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Judicial Responses to World Health Organization Norms: A Comparative Analysis of General Repercussion Cases from the Brazilian Federal Supreme Court and the Indian Supreme Court (2010–2024)

Alex Silva Oliveira & Narender Kumar

Abstract: **This qualitative empirical analysis explores the judicial responses of Supreme Courts in Brazil and India to World Health Organization (WHO) norms from January 1, 2010, to January 15, 2024, in general repercussion cases. Focusing on the period before and after the global pandemic, the study employs deductive and inductive methods to examine the influence of WHO norms on the decision-making processes of national authorities. The research aims to answer specific questions related to the referral of national authorities to the WHO, factors influencing the adoption of WHO norms by judicial, legislative, or executive decision-makers, the major health challenges addressed by national instruments, and the most cited WHO norms by India and Brazil during this period. One of the main findings is that Brazil generally integrates a wide range of WHO norms directly into its legal system, whereas India tends to use them more as complementary guidelines. According to the data analysis, when it is compared to the Indian Supreme Court, Brazilian Supreme Court gave precedence to interpretations that align with WHO's international standards, highlighting the significance of global health regulations over national concerns. Moreover, it was observed that Brazil shows stronger support for WHO standards on environmental and electromagnetic issues, often citing them directly in court cases, while India references them less frequently and typically in a supplementary, non-binding role.**

Keywords: **Brazil; Health; India; Jurisprudence; WHO; World Health Organization.**

I. INTRODUCTION

Brazil and India have participated in many important global initiatives throughout their history. Both are internationally relevant, and share similarities and disparities in their healthcare systems. The latter is illustrated by the challenges faced by both countries in achieving universal healthcare coverage.

In terms of investment in healthcare, from 2008 to 2015, India's public health spending, by both central and state governments, remained steady at around 1.3% of GDP, rising slightly to 1.4% in 2016–17 [1]. The 2017 National Health Policy aimed to boost this to 2.5% by 2025. Including private sector contributions, total health expenditure accounts for 3.9% of GDP [1]. Around 30% of the overall health spending originates from the public sector, a lower proportion compared with similar statistics in other developing and developed nations. Thus, individuals shoulder the burden of their healthcare expenses [1,2].

In Brazil, through the New Growth Acceleration Program (PAC), Ordinance GM/MS no. 1.517 was announced on October 9, 2023, bringing with it a set of measures to strengthen the Brazilian healthcare system. The Ministry of Health announced an investment of almost $6 billion USD by 2026 to enable the universalisation of essential services in the public network. This investment is distributed over five axes: primary care, specialised care, health emergency preparedness, the health economic-industrial complex, and telehealth [3,4]. In 2022, Brazil invested almost $30 billion USD, equivalent to 6.6% of total committed expenditure and 1.6% of GDP [3,4].

India and Brazil have also engaged in international cooperation and collaboration on global health issues, participated in discussions on health policies, shared experiences, and worked together on initiatives related to health research and development. As member parties of the World Health Organization (WHO), the two countries take different approaches to WHO norms and parameters.

In the context of this background, this study aims to examine the relationship between WHO norms and

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the relevant judicial bodies of India and Brazil, as well as their interpretation and application by these bodies. Furthermore, to determine the degree impact of WHO norms on their judicial systems, the study aims to identify the kinds of rules applied by judges and the main health issues addressed by national instruments between January 1, 2010 and January 15, 2024.

The analysis investigates the frequency and manner in which both states cite WHO norms. Moreover, it is possible to determine the legal nature of these instruments and thus ascertain whether the referenced judges from those states prefer to use norms that are 'binding' ('hard law') or simply recommendations, instructions, or suggestions ('soft law'). Concerning the former, 'the term hard law (…) refers to legally binding obligations that are precise (or can be made precise through adjudication or the issuance of detailed regulations) and that delegate authority for interpreting and implementing the law' [5]. The latter is considered as 'one or more of the elements of legalization can be relaxed, [and] softer legalization is often easier to achieve than hard legalization' [5].

To achieve these objectives, this article focuses on the analysis of general repercussion cases from the Supreme Courts in Brazil and India. The chosen period encompasses events before and after the COVID-19 pandemic, providing a comprehensive understanding of the evolving dynamics of international health norms within national legal frameworks.

Keywords such as "*OMS*," "*Organização Mundial de Saúde*," "*Organização Mundial da Saúde*," "*World Health Organization*," and "*World Health Organisation*" were employed to collect relevant data. By employing a qualitative empirical method, this research contributes to the understanding of the role played by WHO health norms in shaping relevant national judicial decisions in India and Brazil. The findings shed light on the relationship between WHO norms and their national legal systems, offering insights into the challenges faced by those states in addressing global health issues.

This study is organised into four sections. The first aims to establish, using a descriptive approach, the differences and similarities from a broader economic and political perspective between the healthcare systems in Brazil and in India. Such context will provide a nuanced comparative analysis between the two countries, considering a comprehensive background of each healthcare system and its peculiarities and challenges. Section Two examines the right to health, through the lens of the major domestic health policies of each country and domestic law of both countries. This legal assessment aims to evaluate the standard of health protection in India and in Brazil, and how this standard aligns with WHO recommendations and the legal instruments in the third section.

Section Three analyses the incorporation of international law into Brazilian and Indian legal systems. The assessment of the mechanisms by which both countries achieve this is fundamental to understanding the challenges and limitations of the application of international norms by their respective Federal Supreme Courts. Therefore, the study's empirical findings will be analysed in the context of each country's legal and judicial framework.

Section Four is dedicated to answering the main questions posed by this article: Are there any similarities or patterns in the dates of the cases examined? What is the nature of the WHO instruments mentioned in the cases? How were those international instruments cited in the judgements? Were they used as a parameter for the decision-maker? Did the issues raised in the cases share any pattern? What is the legal nature of the players involved in the cases (physical person, public or private entity)? In the case of a public entity, what kind of internal power structure is it a part of (legislative, executive, or judicial power)? In the judgements, which interpretation of the standard has prevailed: international or national?

Section I – Healthcare in Brazil and India: More Divergence Than Convergence?

