, its structure and content reflect parameters that intersect with state obligations under instruments such as the ICESCR and the IHR.

Unlike the globally coordinated 2022 SPRP M&E Framework,[805] which formed part of WHO's central planning architecture, the 2020 Guidance was not conceived as a long-term instrument. It was a reactive, region-specific technical tool, intended to support immediate decision-making under conditions of capacity constraint, and built around a set of indicators adaptable to diverse national contexts. The 2020 Guidance sets out indicators pointed at four domains: the availability of essential resources, levels of utilisation, surge capacity, and contextual epidemiological factors. These domains correspond closely to the AAAQ framework's dimensions of availability and accessibility, providing a concrete operationalisation of obligations derived from Article 12 ICESCR and elaborated by the CESCR in General Comment No. 14.[806] The document did not prescribe any quantitative thresholds or target values but rather defined the fields of analysis and a methodological structure through which national authorities were expected to generate data. By doing so, the 2020 Guidance exemplified the WHO's broader methodological role identified in Chapter II – transforming norms into standardised procedures through which compliance could be inferred

[803] WHA, *COVID-19 Response*, WHA73.1 (2020).

[804] As stipulated in point 1(a) of Annex I to the IHR: "States Parties shall utilize existing national structures and resources to meet their core capacity requirements under these Regulations, including with regard to: their surveillance, reporting, notification, verification, response and collaboration activities."

[805] See Section 5.

[806] For example, monitoring the percentage of ICU beds occupied or the availability of mechanical ventilators gives operational effect to the obligation to ensure the availability of essential health services during public health emergencies.

rather than formally enforced. The indicators were designed to be easily quantifiable, enabling rapid integration into systems with varying data capacities.

The 2020 Guidance urged national authorities to collect data at high frequency (weekly in most cases, and daily where circumstances required) and to analyse trends over time so that public health measures could be adjusted continuously rather than at fixed intervals[807]. This enabled ministries of health to reallocate resources or impose targeted restrictions before health system collapse occurred. In this respect, indicators ceased to function as neutral numbers and instead operated as instruments of decision-making power, defining what constituted sufficient preparedness and when corrective action was deemed necessary. In this sense, indicators were framed not merely as descriptive tools but as active instruments of pandemic governance. This approach reflected a wider transformation in global health governance from static contingency planning to real-time, data-driven responsiveness.[808]

An analysis of state practice (albeit significantly constrained by the diversity of national contexts and the uneven availability of documentation) indicates that states in the Western Pacific Region may have incorporated elements of the 2020 Guidance into their national monitoring systems. In the Philippines, the Department of Health implemented the DOH DataCollect Bed Tracker, a system covering all public and private hospitals, which collected daily data on COVID-19 bed numbers and occupancy, ventilator availability, and staff absenteeism. At the peak of the Delta wave in September 2021, the system recorded 28,261 COVID-19-dedicated beds (71,7% occupied) and 1,846 mechanical ventilators (58,5% in use).[809] These figures informed both central and local-level decisions on resource allocation and public health interventions. Similarly, in Fiji, the Ministry of Health, working with the WHO and the UN Office for the Coordination of Humanitarian Affairs (UNOCHA), launched an electronic clinical dashboard to monitor hospitalisations, oxygen consumption, and resource status at national, divisional, and facility levels.[810] This replaced paper-based reporting, enabling real-time adjustments in clinical and epidemiological response.[811]

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[807] WHO Regional Office for the Western Pacific, *supra* note 801, at 2.

[808] See H. Kluge et al., 'Strengthening Global Health Security by Embedding the International Health Regulations Requirements into National Health Systems', (2018) 3 BMJ *Global Health* e000656.

[809] B. Cabaro et al., 'Establishing a National Indicator-Based Surveillance System for Hospital Bed Utilization by COVID-19 Patients in the Philippines', (2023) 14(5) *Western Pacific Surveillance Response Journal* 33, at 33-6.

[810] *COVID-19 UpDATE – 21-06-2021 – MHMS FIJI*, available at www.health.gov.fj/21-06-2021/.

[811] K. Hammad et al., 'Implementation and Use of a National Electronic Dashboard to Guide COVID-19 Clinical Management in Fiji', (2023) 14(5) *Western Pacific Surveillance Response Journal* 16, at 16-21.

These initiatives demonstrate that, even in the absence of formal legal incorporation, the 2020 Guidance could be operationalised effectively when sustained by adequate data infrastructure and administrative commitment. The document left states wide discretion in determining how, and to what extent, its indicators would be integrated into domestic frameworks. Evidence from the region indicates that such integration was shaped by pragmatic considerations of policy coherence and administrative capacity. Yet the practical adoption of these indicators in the Philippines and Fiji also illustrates that, under supportive institutional conditions, technical guidance can influence decision-making in ways that give effect to substantive standards embedded in the right to health. In this context, indicators do not merely inform governance; they clarify the content of state obligations by identifying the aspects that require particular attention from stakeholders.

The publicly available version of the 2020 Guidance and related documentation do not identify the individuals responsible for drafting the indicator framework. The document is attributed broadly to the WHO Regional Office for the Western Pacific, specifically the Division of Health Systems and Services and the WHO Health Emergencies Programme. The absence of precisely identifiable authorship reduces transparency and complicates the assessment of the epistemic authority on which the indicators rest. Authorship in this context is not a merely administrative matter: it could help to determine methodological choices that influence how health-system performance is defined and interpreted. In line with WHO practice, contributing experts would have been required to submit declarations of interest, a measure intended both to reveal potential conflicts and to safeguard them from external pressure.[812] In this case, no declarations are available.

While the design of the document encouraged flexibility and comparability, it also exposed limitations inherent in this form of knowledge production. The focus on measurable parameters risked narrowing the analytical focus to what could be counted, neglecting qualitative aspects of care and concealing inequities in access, especially among marginalised groups. For example, the aggregate number of ventilators does not reveal whether these are equitably distributed or supported by adequately trained personnel. Such omissions can obscure structural disparities and produce an illusion of adequacy where systemic gaps persist. The simplification required for comparability thus operates at the expense of contextual

[812] See *Declaration of Interests*, available at www.who.int/about/ethics/declaration-of-interests.

understanding, with potential implications for how compliance with health-related obligations is perceived.

