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## **The Demagogies of ‘Lack’: The WHO’s Ambivalence to the Right to Health of LGBT People**

Po-Han Lee

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

### **INTRODUCTION**

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

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

Therefore, it is necessary to rethink the role of the WHO in fulfilling its mandate of ensuring *health for all*, when the problems at issue are ineluctably political.

### **THE CRIPPLED SOCIAL-HEALTH FUNCTION OF THE WHO**

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

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

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

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

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

Finally, yet importantly, many states – including Japan, Azerbaijan, Lithuania and Albania – would prefer to wait for coordinated studies on an international level,

since there was not sufficient evidence on this matter yet. However, a lack of evidence does not necessarily prevent states from tackling homo- and transphobia, which contribute to health inequities. In law, the anti-discrimination principle applies to all situations that unreasonably disadvantage certain groups of people. As the Swiss delegate pointed out, the commitment of the international community to data collection and analysis has always been important in the WHO's long history of dealing with various contentious issues.

### **PEOPLE-CENTERED HEALTH AS AN ALTERNATIVE PATHWAY?**

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

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

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

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

With regard to the other two regions, the behavior-based concept of men who have sex with men (MSM) – rather than any reference to sexual identity – has been employed, again, in light of the HIV pandemic. Additionally, transgender situations are simply omitted from both regional committees. The EMRO's discussions over social health are focused on intraregional/interstate disparities, and in fact, there is a

lack of data at the national and subnational levels on inequity. As for the AFRO, its intriguing resolution on *Health and Human Rights* (AFR/RC62/R6) in 2012, which posits the non-discrimination principle “within the context of national legal frameworks,” predetermines African states’ position of national relativism in the 2013 EB debate.

## CONCLUSION

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

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

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

**Po-Han Lee** is undertaking his PhD research at University of Sussex, UK, along with which he has obtained the PGDip in Social Research Methods. Besides engaging in the *Centre for Cultures of Reproduction, Technologies and Health*, and *Sussex Rights and Justice Research Centre*, he also serves as the editor-in-chief of *Plain Law Movement* as well as a contributor to *Queerology*, and *01 philosophy*.

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<sup>1</sup> Meyer, Ilan H. and Mary E. Northridge, eds. *The Health of Sexual Minorities: Public Health Perspectives on Lesbian, Gay, Bisexual and Transgender Populations*. New York: Springer, 2007.

<sup>2</sup> Packard, Randall M. *A History of Global Health: Interventions into the Lives of Other Peoples*. Baltimore: Johns Hopkins University Press, 2016.

<sup>3</sup> WHO-EB. *Executive Board, 133rd Session: Official Records (Including Resolutions, Decisions, Annexes, Summary Records, and List of Participants)*, 2013.

<sup>4</sup> Meier, Benjamin Mason and William Onzivu. "The Evolution of Human Rights in World Health Organization Policy and the Future of Human Rights through Global Health Governance," *Public Health* 128, no. 2 (2014).

<sup>5</sup> Mendelson, Maurice H. "The Subjective Element in Customary International Law," *British Year Book of International Law* 66, no. 1 (1996).

<sup>6</sup> Gostin, Lawrence O. *Global Health Law*. Cambridge: Harvard University Press, 2014.