Background To the Brazilian Healthcare System

The 1988 Brazilian Federal Constitution marks a significant shift in Brazilian healthcare, as it finally declared, under Articles 6 and 196, the recognition of healthcare as a universal right of all citizens and a fundamental duty of the State. Subsequently, Brazil established a Unified Health System (SUS) founded on this premise. Its core principle is free universal healthcare for the country's citizens, including curative, preventive, and rehabilitative care on all primary, secondary, and tertiary levels of healthcare [6].

The SUS is characterised by decentralisation, and involves the cooperation and collaboration of the federal, state, and municipal governments with public and community healthcare initiatives. Funding relies on taxes and social donations.

Despite a commendable effort towards progressive and inclusive healthcare, the SUS is under pressure for several reasons, including questionable policies, underfunding, and economic recession, among others. The system has failed to address systematic and structural issues such as adequate resource allocation, difficulties at state government level, and severe underfunding.

With a projected decline in the health budget of R$415 billion by 2036, Constitutional Amendment 95 (EC 95/PEC 55/PEC 241), passed by Congress in December 2016, established a 20-year cap on federal primary health expenditure, limiting 2017 spending to 15% of Net Current Revenue, and subsequent years to the 2017 spending level adjusted for inflation [7]. The Ministry of Health's financing adjustments eliminated targeted support for particular SUS components (such as primary healthcare (PHC), surveillance, and medications) [7]. Furthermore, on 28 September 2017, through the Consolidation Ordinance n. 2, the Health Minister enacted new restrictions for private health insurance. They were added to redesign the national health policy and included revisions to the Family Health Strategy (FHS) and mental health.

With regard to the 2008 global financial crisis, Brazil demonstrated resistance at first, but the long-term effects became apparent in the years that followed. In 2014–2016, the country suffered a severe recession, with a steep decline in GDP, caused by a combination of falling commodity prices, political unpredictability, and budgetary incompetence. Political corruption, such as the Petrobras affair, further damaged investor trust and the economy.

The COVID-19 pandemic exacerbated Brazil's already precarious economic situation, straining public services such as healthcare and triggering severe economic contractions. Budget cuts and decreased funding significantly affected the quality and accessibility of public healthcare. Austerity measures led to underfunded healthcare services, outdated equipment, deteriorating infrastructure, and shortages of essential pharmaceuticals and medical supplies.

Despite these difficulties, key public health initiatives, such as immunisation campaigns and preventive care programs, persisted. However, the crisis deepened existing disparities in the healthcare system: while wealthier individuals could rely on private healthcare, public services deteriorated for the general population. This decline led to increased morbidity and mortality rates, inadequate mental health resources, and growing public discontent, weakening confidence in the public healthcare system and reducing its utilisation.

The setbacks in progress towards Universal Health Coverage (UHC) pose the risk of catastrophic consequences for Brazil's most vulnerable populations, potentially undermining the social contract established post-military dictatorship. It is crucial to monitor health outcomes, economic burdens, and key health indicators, in order to identify adverse effects and implement protection measures for affected populations. Brazil's struggle to sustain its healthcare achievements amidst political and economic turmoil offers valuable lessons for other nations facing similar challenges.

Indian Healthcare System Background

India’s healthcare delivery system is structured across three principal levels: primary and community healthcare centres (PHCs/CHCs), district hospitals (secondary healthcare centres), and tertiary healthcare centres (national level). The primary and secondary centres are administered by the central and state governments, whereas tertiary healthcare centres are managed primarily by the private sector and address more complex health needs. This structured referral system ensures that patients receive appropriate care at each level, starting from the primary point of contact through to the most specialised tertiary care, thereby optimising the use of healthcare resources and expertise [8]. The following scheme showcases the Indian healthcare infrastructure (Figure 1).

Following neoliberal reforms, the tertiary sector became separated from the larger government-run hospitals, in order to maximise healthcare provision and enhance service efficiency. However, the liberalisation of the healthcare system has increased disparity, making healthcare increasingly unaffordable for the poor sections of society.

Privatisation of the healthcare system has significantly raised the number of Indian hospitals and healthcare providers. Nevertheless, these facilities have furthered the disparity and discrimination against low-income populations. A second aspect of disparity in the Indian healthcare system relates to its vast rural and urban geography. Most of the primary healthcare organisations are in the rural sectors, while secondary- and tertiary-sector organisations are concentrated in the urban regions. Taqi et al. (2017) [9] highlight that, while India has made notable progress in its health

infrastructure since the implementation of the National Rural Health Mission (NRHM) in 2005, these improvements have been unevenly distributed, with significant regional disparities in the accessibility and availability of healthcare services. Taqi et al. (2017) draw four main conclusions: i) inadequate health infrastructure is one of the main problems faced by rural healthcare; ii) the current health centres lack adequate infrastructure and qualified staff; iii) with respect to population coverage, the healthcare system is ineffective and offers limited accessibility; and iv) insufficient connectivity among healthcare centers across various levels.

Greater health equity is a goal in and of itself, and reaching the different global health and development targets will lack significance in the absence of fair distribution across and within populations. In India, healthcare disparity continues to rank among the most challenging issues, with the economically disadvantaged communities frequently experiencing unequal access to healthcare and healthcare facilities [10].

Section II - Interpreting the Right to Health in Brazil and India

Brazil's Constitution and Health Rights

The Brazilian Constitution, in recognising the fundamental human right to health, was inspired by Article 25 of the United Nations' Universal Declaration of Human Rights, of which Brazil was a signatory, enumerating health as one of the necessary conditions for a dignified life. At the time that the 1988 Brazilian Constitution was elaborated, health care professionals demanded from the government the protection, promotion, and recovery of health to uphold the people's fundamental right [11].

The right to health is guaranteed in the Federal Constitution of 1988 as a right of all and a duty of the State, to be ensured through the adoption of public policies, with the guarantee of universal and equal access to services. Under Title VIII - Social Order, Chapter II - Social Security, Section II - Health, Article 196 ('Health is a right for all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of illness and other health hazards, as well as ensuring universal and equal access to actions and services for its promotion, protection, and recovery')

ensures the State's obligations in this regard. Article 196 emphasises that health is: i) a right for all (defining its holders) [12]; ii) a duty of the State (indicating the entity responsible for its provisions, without prejudice to the provisions of article 199, which makes healthcare available to private initiative); iii) guaranteed through social and economic policies - its general mode of action; and iv) these policies must aim to reduce the risk of disease (a purpose that demonstrates concern for prevention) and to achieve universal, egalitarian access to actions and services for the promotion, protection, and recovery of health (a purpose specifying how the social right under examination will be guaranteed).