The 2020 Guidance offers an illustration of the processes through which indicators are used in practice. Its reliance on quantifiable and standardised measures follows the logic by which indicators act as intermediaries between abstract legal obligations and observable conduct. Yet this translation is never neutral. The selection of parameters such as ICU occupancy and ventilator availability reveals an implicit prioritisation of system efficiency over dimensions such as acceptability and quality, which are equally integral to the human rights framework. The absence of any explicit reference to these aspects invites reflection on whether this silence stemmed from strategic caution amid political sensitivities, or a deliberate effort to maintain the document's technical neutrality

The 2020 Guidance thus illustrates the dual character of indicators as both descriptive and constitutive tools. Indicators, once embedded within bureaucratic routines, begin to function as cognitive frames that point out what is to be observed and what counts as evidence of state's performance. Their practical effect depends less on legal form than on institutional uptake. Where adopted, they influence decision-making and channel attention towards selected aspects of performance, thereby contributing to the gradual formation of standards that guide policy without formal enactment. However, what is not measured, risks being marginalised.

2. Surveillance of indirect effects: "A Tool for Selecting Indicators to Signal and Monitor the Wider Effects of the COVID-19 Pandemic"

This section examines how the WHO sought to encourage member states to employ indicators capable of capturing the longer-term and indirect consequences of the pandemic, thereby shifting the focus from acute pressures to sustained effects on population health and the continuity of services. The WHO Regional Office for Europe's 2021 document "Strengthening Population Health Surveillance: A Tool for Selecting Indicators to Signal and Monitor the Wider Effects of the COVID-19 Pandemic" (SPHS)[813] sets out a conceptual framework designed to assist national authorities in developing context-specific monitoring systems rather

[813] WHO Regional Office for Europe, *Strengthening Population Health Surveillance: A Tool for Selecting Indicators to Signal and Monitor the Wider Effects of the COVID-19 Pandemic* (2021).

than prescribing a uniform (centralised) template. The practical necessity of such indicators is illustrated by empirical evidence from the pandemic period. In the United Kingdom, for example, persons with learning disabilities and autism experienced mortality rates more than four times higher than those of the general population, even within younger cohorts.[814] Many also reported reduced access to essential health services and a lack of targeted public health guidance.[815] Such gaps (often invisible in aggregated statistics) could have been more effectively detected and addressed through the type of disaggregated, vulnerability-focused monitoring promoted by the SPHS. This example demonstrate that the proposed framework is not merely a theoretical construct but a response to documented deficiencies in the protection of marginalised groups during public health emergencies.

The document does not refer to a specific legal basis for its issuance. Nevertheless, its character and scope clearly situate it within the WHO's constitutional functions, particularly those enumerated in Article 2, which authorise the Organisation to act as the directing and coordinating authority on international health work and to furnish technical assistance to member states. The SPHS should therefore be understood as a form of guidance issued pursuant to this general mandate as well as resolution WHA 73.1.[816] Its publication formed part of a broader strategic framework,[817] the "European Programme of Work 2020-2025: United Action for Better Health in Europe",[818] which provides the regional implementation platform for WHO's global objectives. Within this framework, the SPHS exemplifies the Organisation's method of exercising influence through technical instruments: rather than generating new obligations, it operationalises existing commitments under the Constitution by translating them into practical measures for national health surveillance.[819]

Unlike the 2020 Guidance, which was developed in the midst of an acute emergency response, the SPHS was conceived as a forward-looking framework designed to assist member

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[814] *People with Learning Disabilities Should Be Prioritised for a Covid Vaccine*, available at www.theguardian.com/society/2020/dec/15/people-with-learning-disabilities-should-be-prioritised-for-a-covid-vaccine.

[815] Ibid.

[816] See Section 1.

[817] *European Programme of Work*, available at www.who.int/europe/about-us/our-work/european-programme-of-work.

[818] See WHO Regional Office for Europe, *European Programme of Work 2020–2025: United Action for Better Health in Europe* (2021).

[819] *Strengthening population health surveillance: a tool for selecting indicators to signal and monitor the wider effects of the COVID-19 pandemic,* available at www.who.int/europe/publications/i/item/WHO-EURO-2021-2297-42052-57877.

states in identifying indicators capable of capturing the indirect and longer-term effects of the pandemic (such as excess suicides, malnutrition, or reduced access to essential care).[820] Importantly, the document promotes the use of indicators designed to integrate epidemiological, social, and economic aspects, thereby stressing the interdependence between health outcomes and their underlying structural determinants. For instance, the framework highlights the need to monitor the wider social consequences of public health measures such as quarantine and social distancing, which, while essential for infection control, can produce severe psychological and social effects, including heightened loneliness, stress, and disruption of support networks.[821] Correspondingly, the framework proposes indicators capturing aspects such as household composition, access to social support, and levels of perceived loneliness, which together provide a means of assessing the broader social costs of containment policies alongside their epidemiological effectiveness.[822] The document outlines a stepwise process for the development of national monitoring systems, beginning with the identification of key domains of concern and followed by the selection, adaptation, and validation of indicators aligned with their domestic needs and capacities.[823] In this context, indicators are conceived as evolving instruments that enable states to translate complex and shifting determinants of health into measurable and empirically traceable forms of knowledge. The framework provides a set of illustrative indicators (including suicide mortality rate, prevalence of depression, perioperative mortality rate) accompanied by methodological guidance concerning data sources and validation procedures.[824]

Research conducted for the purposes of this study did not identify any publicly available sources confirming the direct or indirect incorporation of the SPHS framework into national health monitoring systems. The absence of references in official government documents, technical guidelines, or peer-reviewed literature suggests that the publication has functioned primarily as a non-binding advisory tool. From the perspective of international law, such a design is consistent with the principle that states retain ultimate authority over the configuration of their monitoring mechanisms. At the same time, it limits the framework's capacity to operate as an instrument of structured global health governance, reinforcing the earlier observation that

[820] WHO Regional Office for Europe, *supra* note 813, at 1, 14-15.
[821] Ibid., at 9.
[822] Ibid.
[823] Ibid., at 2.
[824] Ibid., at 21-3.

