

Realising the Right to Health in Our Lifetimes? Towards a Framework Convention on the Right to Health

22 March 2011: This discussion document has been written to try to facilitate discussion and generate ideas at the SECTION27 Southern African Regional Dialogue on Strategies for Accelerating and Unifying Campaigns for the Right to Health, taking place in Johannesburg on March 25 & 26. It attempts to summarise current challenges and opportunities facing campaigns for the human right to health, and to link this to a discussion about whether an international campaign for a UN Framework Convention on the Right to Health would inspire and unify local and national struggles for health rights with a common global vision. It will be further revised after the dialogue.

“ ...international trade law has, like international human rights law, constructed a complex network of institutions and norms to regulate state conduct. But unlike international human rights law, states comply with international trade law and, in the event of non-compliance, an effective dispute settlement mechanism is available to resolve disputes. In other words, what states have been unable to achieve in sixty-five years of international human rights law, is up and running after only fifteen years of international trade regulation.”

Supreme Court of Canada Justice Rosalie Silberman Abella, “The World is Not Unfolding as It Should: International Justice in Crisis, Toronto, February 2010.

“...the changing environment and its demands for new and innovative ways of working signal the need for different kinds of partnerships-those that enable nationally owned responses, foster South-South cooperation and those that move beyond the traditional HIV and health sectors to broader development areas. These partnerships must include political alliances that link HIV movements with movements seeking justice through social change.”

UNAIDS, Strategy 2011 -2015: 12

“In Africa, the realization of human rights is a very serious business indeed. In many cases it is a life and death matter. From the child soldier, the rural dweller deprived of basic health care, the mother unaware that the next pregnancy is not an inexorable fate, the city dweller living in fear of the burglar, the worker owed several months arrears of wages, and the activist organizing against bad government, to the group of rural women seeking access to land so that they may send their children to school with its proceeds, people are acutely aware of the injustices inflicted upon them. Knowledge of the contents of the Universal Declaration will hardly advance their condition. What they need is a movement that channels these frustrations into articulate demands that evoke responses from the political process.”

C.A. Odinkalu, “Why More Africans Don’t Use Human Rights Language,”

Human Rights Dialogue 2.1, 1999.

Introduction:

Despite the Alma-Ata inspired slogan of ‘Health for all by 2000’ in the second decade of the twenty-first century the world is still a sick place. Ill health and disease abound across the globe. The epidemiology of ill health overlies the epidemiology of inequality. The capability to fully prevent or treat ill health is inextricably tied to countries’ levels of economic development, democracy and recognition and protection of rights. Elites of developed and developing countries show little commitment to poor people’s health. But in addition, in poor countries, corruption and maladministration siphon off huge amounts of resources that could otherwise be directed at health and its determinants.

Despite this unhealthy situation, or perhaps because of it, over the last few decades much has been said and written about health. Although the results of the health-babble are far from evident, it is arguable that both national and global responses to health have now entered a different era. In a recent article in the *Equinet Newsletter* (1 March 2011 www.equinet africa.org/newsletter), Tim France argues that we have entered a political conjuncture around health that has created a ‘perfect storm’ of opportunity. Some are not so optimistic.

This discussion document looks at how social movements for health might seize the time to advance the right to health, particularly by building on the strengths and learning from the weaknesses of the HIV/AIDS treatment movement.

Learnings of the movement for ARV treatment and Human Rights:

Since the mid-1980s, one of the most visible and successful struggles for health has been conducted in response to the HIV epidemic. In this campaign the right 'to (the highest attainable standard of) ... health' has been oft cited as justification for the demand for the right to 'universal access' to ARV treatment. In addition the response to the AIDS epidemic has consistently highlighted the centrality of the protection of the human rights of people living with HIV and the inclusion of people with HIV (ie people reliant on the health system) in policy making, planning and resourcing.

The right to health and the right to participate in decisions about health have shaped the global and national responses to the HIV epidemic. As a result, a growing acceptance of human rights arguments about health (at least on paper), has influenced local, national and international responses.

The response to HIV/AIDS has been exceptional. It has been human rights centred. It catalysed sustained and expanding activism over a period of 25 years. As it gathered momentum, it built alliances not only within civil society but also with parts of the United Nations, some states, scientists and the private sector. These relationships were often acrimonious, but they have functioned to move the agenda forward.