In fact, health is characterised by Article 6 of the Brazilian Constitution as a social right, along with education, work, housing, leisure, security, social security, protection of motherhood, childhood, and assistance for the helpless [13]. As the Federal Constitution recognises health as a fundamental right, it should be noted that the norms guaranteeing it are immediately applicable, in accordance with paragraph 1 of Article 5 of the Constitution itself [14]. Furthermore, the right to health is understood along with other fundamental rights, such as the right to life and the protection of human dignity (Article 5, caput).

Article 198, in turn, outlines, in general terms, the organisation of the system, establishing that healthcare actions and services are integrated into a regionalised, hierarchical network and constitute a single system, organised in accordance with the following guidelines: i) decentralisation, with a single direction in each sphere of government (imposing responsibility on the Union, the States, the Federal District, and the Municipalities); ii) comprehensive care, with priority given to preventive activities, without prejudice to care services - (reinforcing the need for preventive actions); and iii) community participation (essential for understanding the right to health as a 'relationship' and not as 'individual power') [15].

Like Indian jurisprudence, the Brazilian Federal Supreme Court has advanced the implementation of the right to health [16,17]. For instance, when a state enacts legislation to provide certain medications, the government must ensure the program's validity and fulfil its obligation to provide the medications, given legal requirements are met. This underscores the duty of public entities to uphold the fundamental right to health, as stipulated in regulations aimed at ensuring its effectiveness.

Another landmark decision by the Brazilian Federal Supreme Court ensured access to free medication

for HIV patients, despite lacking budget allocation, thereby overriding constitutional budgetary constraints. This highlights how budgetary limitations, though crucial, cannot restrict citizens' access to constitutionally guaranteed healthcare (see the case of AgRg-RE 271.286-8/RS. Judgment rendered by the Second Chamber of the Brazilian Federal Supreme Court, adjudicated on September 12, 2000, Rapporteur Minister Celso de Mello, published in the Official Gazette on November 24, 2000).

India's Constitution and Health Rights

According to the Constitution of India, the Indian State is obligated not only to provide healthcare for its citizens, but also to take measures to improve healthcare rights. Through an extended interpretation of the Constitution, under Article 21 ('no person shall be deprived of his life or personal liberty except according to procedure established by law'), the right to health is identified as a fundamental right.

It is interesting to note that the Indian Constitution identified a close relationship between a healthy environment and the health of the Indian population. The 42nd Amendment Act of 1976 added to the Constitution a list of Fundamental Duties, provided under Article 51-A. Article 51-A (g) imposes on citizens the duty to protect and improve the natural environment, including forests, lakes, rivers, and wildlife, and to have compassion for living creatures [18].

In this context, the Supreme Court of India played a fundamental role in ensuring the interpretation and implementation of the right to health. Framed within the second dimension of human rights [19], the obligation to protect life as an element of the right to health was stated as a state responsibility (see the case of Vincent Panikurlangara v. Union of India, reported in AIR 1987 SC 990). It was also asserted by the Supreme Court that the concept of the right to life extends beyond mere existence, encompassing essential elements such as access to food, clothing, a decent environment, and suitable accommodation conducive to holistic growth—physical, mental, and intellectual.

This expansive interpretation underscores the right to lead a dignified existence (see the case of Narayan Khimalal, Gotame & Ors., [(1990) 1 SCC 520]). In one case (Paschim Banga Mazdoor Samity v. State of W.B, (1996) 4 SCC 37), the lack of availability of beds in public hospitals resulted in the payment of civil compensations by the State to the petitioner. The right to health also entails safeguarding the well-being and vitality of workers. In Article 21, the term 'life' extends beyond mere physical survival. It encompasses broader aspects such as the right to livelihood, improved standards of living, hygienic workplace conditions, and opportunities for leisure (see the case of Consumer Education & Research Centre v. Union of India 1995 3 SCC 42).

Articles 36 to 51 encompass the Directive Principles of State Policy, embodying India's ethos as a welfare state dedicated to advancing the well-being and safety of its citizens. These principles guide the State, urging proactive measures to enhance public welfare and foster economic democracy. However, they are not legally enforceable through the courts.

Article 243-W of the Constitution stipulates that the state legislature has the authority to empower municipalities with the functions necessary to operate as entities of local self-government. This authority extends to matters outlined in the Twelfth Schedule, specifically item 6, which includes public health, sanitation, conservancy, and solid waste management. Article 243-G provides a similar provision for Panchayats concerning matters outlined in the Eleventh Schedule, particularly item 23, encompassing health and sanitation, which includes hospitals, primary health centres, and dispensaries. In India, then, the concept of the right to health has been examined from various perspectives, including access to healthcare, a clean environment, safe working conditions, the right to adequate food and nutrition, reproductive health, maternity and menstrual benefits, as well as emotional and mental well-being, among other factors.

Nevertheless, despite constitutional and international acknowledgment of the right to health, the practical situation in India falls short of expectations. Significant disparities exist in access to healthcare facilities, especially in rural and remote regions, and the quality of healthcare services across many parts of the country remains inadequate [20].

Section III - Challenges in Interpreting International Law in Brazil and India

Brazilian Legal System and International Law

Despite the significant number of Constitutions promulgated in Brazil since the time of the Empire, the rules governing relations between domestic law and international law have remained practically the same since the first Constitution of the Republic

[21]. Article 84, clause VIII, and article 49, clause I of the 1988 Brazilian Federal Constitution maintains the provisions of previous Constitutions, assigning to the President of the Republic exclusive competence to 'conclude treaties, conventions, and international acts, subject to the approval of the National Congress', and to the National Congress exclusive competence to 'definitively adopt treaties, agreements, or international acts that entail burdensome commitments or obligations to the national patrimony'.