WHO's influence is exercised predominantly through the production and dissemination of expert knowledge, the uptake of which remains contingent on states' political will.

The document exhibits a notable degree of methodological transparency. WHO details the multi-stage process through which the indicators were developed, beginning with a literature review and internal expert consultations, followed by external engagement and public review.[825] It further names the individuals involved in the drafting process, thereby enhancing the traceability of its development.[826] However, the document does not indicate whether these contributors submitted declarations of interest, leaving unresolved the question of potential conflicts. By making the tool available for public consultation and incorporating selected feedback, the WHO introduced elements of participatory refinement into its drafting process.[827] The explicit acknowledgement of the provisional nature of the evidence base, coupled with the commitment to revise the tool as new data become available,[828] contributes to procedural transparency; however, whether these features facilitate national uptake depends largely on how member states perceive and operationalise such initiatives within their own monitoring systems.

While the framework's adaptability allows national authorities to tailor indicators to local contexts, it simultaneously heightens the risk of inconsistency and selective data inclusion. The absence of detailed guidance on validation procedures, harmonisation methodologies, or minimum standards for disaggregation raises concerns regarding the comparability of results, particularly in cross-national assessments and in the coordination of responses at the regional level. In the absence of a shared methodological baseline, the framework may inadvertently contribute to fragmentation of state's practices.

This approach by the WHO reinforces the broader argument advanced in earlier chapters, namely that the Organisation seeks to exercise its role in global health governance primarily through the dissemination of expert knowledge and the promotion of technical frameworks designed to guide, rather than compel, state action. Such instruments operate by shaping policy preferences and practices through their alignment with internationally recognised standards, rather than by invoking binding regulatory authority. This reflects a deliberate institutional choice aimed at maximising the likelihood of adoption while minimising

[825] Ibid., at 3.
[826] Ibid., at IV.
[827] Ibid., at. 3.
[828] Ibid., at 4.

the political sensitivities that often arise in connection with more prescriptive forms of international coordination.

3. Operational indicators in practice: "Monitoring and evaluation framework for the COVID-19 response in the WHO African Region"

The "Monitoring and evaluation framework for the COVID-19 response in the WHO African Region" (M&E Africa)[829] was developed and issued by the WHO Regional Office for Africa (WHO African Region) in early 2020, in direct response to the rapid escalation of COVID-19 cases and the urgent need for coordinated oversight of national preparedness and response measures. The framework was conceived in the context of the first months of the pandemic, when divergent national monitoring practices and uneven data quality were hampering the regional picture of COVID-19 response capacity.[830] WHO African Region aimed to standardise monitoring across member states, both to enable comparability and to create a basis for prioritising technical and logistical support.[831]

While not adopted through a formal resolution of the WHO Regional Committee, the framework drew on the WHO Constitution's mandate[832] to provide technical guidance and on the Organisation's role under the IHR[833] to coordinate international action during public health emergencies of international concern. It constituted a non-binding, technical instrument (comparable to other WHO 'guidance' documents) intended for immediate use by ministries of health in all 47 African member states. The M&E Africa was not adopted as a formal WHO publication. The final page of the document contains the disclaimer: "This is not an official publication of the World Health Organization."[834] Such a caveat may carry both legal and institutional implications: it might suggest that the publication did not undergo WHO's full clearance and endorsement procedures, thereby limiting its potential within the Organisation's

[829] WHO African Region, *Monitoring and Evaluation Framework for the COVID-19 Response in the WHO African Region* (2020).
[830] Ibid., at 6-7. See WHO African Region, *Report on the Strategic Response to COVID-19 in the WHO African Region February – December 2020* (2021), 7.
[831] WHO African Region, *supra* note 830, at 5-8.
[832] Art. 2(a)(d) of the WHO Constitution.
[833] See L. O. Gostin and R. Katz, 'The International Health Regulations: The Governing Framework for Global Health Security', (2016) 94(2) *Milbank Quaterly* 264.
[834] WHO African Region, *supra* note 829, at 25.

legal framework and potentially affecting its perceived authoritativeness. In practice, this means the framework operates as a working or advisory tool rather than an official WHO position, which may further weaken its influence on member states and reinforce its status as a soft governance instrument.

The document's target audience was national health authorities, supported by WHO country teams, who were tasked with collecting and reporting data on a weekly basis using the agreed common format.[835] At its core, the M&E Africa set out 31 Key Performance Indicators grouped into domains such as infection prevention and control, laboratory testing capacity, and continuity of essential health services[836] which correspond to the AAAQ dimensions of the right to health. The framework organised these indicators into a results chain (inputs, outputs, and outcomes) and introduced a "traffic-light" scoring system, with the stated purpose of enabling WHO African Region to identify priority states for targeted support.[837] Data for these indicators were collected by national authorities and then transmitted to the Regional Office for consolidation and analysis.[838] WHO African Region's monitoring role was thus dependent on state-reported data.

The framework was implemented rapidly. By March 2020, 33 states had submitted national COVID-19 preparedness and response plans incorporating the framework's monitoring component.[839] These plans established coordination mechanisms, reporting schedules, as well as designated focal points for data transmission. The system was used throughout 2020 to identify gaps such as insufficient infection prevention capacity in healthcare facilities and shortages in PCR testing availability. Then, this data informed the allocation of emergency supplies.[840] In this sense, M&E Africa bridged the gap between normative aspirations and operational decision-making, showing how even an unofficial instrument can serve as a platform for collective learning and situational awareness during crises.