The movement was not planned as a 'network', but spread on the basis of a growing understanding of shared possibility, vision and the need for co-ordinated action around demands for health goods, in this case ARVs. Today it encompasses activists in Eastern Europe, China, many African states, Latin America, North America and Europe.

Overall it has set an example of the potential for movements for health if they are coordinated, driven from below and rooted in human rights and empirical evidence.

Money for health

AIDS activism has brought much more money into health. It is reported that official development assistance for health increased from \$7.6 billion in 2001 to \$26.4 billion in 2008 (in nominal dollars and including water and sanitation). Paul Farmer describes the primary achievement of the AIDS movement as being to bring about ‘the influx of funds designated to treat poor people with AIDS **in the spirit of providing a public good, rather than a commodity**’. He describes this as a successful challenge to ‘modern public health orthodoxy’ and states that ‘it was not until diagnosis and care were made rights rather than commodities that people living with AIDS and in poverty had any hope of help’.

With a warning about the danger of entering into arguments about the ‘cost effectiveness’ of health interventions rather than people’s rights to health services and goods, Farmer goes on:

‘Although many will no doubt conclude that it is ultimately cost effective to lessen, through the only means possible, the horrific mortality registered among poor people living with HIV, the large scale efforts I am referring to were not launched on the grounds of cost effectiveness. Instead, they were the result of powerful thinking about ethics and the alleviation of suffering. Human rights and social justice, once the staples of public health, are slowly being revived on a grand scale.’

Gorik Ooms draws similar conclusions, pointing out that:

‘the AIDS response so far has been possible only because of the creation of a “global AIDS community” - including people living with AIDS, people most at risk, and their friends - that takes global justice seriously and therefore was and is willing to promote a kind of solidarity that did not exist before. Sure, there always has been some international solidarity, but it is temporary: aimed at helping countries help themselves. It is very different from national solidarity, that is designed to be open-ended: people constantly contribute and receive to social health protection (for example). AIDS treatment in low income countries would not have been possible within conventional international assistance or solidarity. It became possible with the creation of the Global Fund, which is a kind of global social protection

mechanism, and that was only possible because of the existence of a global AIDS community, with people feeling that they should have the same kind of solidarity with people living in other parts of the world as they have for people in the same country.'

Forcing Political Will

As a result of the type of activism described by Farmer and Ooms, for the last two decades HIV and AIDS have occupied unprecedented global attention. In large part due to this movement, HIV received global political recognition as an emergency by the late 1990s. The 2001 UNGASS 'Declaration of Commitment' was both a victory for this movement and a platform for ensuring the ongoing accountability of states for their response.

Because of unrelenting pressure it can be argued that, in a relatively short period, significant progress has been made in the development of science, treatment and (arguably) even prevention.

The HIV/AIDS movement, together with other campaigns on issues such as health worker migration, contributed to making health one of the preeminent moral and political issues of the last century. As discussed more fully below, it once more brought to the fore the notion that health is a human right. Ironically, given that it is criticised for its 'verticality' and 'exceptionalism', the response to HIV has contributed to bringing about a renewed focus on other aspects of global health. It has spawned innovative new institutions based on solidarity, such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), led to huge additional expenditure on AIDS directly and health indirectly, and contributed to the creation of a global health rights activist movement.

But today the response to AIDS has reached a point where it is more and more revealing the inadequacy of national and global health systems and the importance of simultaneously addressing other health challenges with the same vigour, rights driven insistence and co-ordination. The roll out of ARV treatment to nearly five million people in developing countries casts a bright light on eroded health systems, and demonstrates *as a matter of delivery rather than theory* the stark facts and consequence of health worker migration. The

sustainability of the AIDS response depends upon urgently addressing issues of health systems and health resources. Allowing the AIDS response to be undermined will remove this urgency.

The changing climate for health and AIDS:

As already mentioned, five million people are alive who would otherwise have died. Yet the response to AIDS is far from over or sufficient. Nearly a million people will die of AIDS in East and Southern Africa in 2011. An estimated nine million people still require treatment across the globe.