Therefore, the Brazilian legal system constitutionally creates a mechanism for the reception of international norms, which, according to Brazilian practice since before the Republic, follows this format: commitments negotiated and adopted by the Executive power at the international level will be submitted for approval by the Legislative power domestically, whereupon they may be ratified by the former again at the international level. However, for it to be valid and effective domestically, the agreement must also be promulgated by an Act of the Executive power, following ratification at the international level [21]. After approval by the Legislative power, if ratified, the treaty enters into force internationally on the date stipulated therein. Nonetheless, for it to take effect in Brazil, it must be promulgated by the Head of the Executive power—it is the Promulgation Act that affirms the existence of a legal norm. Through it, the Executive declares that the formalities for the enactment of the norm have been met. It does not transform international law into domestic law; it simply reports the existence of a valid treaty domestically. Publication, in turn, is necessary to announce the Promulgation Act. From this point, the treaty must be observed by individuals and applied by the Courts [21,22].

Brazil also enacted and incorporated the 1969 Vienna Convention on the Law of Treaties (VCLT) in 2009. In its preamble, this Convention states that disputes under international or treaty law "must be settled by peaceful means and in accordance with the principles of Justice and International Law". Furthermore, "a party cannot invoke provisions of its domestic law as justification for non-compliance with the treaty" (good faith principle). In addition, it is deduced from Article 31(1) of VCLT that "a treaty shall be interpreted in good faith and in accordance with the meaning of its terms in its context, in the light of its object and purposes" [23].

The VCLT, together with the Federal Supreme Court repercussion decisions on cases 80.004/SE and 466.343/SP, as well as the Brazilian Constitution, establish hermeneutic principles governing the interpretation of treaties in the Brazilian legal system. The first case resulted in the declaration of the equivalence in hierarchy between treaties and acts. The second case addressed the interpretation of Article 5, section LXVII, and paragraphs 1, 2, and 3 of the Brazilian Constitution in light of Article 7, paragraph 7 of the American Convention on Human Rights. These specific judgements altered the hierarchy of human rights treaties within the Brazilian Constitution.

It should be noted that the VCLT was only incorporated in Brazil twenty-nine years after it entered into force in 1980. Thus, at the time of the appeal in case 80.004/SE, Brazil had not yet ratified the VCLT. Notwithstanding the absence of ratification, the Legal and Consular Department of Foreign Affairs, in 1989, managed its treaty negotiations in accordance with the provisions of the VCLT [24].

The VCLT was incorporated as an ordinary federal law, lower in hierarchy than the constitutional legal framework. However, the two aforementioned cases considered human rights treaties to have 'supralegal' status—an intermediary level between ordinary and constitutional law—and, depending on the procedure of incorporation of the treaty by the legislative power, possibly also constitutional status. In 2004, a legal reform enacted through Constitutional Amendment 45/2004 stipulated that human rights treaties could attain the status of constitutional amendment if they met the provisions established in Article 5, paragraph 3 of the Brazilian Constitution (three-fifths vote, two shifts in each legislative house). If it is considered that some human rights treaties could have constitutional or 'supralegal' status, or even constitute a 'constitutional framework', and the VCLT is considered an ordinary federal law, how could this latter then guide the interpretation of hierarchically superior treaties?

Some authors believe that the legislative procedure for incorporation of treaties established in article 5, paragraph 3 of the 1988 Brazilian Federal Constitution (CF/88), introduced by Constitutional Amendment 45/2004, ratifies the constitutionality of the contents in human rights treaties' provisions. Therefore, in accordance with article 60, paragraph 4 of CF/88 and the principle of non-retrocession,

these rights and guarantees cannot be overridden or abrogated by subsequent legislation *(lex posteriori)*. However, a teleological interpretation of the insertion of paragraph 3 to article 5 suggests that it may function less as an endorsement and more as a potential barrier to the recognition of the constitutional status of such norms (see more in [25]).

Moreover, if the hierarchy of treaties is understood as constituting a 'constitutional framework', as it is in Piovesan's theory [26], this amounts to acknowledging a form of monism that grants hermeneutic primacy to international law. It is common legal knowledge that 'the leading adherent of monism is Kelsen. For him, jurisprudence is a science, and the object of a science is formed by cognition and its unity. Unity of cognition connotes unity of object, and this unity must be found in the relation between municipal law and international law' [27].

André de Carvalho Ramos (Ramos 2022, 625–633) developed the control of conventionality theory, in which he rejects the possibility of hermeneutic primacy for international law; the country's legal system would be defined as dualistic. From this perspective, interpretive authority over international conventions (international hermeneutic primacy) would be reinstated. This would, in effect, be a return to a scenario akin to Kelsenian monism, further complexifying Brazil's normative framework, rather than simplifying and even streamlining it.

Briefly, then, we can conclude that there are four possible scenarios for the incorporation of treaties into the Brazilian legal system: i) human rights treaties approved under an ordinary (non-qualified) quorum have 'supralegal' status; ii) human rights treaties approved under a qualified quorum by National Congress (under Article 5, paragraph 3 of the 1988 Brazilian Constitution) have the status of a constitutional amendment; iii) non-human-rights treaties have the status of ordinary federal law; iv) some authors argue for an exception to this last rule in the case of tax treaties which, based on an interpretation of Article 98 of the National Tax

Code, could be granted supralegal status.

It is undeniable that a well-defined open normative clause plays an essential role in resolving interpretive issues. At the same time, important legal concepts must be revised, in order to modernise and adapt the whole system to meet social demands, particularly in the field of human rights. To view the law of treaties strictly from a classical or constitutional standpoint inevitably leads to interpretive failure.

Globalisation and international influence on domestic law are two aspects that have altered the perspective from which the State's legal order should be interpreted. National judges must approach these matters from a framework of contemporary legal theories, for two key reasons: i) to identify frameworks that better explain the current interaction between international and domestic law, and ii) to avoid simplistic, outdated hermeneutics founded on rigid ideas such as absolute State sovereignty, these no longer aligning with today's social and global reality [28].

Indian Legal System and International Law

International treaties are not automatically incorporated into Indian national law; this must occur done through appropriate domestic legislation. Nonetheless, Indian national courts generally interpret statutes in such a way as to preserve harmony with the rules of international law. Notwithstanding, Indian national legislation must be respected, even if contrary to international law. Under Article 253 of the Indian Constitution, the power to enact treaties lies exclusively with the Union [29].