The M&E Africa contains no information regarding the process of its development, the composition of the authoring team, or the organisational unit within WHO African Region

[835] Ibid., at 6.
[836] Ibid., at 8, 16, 21-4.
[837] Ibid., at 18.
[838] B. Impouma et al., 'Monitoring and Evaluation of COVID-19 Response in the WHO African Region: Challenges and Lessons Learned', (2021) 149 *Epidemiology and Infection* 1, at 2.
[839] Ibid., at 2.
[840] Ibid., at 3.

responsible for its preparation. The absence of such details hinders external control of the indicator selection process and makes it impossible to assess whether (and what) political or institutional considerations may have influenced their design. A framework that aspires to guide the implementation of the right to health must be grounded in transparent procedures of knowledge production, reflecting the participatory and accountable ethos that human rights entail. In this case, the opacity surrounding the drafting process also raises questions about the epistemic validity of the indicators.

The framework also embodied significant risks. The epistemic risk of invisibility stemmed from the absence of mandatory disaggregation by sex, age, disability, or other grounds of discrimination. This omission, whether motivated by expediency or by capacity constraints, meant that systemic inequalities remained largely unrecorded, thereby limiting the framework's ability to capture the dimensions of accessibility and acceptability that form part of states' obligations under the right to health. The risk of reductionism arose from compressing complex realities into a three-tier traffic-light scale, which could obscure contextual differences and shift attention from real (structural) causes to numerical performance. Implementation further exposed the problem of fragmentation: in many member states, the absence of dedicated monitoring personnel and the multiplicity of reporting demands from different WHO units and external partners resulted in inconsistent data and procedural duplication.[841]

Notably, however, despite the disclaimer indicating that the framework was not an official WHO publication, the document nevertheless triggered tangible responses, including targeted technical assistance, the delivery of medical supplies, and capacity-building initiatives in states identified as requiring additional support. This paradox reveals that even non-binding, advisory instruments can exert substantial influence when they are embedded in existing institutional workflows and respond to immediate operational needs during a public health emergency. In this sense, the M&E Africa framework illustrates how soft governance tools may acquire *de facto* regulatory significance by shaping state behaviour and resource allocation without the backing of formal legal authority. Its effectiveness derived less from coercive power than from epistemic credibility and institutional embeddedness, enabling it to function as a coordinating mechanism across a fragmented regional landscape. The case thus demonstrates

[841] Impouma et al., *supra* note 838, at 3. See also K. Wellens, 'Fragmentation of International Law and Establishing an Accountability Regime for International Organizations: The Role of the Judiciary in Closing the Gap', (2004) 25 *Michigan Journal of International Law* 1159.

that the legal relevance of indicators in global health governance does not lie in their binding force but in their ability to generate shared standards of evaluation that influence how international obligations are interpreted and acted upon.

4. Equity aspirations and political realities: "2020 Concept for Fair Access and Equitable Allocation of COVID-19 Health Products"

To demonstrate an attempt to operationalise equity principles in the global pandemic response, this section examines the "WHO Concept for Fair Access and Equitable Allocation of COVID-19 Health Products" (2020 Concept), issued in September 2020.[842] Prepared by the WHO Secretariat at an early stage of vaccine development, and in parallel with debates on global allocation mechanisms, the document represented the Organisation's explicit attempt to embed indicators within a framework of distributive decision-making. It was addressed primarily to WHO member states participating in the COVAX Facility, and secondarily to institutional partners such as the Gavi, the CEPI, and the UNICEF. Conceived as a strategic instrument, the 2020 Concept was intended to guide the allocation of vaccines and related health products. Its significance lies not only in the technical criteria it proposed but also in the broader assertion that resource distribution during a health emergency should be grounded in transparent, data-based criteria rather than in *ad hoc* political bargaining.

The issuance of the 2020 Concept was grounded in WHO's constitutional mandate under Article 2, in a manner comparable to other instruments examined in this chapter. It was also directly connected to WHA Resolution WHA73.1, which expressly called upon WHO to support the global effort to secure equitable access to COVID-19 vaccines and health products.[843] Although the 2020 Concept was formulated as a non-binding strategic proposal, its legal relevance may nonetheless be discerned from its functional role in translating into practice obligations already incumbent upon states under international law.[844] Through establishing allocation criteria informed by indicators of need (such as infection rates, mortality levels, and population vulnerability) and capacity (including the availability of health infrastructure and resources), the document sought to give practical effect to states' duties of non-discrimination

[842] WHO, *WHO Concept for Fair Access and Equitable Allocation of COVID-19 Health Products* (2020), 6.
[843] Ibid., at 6.
[844] Most notably the right to health as recognised in Article 12 of the ICESCR.

and international cooperation. Its implications also intersect with the IHR, insofar as the equitable distribution of essential medical countermeasures forms part of the collective responsibility to prevent and respond to public health emergencies of international concern.[845]

The 2020 Concept set out a two-phase allocation mechanism intended to guarantee universal access to vaccines and other COVID-19 health products, while also allowing for prioritisation of states most in need. In the first phase, resources were to be distributed proportionally according to population size, with the aim of ensuring that every participating state would obtain an initial tranche sufficient to cover a fixed percentage of its population.[846] The second phase envisaged a shift to a needs-based approach, under which allocation decisions were to be guided by indicators reflecting epidemiological risk and the capacity of national health systems.[847] These included factors such as infection rates, the availability of intensive care units, and the capacity to absorb and effectively deploy limited supplies. In this context, indicators assumed the role of operational thresholds rather than descriptive measures: a state experiencing high transmission and limited critical-care capacity would, in principle, be prioritised for additional allocations over a state with stronger infrastructure or less acute outbreak dynamics. In this way, the 2020 Concept sought to institutionalise fairness through indicator-informed triage, presenting quantitative data as safeguards against purely political or bilateral modes of distribution. At the same time, however, it reflected a technocratisation of decision-making, whereby questions of equity and need were reduced to numerical criteria and managed through technical procedures.