After a decade of progress on AIDS the picture ought to be an optimistic one. But it is not. In 2010/2011 a number of donor governments have cut back on their AIDS aid pledges. For the first time in a decade money for AIDS has flat-lined. Across parts of the world cuts in health 'aid' are taking place. The GFTAM achieved a larger financial replenishment than ever in October 2010, but it was still less than the lowest need scenario and is not sufficient to reach targets of universal access. Cut backs and stock-outs of medicines are reported all over the world.

It is also important to note that the roll-back of resources is being accompanied by a multifarious assault on the human rights principles that have been the foundations of this movement. In Africa, governments such as that of Malawi, Kenya and Zimbabwe are unapologetic about their homophobia, and the rest of the African Union members are silent. In China AIDS activists such as Tian Xi have been imprisoned for minor offences with impunity. In Eastern Europe, states, led by Russia, bluntly refuse services to injection drug users. Across Asia an estimated 350 000 people are in compulsory drug user detention centres. Within the United Nations some states are even challenging the core established principles of inclusion of civil society and non-discrimination of vulnerable groups.

Side by side with this overt attack is a more subtle but calculated effort by high income democracies to challenge the AIDS response by pitting its resource requirements against the resource requirements of other health issues and emerging global challenges. Real global emergencies such as climate change, food insecurity and natural disasters are being used as cause to shuffle AIDS (and to some extent health) to the background of global priorities. Although the populations of developed countries appear grudgingly to accept that their governments may draw upon unlimited resources to combat terrorism or financial instability, the same does not apply to health and development.

This is a different political and economic environment. But, according to Rene Loewensen, it was not unpredictable.

“The global AIDS response largely centred on making drugs available through the mobilisation of global resources without addressing underlying crises, or until recently strengthening the health systems that deliver these commodities. It has not been as successful in prevention or tackling the determinants of AIDS. Food security and the retention of health workers are important issues to test whether and how the global community will sustain this approach of the mobilisation of resources for singular responses (as against a deeper struggle over the determinants).”

One important question however, is what a ‘deeper struggle over determinants’ would look like.

Today the AIDS movement must face up to the fact that what it is now facing is the inherent constraints within governmental and the health systems on the delivery of the right to health. The problems that face AIDS face health generally. The AIDS movement must now challenge the way in which the state is organised and the degree to which human rights, in this case the right to health, are budgeted and planned for. Movements such as the AIDS and Rights Alliance of Southern Africa (ARASA) have deepened democracy by demanding accountability from governments who have not been accustomed to such pressure. But now it seems that these governments feel they have given enough. In several key African

countries the fight for resources and inclusion has reached the limits of 'democracy' that will be tolerated by governing elites.

This problem is not unique to Africa. In China AIDS activists are hemmed in by the dictatorship of the CCP and face the same barriers as other movements that fight for labour rights, to protect the environment or for democracy. In some Eastern European countries the stalemate over harm reduction is a reflection of the lack of democracy and accountability faced by governments. Across the globe the apparent impasse is created by grossly inadequate levels of funding for health generally; the lack of coordination and commitment to poor people's health. Bodies such as the WHO reveal their impotence and lack of will to analyse or overcome this situation.

There are of course exceptions that merit study and discussion. Brazil is one. Ironically South Africa may be another.

Consequently both the AIDS movement and other campaigns for health are at a turning point. The AIDS movement would have reached this point regardless of the global financial crisis, but unless it grapples with the space it now occupies it will falter and ultimately fail. Alternatively it can play a central part of a new movement that aims to raise the response to global health as a whole to the levels of the AIDS response, and higher.

A re-articulation of strategy and vision for the human right to health movement – one that goes beyond recognizing this new context to building unity and identifying a programme of action and demands to address it – is necessary. Continuing as is will hinder and make impossible the vision of 'universal access' to health care services and conditions that permit people to be healthy.

Some of these insights lie behind the decision of a number of organisations and individuals to form a 'Joint Learning and Action Initiative (JALI) on National and Global Responsibilities for Health'. This initiative, which is at an early stage, aims to conduct research and advocacy intended to provide tangible answers to four critical questions:

- What are the essential services and goods guaranteed to every human being under the human right to health?
- What is the responsibility that all states have for the health of their own populations?
- What is the responsibility of all countries to ensure the health of the world's population?
- What kind of global health governance is needed to ensure that all states live up to their mutual responsibilities?