Like the Brazilian Federal Constitution, there is no specific article in the Indian Constitution establishing how Indian domestic law interacts with international law, or how international legal instruments should affect Indian domestic law [30]. Inspired by the Havana Convention adopted at the Second Conference of American State Members of the International Labor Organization, 1939 [31], Article 51 of the Indian Constitution is generally referenced as the legal cornerstone guiding the relationship between domestic law and international order. This provision has the legal nature of a directive, and is a judicially non-enforceable principle of governance [30]. Rather than a legal norm that clearly establishes how international obligations should be approached in domestic law, Article 51 is used to guide Indian political foreign affairs [31].

As previously mentioned, Article 253 of the Indian Constitution explains that the power of Parliament to enact laws implementing international obligations extends even to matters that would otherwise fall within the legislative competence of states [30]; however, Parliament has yet to pass any such legislation.

In fact, according to Article 73 of the Constitution, Indian practice is the same as British practice with regard to the implementation of international obligations [32]. The Union Executive has the power 'to act on all matters, and only on the matters, over which Parliament has been accorded competence by the Constitution, even in the absence of legislation on the point'. [30] (see the case of Union of India v Azadi Bachao Andolan, (2004) 10 SCC 1).

In practice, the Executive has the power to assume international obligations without Parliament's pre-ratification approval [32–34]. Nevertheless, according to the Supreme Court, if the international law to be incorporated modifies any existing domestic law, parliamentary legislation will be required for such purposes (see the case of Maganbhai Ishwarbhai Patel v Union of India, (1970) 3 SCC 400). Briefly, the incorporation of treaties into the Indian legal system requires implementation through domestic legislation (see the case of Jolly George Varghese v Bank of Cochin, AIR 1980 SC 470).

This legal framework for incorporation is referred to as dualism. It is 'deeply rooted in the Hegelian notion of the state-will, a notion whose persistence well illustrates the tenacity of unproved and irrational dogma (…) Triepel and Anzilotti are the leading exponents of the dualist construction. Triepel treats the two systems of state law and international law as entirely distinct in nature. He contends first that they differ in the particular social relations they govern; state law deals with individuals, international law regulates the relations between states, who alone are subject to it. Secondly, he argues, their judicial origins are different; the source of municipal law is the will of the state itself, the source of international law is the common will (Gemeinwille) of states' (Starke 1936, 68, 70). India's dualist legal system was affirmed by the Supreme Court (see the case of Bhavesh Jayanti Lakhani v State of Maharashtra, (2009) 9 SCC 551). Nonetheless, India follows the tradition of common law states when it comes to customary international law: when not contrary to domestic law, rules derived from customary law are directly incorporated, without legislative interference (see the case of Peoples' Union for Civil Liberties v Union of India, AIR 1997 SC 568).

Notwithstanding India's dualistic legal structure, in defining the judiciary's own powers to engage with international law, the Supreme Court has shifted over the years from a dualistic approach towards the monist doctrine of incorporation. The latter allows courts to directly enforce international law without any legislative intervention, unless faced with a contrary domestic norm of higher status [30] (see the case of Gramophone Company of India Ltd. v Birendra Bahadur Pandey, (1984) 2 SCC 534). In this view, Parliament's role shifts from permitting the incorporation of international laws to prohibiting them if and when they are contradicted.

Section IV - Indian and Brazilian Repercussion Cases: A Comparative Analysis of the Right to Health in Federal Supreme Courts (2010–2024)

The temporal distribution of legal cases concerning the right to health in Brazil and India reveals notable disparities, with Brazil's first judgement dating back to 2016, and India's first recorded case in 2011. Remarkably, the most recent case in India concluded in 2020, while Brazil's took place in 2022. Within this time frame, Brazil documented a mere four cases, contrasting with India's six, among which two pertain specifically to the ramifications of COVID-19. The absence of COVID-19-related legal cases in Brazil raises conjecture regarding either the comparatively minimal impact of the pandemic on the nation, or potential deficiencies in governmental infrastructure— such as the absence of a dedicated regulatory authority—to adequately address public health concerns related to COVID-19.

Concerning the total number of direct mentions of 'WHO', our research revealed a notable difference between the Indian and Brazilian Federal Supreme Courts. The former counts only nine direct citations, while the latter mentioned 'WHO' 47 times, as illustrated in the graph below (Figure 2).

Various legal cases spanning a spectrum of issues, including matters concerning pharmaceutical agencies and incidents of driving under the influence of alcohol or other substances, are evident in both Brazil and India. Noteworthy among these are cases pertaining to the effects of electromagnetic radiation on human health in Brazil, and concerns over the deleterious impacts of specific chemical additives in soft drinks and foods in India. This diverse array of legal proceedings underscores the significance of the WHO and its regulatory framework for public health matters in both nations. Specific aspects of public health governance in Brazil, such as the pharmaceutical pricing policy established under the 2022 Drug Control Policy and the constitutional considerations surrounding the technical responsibilities of pharmacists as

stipulated in Act 13.021/2014, are subject to regulation in accordance with WHO directives. Similarly, in India, a case addressing food safety and public health (case number: Writ Petition (Civil) n. 681 of 2004) draws on a study conducted by the WHO concerning the adverse effects of misleading advertising, particularly targeting children, as evidenced by various international journals. Despite the absence of explicit invocation of WHO instruments by the courts or plaintiffs, the WHO serves as a prominent reference point for numerous legal cases within the Indian context.

The utilisation of WHO instruments in legal cases appears to be less common in India than in Brazil, where such instruments serve as significant regulatory mechanisms in matters pertaining to public health. An illustrative example of this distinction is that, beyond the inclusion of the WHO Global Status Report on road accidents, dated November 20, 2011, as supporting evidence in a criminal appeal concerning a ruling in a drink-driving case in India, references to WHO resources have been primarily supplementary in nature, reinforcing arguments across various legal contexts. Conversely, in Brazil, WHO instruments are frequently invoked directly within legal proceedings, serving as enforcing mechanisms to regulate Brazilian public health.

Among the four documented cases in Brazil, three prominently feature direct references to one or more WHO regulations. For instance, in a case concerning the environmental impacts of human exposure to electric, magnetic, and electromagnetic fields generated by radio transmitting stations, user terminals, and electric power systems, two WHO instruments are explicitly cited: 1. Framework to Develop Precautionary Measures in Areas of Scientific Uncertainty (2003, revised 2007), and 2. Model Legislation for Electromagnetic Fields Protection (the Electromagnetic Fields Human Exposure Act). This exemplifies the substantive role played by WHO directives in shaping legal discourse and decision-making processes within Brazil's jurisdictional framework.