Despite its emphasis on transparency and equity, the 2020 Concept did not clarify how the reliability and comparability of the proposed indicators were to be ensured. The framework presupposed the availability of timely, standardised, and cross-nationally comparable data – an assumption that proved unrealistic, particularly in low-resource settings with fragile surveillance infrastructures. Key indicators such as reported infection rates or intensive care capacity were frequently based on incomplete or delayed reporting or were compiled according to divergent national methodologies, that undermined their comparability.[848]

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[845] WHO, *supra* note 842, at 7.
[846] Ibid., at 24.
[847] Ibid., at 25-7.
[848] M. Stoto et al., 'COVID-19 Data Are Messy: Analytic Methods for Rigorous Impact Analyses with Imperfect Data', (2022) 18 *Globalization and Health* 2, at 2-7.

As a result, allocation decisions risked being made on the basis of data that did not accurately reflect realities. In such circumstances, the very mechanism designed to mitigate global disparities risked reinforcing them: states with stronger reporting capacities could appear more eligible for priority access, while those with weaker infrastructures (often those most in need) were placed at a disadvantage.[849] These shortcomings illustrate that reliance on indicators is never neutral, since the design and application of indicator-based criteria invariably privilege certain types of data over others. Within the COVAX allocation mechanism, for instance, the inclusion of "operational capacity" as one of the parameters for dose allocation meant that states with stronger administrative systems and infrastructures were perceived as more "ready" to receive vaccines.[850] While this approach aimed to prevent wastage and ensure efficient deployment, it inadvertently created a structural bias favouring those states already endowed with robust governance and reporting structures.[851] In effect, the very criteria intended to optimise global efficiency reproduced inequalities: operational readiness was rewarded, while structural vulnerability was penalised.[852] In practice, this dynamic was compounded by the highly irregular nature of vaccine donations, many of which were *ad hoc* and supplied with very short expiry periods.[853] Two-thirds of doses delivered through COVAX had less than three months of shelf life, demanding rapid absorption that only well-resourced systems could achieve.[854] States struggling with fragile health infrastructures were therefore placed at a distinct disadvantage. This paradox underscores the epistemic and structural bias inherent in indicator-based governance. Indicators are not passive instruments of measurement, but they actively shape the very structures they claim to correct.

Equally significant were the procedural shortcomings of the 2020 Concept. Although the document presented indicator-based allocation as a mechanism of fairness, it failed to specify how the relative weight of different criteria (such as whether high transmission rates should outweigh limited intensive care capacity) was to be determined. The absence of transparent weighting rules undermined the claim to objectivity and opened space for discretionary or politically influenced interpretation. Nor did the framework provide any avenue

[849] COVAX, *Key Learning for Future* (2022), 6.
[850] Puyvallée and Storeng, *supra* note 380, at 3.
[851] Ibid., at 3, 6.
[852] See The Independent Panel for Pandemic Preparedness & Response, *COVID-19: Make it the Last Pandemic* (2021), 12.
[853] Ibid., at 3, 4, 6.
[854] *The race to reach missed deadlines: COVID-19 vaccination targets & the TRIPS Waiver*, available at genevahealthfiles.substack.com/p/the-race-to-reach-missed-deadlines.

for review or appeal in cases where states might be disadvantaged by its assessment. Notably, more than 80% of the representation in COVAX governing bodies originated from high-income states, while the purpose of the mechanism was explicitly to ensure equitable access for low- and middle-income countries. This discrepancy seems to confirm that the governance of COVAX was shaped less by principles of solidarity than by donor-driven priorities.[855] Another problem was the limited inclusiveness of the process by which the criteria were developed. The allocation framework was elaborated centrally, without systematic consultation with member states or civil society actors, despite its direct distributive implications. This procedural opacity further reinforced the perception that the allocation model reflected technocratic assumptions rather than genuinely shared ethical priorities. By presenting indicators as neutral and technical, the 2020 Concept concealed the choices inherent in defining which dimensions of need or capacity should be treated as decisive, thereby conferring a false aura of objectivity on what were, in essence, value-laden policy judgments.

The subsequent implementation of the allocation framework under the COVAX Facility exposed the divergence between the ambition of the 2020 Concept and the political realities that shaped vaccine distribution.[856] COVAX was conceived as "a beautiful idea" but ultimately fell short of its equity objectives, as high-income states secured priority access through bilateral agreements and advance purchase commitments with pharmaceutical companies, leaving broader support dependent on their voluntary donations.[857] In this environment, the indicator-based criteria envisaged by WHO exerted only a limited constraining effect. Distributional decisions were influenced less by the transparent thresholds articulated in the 2020 Concept than by the bargaining power and financial leverage of wealthier participants. This outcome illustrates the inherent limitations of indicators when detached from enforceable legal frameworks. Although the 2020 Concept presented a model of fairness grounded in measurable criteria, the dominance of political and economic asymmetries meant that its reliance on indicators could not, in practice, secure equitable allocation.

In sum, the 2020 Concept illustrates both the promise and the fragility of indicator-based global health governance. By articulating transparent, data-driven thresholds for distributive decision-making, WHO sought to demonstrate that resource allocation during a global

[855] A. Pushkaran, V. K. Chattu and P. Narayanan, 'A critical analysis of COVAX alliance and corresponding global health governance and policy issues: a scoping review', (2023) 8(10) BMJ *Global Health* e012168, at 7.
[856] See MSF Access Campaign, Médecins Sans Frontières, *COVAX: A Broken Promise to the World* (2021), 3-4.
[857] A. D. Usher, 'A Beautiful Idea: How COVAX Has Fallen Short', (2021) 397 *The Lancet* 2322, at 2322.

emergency could be grounded in measurable criteria rather than political expediency. Yet the specific design of this mechanism, coupled with strong political influence, significantly limited both its legal relevance and its practical effectiveness. As the experience of COVAX confirmed, indicators alone could not overcome entrenched inequalities, nor could they constrain the political and economic leverage of powerful states. The 2020 Concept thus represents an important attempt to operationalise equity through indicators, but also a reminder of their dependence on institutional design and international cooperation for their efficacy.