Our data suggests that both national and international standards are invoked before the Indian Federal Supreme Court, though the former are more prevalent. While some cases (e.g., Case Number: Criminal Appeal n. 1318-1320 of 2007) refer to international standards set by the WHO, others (e.g., Case Number: Writ Petition (civil) Diary No. 10795/2020) concentrate on national norms and policies.

In contrast, we note a widespread use of WHO standards in the judgement of cases by the Brazilian Supreme Court. The graph in Figure 3 illustrates the difference in prevalence of domestic and WHO standards in the cases analysed.

Litigation involves a variety of actors, including public interest groups, NGOs, government agencies, businesses, and individuals, each party's relevance dependent upon their role in the case. For instance, public interest groups and NGOs often advocate for public health concerns, while government agencies are generally responsible for implementing health policies. As illustrated in the following graph (Figure 4), government agencies, particularly in the Brazil Federal Supreme Court, appear more frequently than any other actor in the cases analysed: Our analysis, taken as a whole, emphasises the varied nature of health-related legal proceedings that employ WHO instruments, with decision-makers referencing and applying a combination of national and international norms. The fact that WHO instruments are cited in non-binding ways indicates their importance in influencing legal debate and decisions pertaining to public health concerns. WHO instruments were widely referenced in the Brazilian Federal Supreme Court, while just one direct reference was identified in the Indian Federal Supreme Court. Both Federal Supreme Courts have applied WHO instruments mainly as 'soft law', as seen in the graph below (Figure 5).

In the context of public health governance, Brazil and India differ significantly in their use of WHO legal instruments in supreme court judgements. Brazil demonstrates stronger support for WHO standards in a variety of cases, such as that of the environmental effects of electromagnetic radiation, as seen by the direct citations found in the cases analysed. By contrast, although WHO resources are mentioned from time to time in Indian cases, their use seems to be less common, with supplemental rather than binding functions. The legal systems of both nations indicate their engagement with both national and international standards, involving a range of stakeholders including government agencies, NGOs, and public interest groups.

II. CONCLUSION

Both Brazil and India recognise the right to health in their legal frameworks. India secures this right through Article 21 of its Constitution, while Brazil

explicitly guarantees it as a universal right and state duty in its 1988 Federal Constitution, with provisions for equal access to services outlined in Articles 6 and 196. Moreover, both countries acknowledge that the right to health extends beyond legal definitions, hinging on policy implementation, community involvement, and prioritisation of prevention strategies, as highlighted in some paradigmatic Supreme Court cases.

Despite the unique characteristics of each nation's legal system, both generally follow a pattern whereby international ratification precedes domestic promulgation by the Executive, with consent required from the Legislative branch before a treaty takes effect. Nonetheless, the absence of clear constitutional principles guiding the interpretation and hierarchy of international law in these domestic legal systems presents unnecessary challenges.

In Brazil, another source of complexity arises from the 1969 Vienna Convention on the Law of Treaties (VCLT) and the jurisprudence of the Brazilian Supreme Court, which together create ambiguity regarding the hierarchical status of treaties, human rights treaties in particular. This gives rise to debates between monist and dualist perspectives, affecting the primacy of international law in interpretation.

Similarly, India lacks explicit legislation concerning the observance of international obligations, despite Parliament's exclusive constitutional authority in this area. The complexity of incorporating international law is evident in the Indian Supreme Court's oscillation between dualist and monist approaches, implementing customary law directly only when it coincides with domestic laws.

Resolving the conflict between domestic sovereignty and international obligations, especially regarding human rights, will require intricate legal interpretation and revisiting longstanding legal concepts to align with contemporary global realities and societal needs. Clear constitutional interpretative articles, or even guidelines determined by the Federal Supreme Courts, would improve the implementation and application of international instruments, such as WHO norms and directives, by these judicial entities.

Between 2010 and 2024, the Supreme Courts of both India and Brazil relied increasingly on WHO norms when ruling on significant cases related to life, health, and public health. However, analysis suggests that the use of these norms differs between the two countries. While Brazil tends to directly incorporate a variety of WHO norms into its legal framework, India employs them more as supplementary references. Brazil relies heavily on direct citations of WHO standards in cases involving topics such as the environmental impact of electromagnetic radiation, whereas India uses WHO resources less frequently and primarily for supplemental rather than binding purposes.

Both countries' legal systems adhere to various national and international standards, and involve diverse stakeholders including NGOs, government agencies, and public interest organisations. This highlights the complex interplay between national and international health governance frameworks. The sampled cases consistently reference WHO instruments across different legal contexts, highlighting the global importance of WHO recommendations.

These instruments, ranging from guidelines to reports, serve as decision-making parameters, with some being binding (e.g., the WHO's Constitution) and others non-binding (e.g., Framework to Develop Precautionary Measures in Areas of Scientific Uncertainty, 2003, rev. 2007; Model Legislation for Electromagnetic Fields Protection, ISBN 92 4 159432 2 (The Electromagnetic Fields Human Exposure Act); OMS Drinking and driving: a road safety manual for decision-makers and practitioners (Geneva, Global Road Safety Partnership, 2007); etc.).

The cases analysed cover public health issues such as road safety, food safety, and pharmaceutical regulations, involving individuals, public entities (government bodies and regulatory agencies), and private entities (companies and NGOs). Supreme Courts prioritise interpretations in line with the WHO's international standards, emphasising the global importance of health regulations over domestic considerations.

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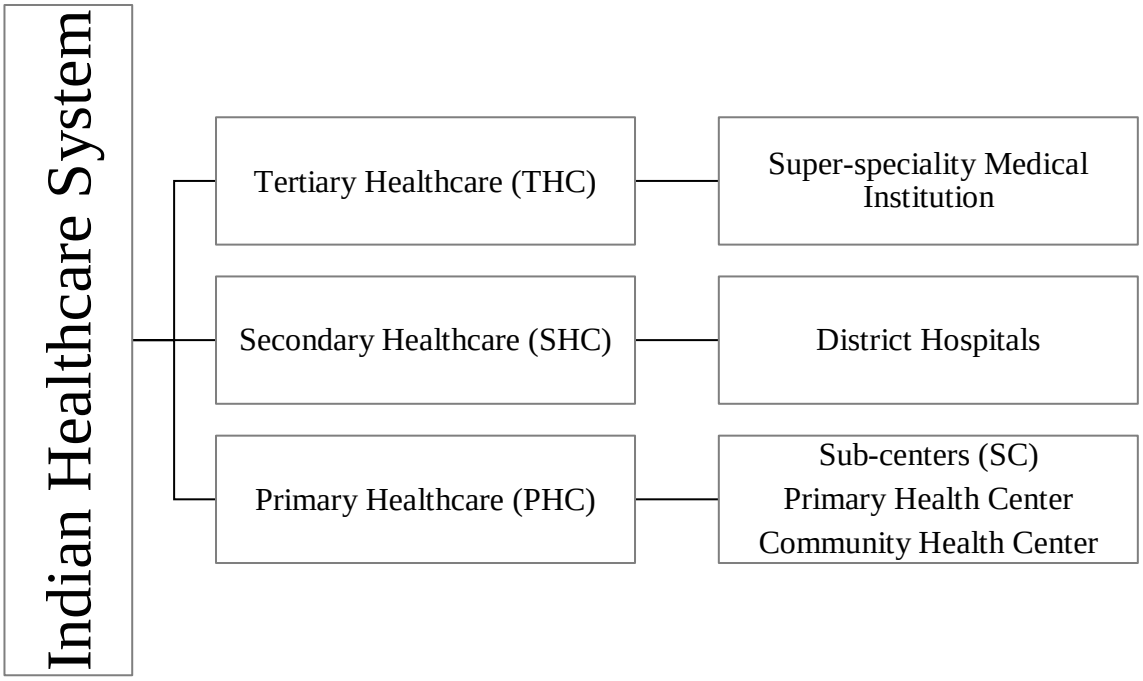

Figure 1. The Indian healthcare infrastructure. *Scheme created by the authors, adapted from (8).*

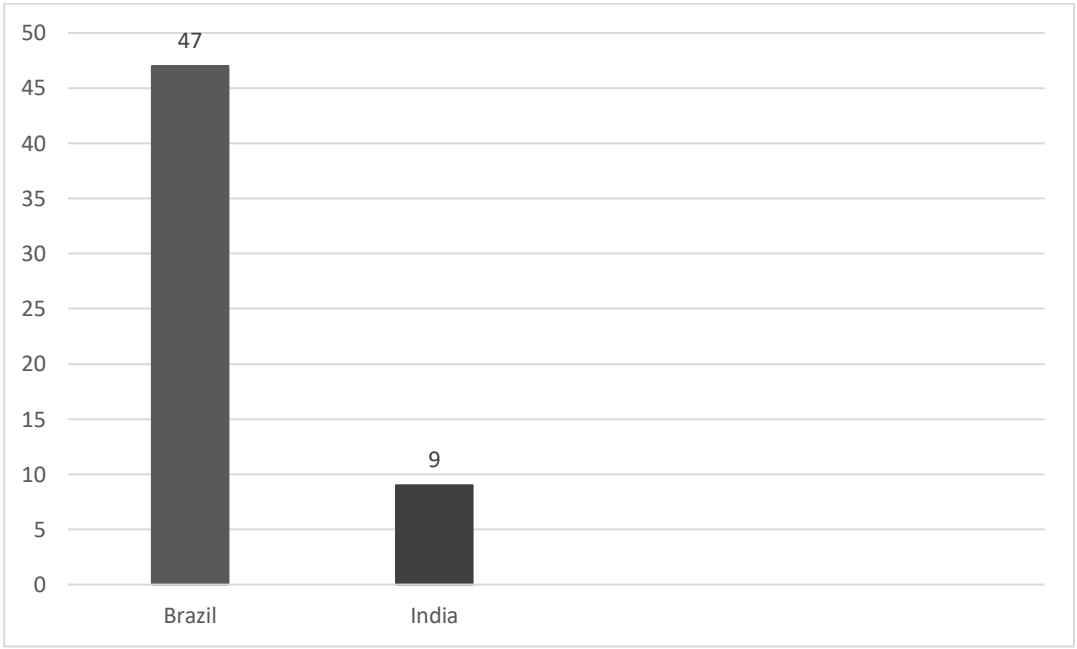

Figure 2. Number of direct mentions of 'WHO' in the Indian and Brazilian Federal Supreme Courts. *Graph generated by the authors.*