5. Standardising pandemic governance: "COVID-19 Strategic Preparedness and Response Plan 2022: Global Monitoring and Evaluation Framework"

The COVID-19 Strategic Preparedness and Response Plan 2022: Global Monitoring and Evaluation Framework (2022 SPRP M&E) was issued by the WHO Secretariat in September 2022.[858] By that stage, more than two years into the pandemic, WHO and its partners were confronted with fragmented national reporting, the uneven use of indicators across regions, and increasing pressure from donors for transparent and comparable data. In this context, the 2022 SPRP M&E was designed as a tool for harmonisation of pandemic-oriented global efforts,[859] as well as an attempt to restore coherence to WHO's governance strategy during the later stages of the global response.

The framework's legal basis lies in WHO's constitutional authority to coordinate international action in health emergencies and to provide technical guidance to member states.[860] By referring explicitly to the IHR, WHO linked the 2022 SPRP M&E to the broader international legal architecture governing public health emergencies.[861] This cross-reference situates the framework within the continuum of instruments intended to ensure transparency and cooperation in pandemic governance. Although non-binding, the 2022 SPRP M&E carries

[858] WHO, *COVID-19 Strategic Preparedness and Response Plan 2022: Global Monitoring and Evaluation Framework* (2022).
[859] Ibid.
[860] Art. 2(a)(d) of the WHO Constitution.
[861] "[The Framework] links with adapted regional reporting frameworks under the COVID -19 SPRP 2022. In addition, the framework interfaces with other existing preparedness and response frameworks, including International Health Regulations (IHR 2005) and the White Paper on Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience to contextually align and maintain coherence in global and national programmatic monitoring." Ibid., at 2.

normative weight by operationalising duties of coordination and information-sharing inherent under international law, particularly within the IHR system.

The 2022 SPRP M&E stated a dual objective. First, it was intended to provide member states with a standardised set of indicators to guide the monitoring of their national response capacities. Second, it aimed to furnish donors, implementing agencies, and WHO offices at both state and regional level with a common standardised evidential reference point for the purposes of oversight and coordination of assistance[862]. Structurally, the 2022 SPRP M&E arranged its indicators under five operational pillars (emergency coordination, collaborative surveillance, clinical care, community protection, and access to countermeasures) and associated them with platforms such as the Global COVID-19 Access Tracker (GCAT), the Response, Readiness and Requirements Tracker (3RT), and the Early AI-supported Response with Social Listening (EARS).[863] Within this design, "progress" was captured as measurable improvement within these domains (for example, higher coverage among priority groups, increased surveillance throughput, or strengthened supply continuity).

Evidence suggests that the indicators contained in 2022 SPRP M&E influenced the COVID-19 response in practice. The WHO Monthly Operational Update for November 2022 records that the COVID-19 Vaccine Delivery Partnership (CoVDP) focused support on a cohort of 34 low-vaccine-coverage countries and undertook targeted technical and high-level missions (for example, the Democratic Republic of Congo, Malawi, Sudan and the Syrian Arab Republic) to raise vaccination coverage in predefined priority groups.[864] A CoVDP situation report for August 2022 also illustrates how the 2022 SPRP M&E indicators were used to guide operational decisions. Drawing on indicators, WHO identified 34 states where vaccination progress lagged behind regional targets and where barriers such as limited cold-chain capacity or inadequate delivery networks of vaccines persisted. On the basis of this assessment, WHO established an emergency delivery funding window of $30 million to provide targeted assistance aimed at vaccine deployment. In addition, the same indicator framework was used to monitor vaccination coverage among health workers and older adults (groups identified as most at risk) thereby enabling WHO to prioritise follow-up support and measure the effectiveness of national campaigns over time.[865] In parallel, WHO's December 2022 update

[862] Ibid.
[863] Ibid., at 7-11.
[864] WHO, *WHO's Monthly Operational Update on COVID-19* (November 2022), 25.
[865] CoVDP, *Situation Report August 2022* (2022), 10.

records concrete deployments and capacity investments, including rapid support and supplies for Tuvalu and pre-installation assessments for oxygen PSA plants in Bhutan, actions mapped to the pillars on clinical care and access to countermeasures, reported within the same system.[866] Read together, these traces suggest that the 2022 SPRP M&E arguably set criteria through which WHO and its partners channelled funding and technical support.

The fact that the indicators were developed within WHO's technical departments with the involvement of external partners,[867] indicates the seriousness with which the Organisation undertook the task of indicator design. Such drafting process may be seen as an attempt to ensure participation across different institutional levels and to reinforce both the clarity and the legitimacy of the proposed framework. In this respect, the 2022 SPRP M&E was presented not solely as a technical instrument but also as one intended to secure wider engagement in shaping the monitoring framework.[868] However, the documentation available does not clarify how WHO balanced donor demands for comparability with states' concerns about data sovereignty, nor whether participating entities had equal input in indicators design and selection.

Aspects like participation, cultural acceptability, or clinical quality were largely excluded from measurement, possibly because they do not lend themselves to standardised quantification and cannot be easily compared across contexts. This omission is significant from a legal perspective, as it reveals how the monitoring process itself can bring attention to certain aspects of the right to health while omitting others. In seeking to align technical monitoring with human rights principles, the 2022 SPRP M&E framework prioritised dimensions that could be readily quantified, such as coverage rates or supply chain performance. This focus necessarily narrowed the interpretive range of the right to health, relegating aspects such as participation, transparency, and dignity to a peripheral position.

The 2022 SPRP M&E framework exemplifies both the ambition and the constraints of indicator-based governance. By providing a common vocabulary for states, donors and WHO itself, it helped to organise reporting and channel assistance, thereby reinforcing WHO's role as coordinator of pandemic response. At the same time, its reliance on easily quantifiable information reduced complex dimensions of the right to health, privileging comparability over validity. The framework thus confirms the double edge of indicators in global health law: they

[866] WHO, *WHO's Monthly Operational Update on COVID-19* (December 2022), 1-5.
[867] Ibid., at 6.
[868] Ibid., at 2.

can anchor human rights language in operational practice, but they also risk narrowing that practice to what can be counted.

6. WHO and pandemic-related indicators

The documents analysed in this chapter reveal the diverse roles that indicators played in WHO's pandemic response. Initially conceived as tools for technical monitoring, indicators progressively acquired a more constitutive function, shaping not only data collection practices but also patterns of institutional engagement and resource allocation. Taken together, these materials can be seen to reflect a partial institutionalisation of indicator-based governance within WHO during the COVID-19 pandemic, as well as a broader movement toward evidence-informed decision-making in global health governance.

Across the examined cases, WHO relied on indicators not as binding standards but as advisory tools intended to inform decision-making at multiple levels. This approach corresponds to WHO's institutional identity as an expert body without coercive powers, whose influence depends on epistemic authority and the consent of its member states. The overall approach reflected an emphasis on persuasion rather than obligation. WHO developed standardised monitoring tools and promoted their voluntary adoption but refrained from prescribing binding requirements or enforcement mechanisms. Implementation remained a matter of national discretion, guided by encouragement and technical support rather than by legal or institutional compulsion. Indicators thus functioned as instruments of guidance: scientifically grounded, actionable, and overlapping with legal standards.

Although the documents refrain from referring explicitly to international human rights instruments, the orientation of their indicators reflects normative principles consistent with the international law. The frameworks had operationalised abstract elements of the right to health into observable points of reference. Although avoiding legal terminology, their design demonstrates how human-rights-based reasoning can be embedded within ostensibly technical instruments. Such an alignment between indicators and international human rights law supports the view that such frameworks, even when drafted in non-legal terms, possess a form of legal relevance; one that stems from their capacity to interpret and operationalise state obligations through empirical data rather than through direct legal articulation. However, as it is demonstrated by the 2020 Concept, despite the language of equity, solidarity and transparency,

the document did not provide a mechanism through which individuals or states could contest allocation outcomes, nor did it impose duties of justification or disclosure on decision-makers (which, moreover, would have been difficult to envisage given the legal framework within which the Organisation operates); an issue that appears inherent to the current functioning of the WHO.[869]

In this respect, indicators may contribute to clarifying and operationalising human rights obligations, not by prescribing their precise content but by offering measurable reference points that could shape expectations of performance. Although such interpretations do not carry formal legal status, their repeated use in institutional practice may, over time, influence how human rights standards are understood in the context of health governance. At the same time, the analysis of WHO's pandemic-related indicator use reveals several limitations. Most notably, the Organisation has not articulated clear procedural mechanisms for validating indicators, updating them in response to contextual changes, or incorporating the perspectives of affected communities into their design. In many cases, indicators were developed through internal expert processes (insufficiently clarified and lacking comprehensive treatment in the relevant documentation) and disseminated as technical tools without meaningful stakeholder involvement. While certain documents, such as the SPHS, demonstrated greater procedural transparency, such efforts remained isolated rather than systemic.

The concerns outlined in the previous chapter regarding technocratic reductionism, procedural opacity, and legal ambiguity find partial corroboration in the WHO materials analysed. Indicators might oversimplify complexities of reality. Still, using such tools does not automatically mean that the legal meaning is distorted. This dissertation has not undertaken a systematic evaluation of whether such simplification leads to misrepresentation or bias, as such an inquiry would require empirical and statistical tools that fall outside the methodological scope of the present legal analysis. Nonetheless, it is notable that WHO itself offers no explicit recognition of this risk in the analysed documents, nor does it appear to have instituted safeguards to mitigate it.

There is also a risk that indicators embed particular priorities within apparently technical criteria, thereby limiting the scope for political debate. The 2020 Concept illustrated this most clearly: while presented as a mechanism of fairness, its reliance on operational capacity and

[869] See Barcik, *supra* note 86, at 212-13.

data comparability effectively favoured states with stronger infrastructures and reporting systems. WHO's reliance on this kind of tools illustrates a tendency to frame governance challenges as matters of technicalities. While this approach facilitates procedural clarity and cross-country comparability, it can also obscure the ethical and distributive questions that arise when indicators determine access to limited resources, such as vaccines or oxygen supplies. In this sense, WHO's documents often emphasise coherence and efficiency of implementation, while offering little scope for contesting the underlying assumptions about which needs should be prioritised. As a result, indicators may be perceived as neutral tools, even though their design reflects specific legal and policy choices.

While WHO cannot compel states to adopt specific indicators, its role as an expert body entrusted by member states with the formulation of legal guidance endows its technical standards with legal relevance. The persuasive power of indicators stems from this unique institutional mandate: WHO does not speak with the authority of an international court, but its standards nonetheless shape how health obligations are understood and measured. This capacity to influence interpretation (especially under conditions of legal indeterminacy) may have far-reaching consequences for the evolution of global health law.

The examples considered suggest that while indicators can help to clarify expectations and guide operational choices, their consistent, transparent, and inclusive use depends on the institutional settings in which they are deployed. The tangible operational impact of the M&E Africa and 2022 SPRP M&E frameworks demonstrates that technical sophistication alone does not determine effectiveness; political will and institutional integration are equally decisive. In this respect, the effectiveness of indicators as tools of global health governance appears less a function of their technical design than of the procedures that govern their application and the political will of state-level decision-makers.

Taken together, these findings demonstrate that indicators occupy a distinctive position in the landscape of global health governance. They are neither neutral measures of performance nor binding sources of obligation. Instead, they function as hybrid instruments, deriving authority from technical design and their resonance with existing legal and ethical standards. Their potential to influence human rights compliance is real, but at the same time it remains conditional. The case studies analysed in this chapter therefore highlight both the opportunities and the limitations inherent in WHO's reliance on indicators, pointing to the need for further

inquiry into the conditions under which such tools can meaningfully support international legal commitments in the field of health.

Chapter VII

Concluding remarks

The concept of health, usually associated with a paramount human value, resists normative anchoring, possesses a modal character, and varies in scope over time.[870] This indeterminacy explains the growing reliance on indicators as tools for translating broad principles into tangible standards. Against this background, the findings of the dissertation support the hypothesis stated in Chapter I, indicating that indicators developed and applied within the WHO's institutional practice influence both the interpretation and implementation of health-related human rights and shape the epistemic conditions of global health governance.