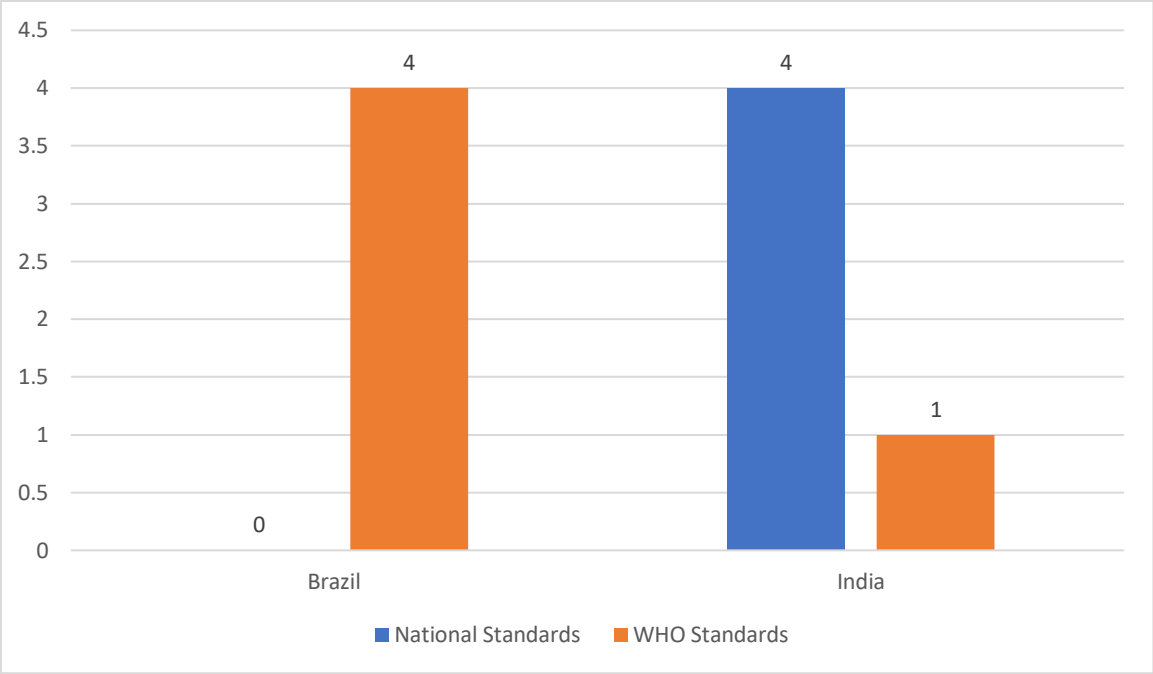

Figure 3. Prevalence of National and WHO Standards in Federal Supreme Courts. *Graph generated by the authors.*

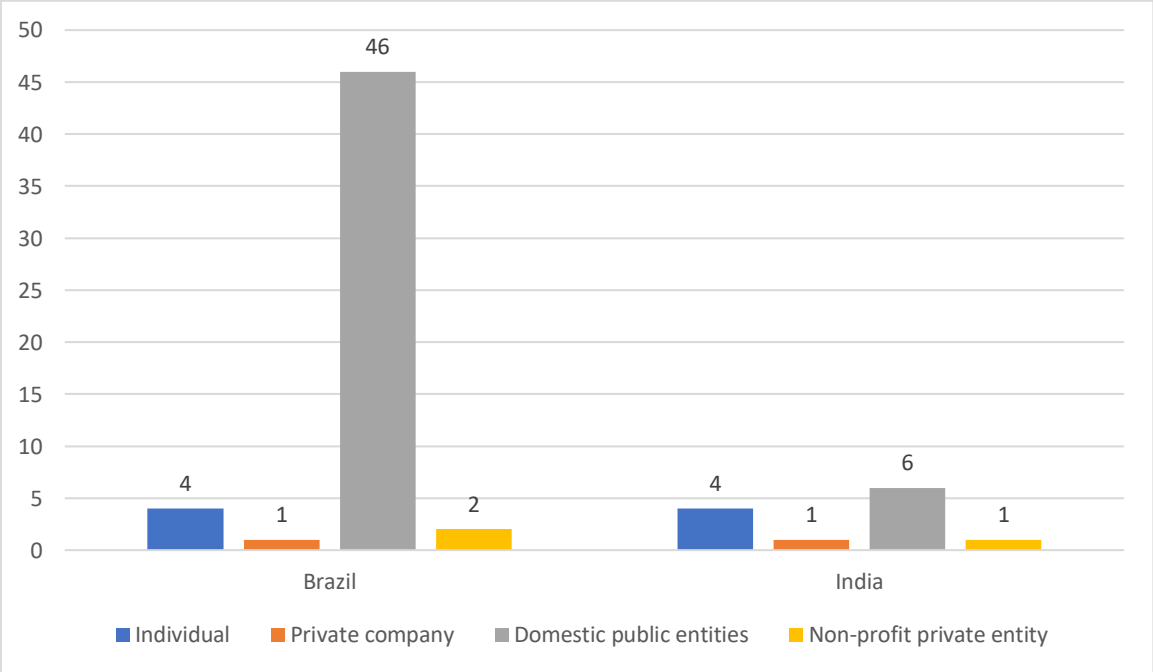

Figure 4. Prevalence of Different Parties in Litigation Cases. *Graph generated by the authors.*

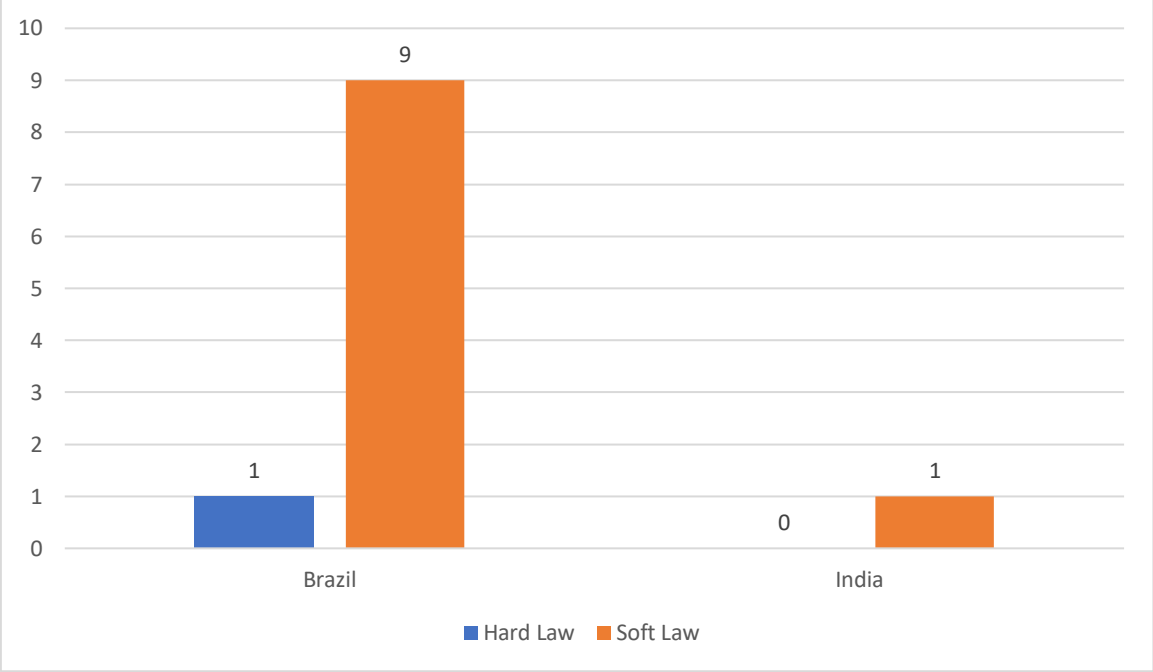

Figure 5. Number of direct references to WHO instruments in Indian and in Brazilian jurisprudence.

Graph generated by the authors.