Based on doctrinal sources and institutional practices, including those of the WHO, the analysis has sought to trace the multiple functions of indicators. The study demonstrates that indicators serve several distinct purposes: they specify and clarify the content of legal norms, orient and guide policy action, and facilitate systematic observation and assessment of situations.[871] In doing so, they enable international actors to translate abstract legal commitments into operational standards and subsequently to evaluate performance. Indicators thus emerge as instruments actively employed across different levels of governance, being utilised by states and non-state actors alike.

Given the fluidity of health-related human rights standards, and of the right to health in particular, their interpretation often proves challenging when defining the precise scope of state obligations.[872] This indeterminacy highlights the necessity for interpretative tools that can translate abstract legal principles into concrete forms of expected behaviour. Among such tools, indicators have become increasingly significant as instruments capable of providing measurability to otherwise open-ended commitments. While they lack formal legal force, indicators influence both how compliance with human rights obligations is understood and guide institutional practices within the global health governance structures.

[870] Tabaszewski, *supra* note 312, at 209.
[871] See Section 1 of Chapter V.
[872] See Section 4.3 of Chapter III.

The study has sought to establish that indicators shape the epistemic foundations of governance by determining what counts as evidence and whose knowledge informs decision-making. Frameworks such as the M&E Africa,[873] the SPHS,[874] the SPRP,[875] the 2022 SPRP M&E,[876] and the 2020 Guidance[877] or the 2020 Concept[878] exemplify this trend. Through these instruments, indicators were used not only to monitor pandemic response but also to steer global priorities and allocate resources,[879] thus framing expectations of compliance with health-related human rights. While indicators can enhance transparency and foster comparability, the apparent precision of numerical data can obscure interpretative choices and value judgments.[880] As the study has attempted to demonstrate, process of designing and using indicators is never neutral: they embed assumptions about what constitutes progress, compliance, or fulfilment of human rights.[881] Indicators thus participate in constructing the very realities they claim to describe. This performative dimension carries consequences for international law, as it reveals how authority can be exercised through data rather than through formal coercive means.

The WHO's reliance on data-driven tools further underlines how indicators can influence both operational and normative dimensions of health governance. In this context, indicators functioned as a partial substitute for the Organisation's lack of coercive authority, being an alternative mode of data-based governance.[882] Importantly, indicators do not replace law. Rather, they operate in parallel with legal instruments, enhancing the probability that WHO-recommended practices would be taken up and that national policies would be adjusted in line with WHO guidance. When anchored in legal norms, they acquire normativity.

The findings therefore confirm the dual nature of indicators anticipated in the research hypothesis. Normatively, indicators help to clarify the content of health-related human rights in practice. Epistemically, they influence what kind of information is recognised as evidence for assessing whether states meet their obligations. The interplay between normative and epistemic

[873] See Section 3 of Chapter VI.
[874] See Section 2 of Chapter VI.
[875] See Section 4.1 of Chapter III.
[876] See Section 5 of Chapter VI.
[877] See Section 1 of Chapter VI.
[878] See Section 4 of Chapter VI.
[879] Ibid.
[880] See Section 2 of Chapter V.
[881] See Chapter V.
[882] See Chapter II.

authority helps to explain why indicators occupy an important place in the WHO's governance mode, connecting the Organisation's legal commitments with evidence-based practices.

The study cautions against an uncritical embrace of indicator-based governance.[883] The quantification of human rights may risk marginalising qualitative dimensions of real-life experiences, such as human dignity or contextual specificity, that cannot be easily quantified. Indicators may reproduce existing power asymmetries, privileging those actors who control the means of data production and interpretation. For these reasons, indicators should not be treated as neutral tools but as instruments of governance whose design and use are inherently political.

The conditions under which indicators can meaningfully contribute to human rights protection are also identified.[884] In the realm of human rights, indicators can elucidate state obligations only when formulated in a context-sensitive manner, meaning that they must take into account local and social contexts in which obligations are to be implemented. For indicators to effectively fulfil their human rights-related objectives, they necessitate institutional safeguards, encompassing independent oversight and monitoring mechanisms. Moreover, indicators must rely on comprehensive data that facilitates the identification of disparities, and they should be developed with meaningful stakeholder engagement. Their importance, when developed and utilised in this manner, arises not from a facade of objectivity but from procedural guarantees that enhance inclusiveness and transparency. In this respect, the dissertation's findings correspond to its initial objective of assessing the potential of indicators to contribute to the protection of health-related human rights.

At the same time, the study indicates that current practices of indicator design remain fragmented. Although most human rights bodies recognise the importance of participation, transparency, and accountability, there is no consistent and universally agreed framework on how indicators should be constructed and used in practice. This is particularly evident in the case of data disaggregation, which continues to be applied unevenly across institutions and monitoring frameworks. Further institutional efforts seem necessary to develop common, human-rights based methodological standards. Such work could make the design and use of indicators more transparent and, ultimately, more reliable. Nonetheless, reaching such consensus within international law is inherently difficult, given the diversity of competing

[883] See Section 2 of Chapter V and Section 6 of Chapter VI.
[884] See Sections 4-10 of Chapter IV.

political interests steering decision-making. It is therefore possible that full agreement on issues mentioned may never be achieved.

Ultimately, the findings of this dissertation suggest that indicators occupy an important position in human rights law. In the evolving landscape of global governance, where data increasingly mediate legal interpretation, the challenge is to ensure that indicators enhance justice instead of reducing it to a question of administrative tasks. When used reflectively and responsibly, indicators can bridge the gap between aspiration and implementation, providing the tools through which the protection of human rights becomes meaningfully realised. In sum, the study confirms that indicators have become integral to the interpretation, operationalisation and monitoring of health-related human rights. Their dual normative and epistemic functions illustrate how international law increasingly draws on data-driven forms of authority.[885]

[885] See M. Koskenniemi, 'The Fate of Public International Law: Between Technique and Politics', (2007) 70(1) *The Modern Law Review* 1, at 1.

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