It also aims to develop a campaign to identify consensus demands on immediate steps that must be taken to fulfil the right to health. The rationale for this initiative is briefly set out below.

Defining and Balancing National and International Responsibilities

Under the subheading 'Solidarity' the UN Millennium Declaration states:

“Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.”

This does not detract from the fact that meeting a population's needs for health is primarily a national responsibility. According to international law, every state has an obligation to provide adequate health goods and services to its inhabitants. Recently there has also developed a clearer agreement and understanding among states that universal access to proper health care is also essential for realisation of the right to development and the attainment and maintenance of a healthy and productive society.¹ This is evident in the recommendations of WHO Commissions such as those on Macroeconomics and Health (2001) and on the Social Determinants of Health (2010).²

¹ The right to development is recognized in the 1986 United Nations Declaration on the Right to Development, the 1981 African Charter on Human and People's Rights, the 1992 Rio Declaration and the 1993 Vienna Declaration and Programme of Action.

² Few of these Commission's recommendations have been implemented. It seems unlikely that they will be, except in a piecemeal and ad hoc fashion.

Civil society has a duty to put continual pressure on governments to improve the financing, management, equity and delivery of health.

However, it also accepted that, in the words of the WHO, health is a global 'shared responsibility, involving equitable access to essential care and collective defence against transnational threats'. Yet this recognition rarely translates into action. If anything, the gap between the rhetoric of health as development and health realities widens.

Consequently, health care remains inadequate for billions and even deteriorating in some parts of the world. In their efforts to create health systems states discover that the financial and human resources that are needed to create a sustainable and thriving health system are out of reach of many developing (and developed) nations -- and always will be if these nations are denied predictable international assistance. Neither is there a plan to quantify or create these resources.

Below are some of the symptoms of this malaise:

Growing inequalities in health:

- Inequalities *between* countries have increased and in some large countries, including South Africa and China, inequalities *within* countries have increased.
- Since the adoption of the Millennium Development Goals (MDGs) there have been improvements in some health outcomes-- such as a reduction in child mortality rates and the expansion of HIV treatment in some countries. But HIV, tuberculosis and malaria remain major health threats to millions, as do neglected diseases and non-communicable diseases.

Overlooking the determinants of health:

- Just as many diseases are preventable, so are their social determinants (including pollution, patterns of diet, malnutrition, unplanned urbanization). The failure to address the determinants of ill health is behind the epidemic of NCDs and the growing burden it places on health systems.

Lack of co-ordination in responses to health:

- The multiple responses to communicable and non-communicable diseases in developing countries are usually ‘siloed’, not integrated or complementary but overlapping, uncoordinated and even competing. Many well-funded initiatives lack mechanisms of accountability and transparency and tend to focus on short-term results.
- This is exacerbated by the lack of coherence and the contradictions between the economic and trade agreements reached by governments and their health and social commitments. TRIPS is a case in point, as are the customs unions being negotiated between the European Union and other trading blocks.
- Insufficient attention is paid to the fact that threats to health that appear unrelated are in fact interconnected and require holistic approaches to their prevention and treatment.

Impact of the global on the national and unequal power:

- States that have made efforts to deliver on health obligations, for example through efforts towards comprehensive national health systems, often find that issues of global power influenced and determine the extent of the national response.
- Linked to this, the ‘responsibility’ that the developed world has assumed for global health is still treated as a form of charity rather than an obligation. Fleeting political initiatives and policies lack enforceability and sustainability and, as a result, developing states face inconsistent commitments.
- Particularly evident with HIV are the power imbalances that allow donors to shift attention from one health issue to the next without focusing on building long-term national health stability.
- Although national health systems are the most immediate victims of this unpredictability, civil society advocacy organisations and NGOs – who have been the motor force of the response to AIDS and are needed to drive campaigns for the right to health – are also threatened by this donor fickleness. For example, all over the world financing for civil society organisations working on AIDS is drying up.

Admittedly, there have been repeat attempts to address these imbalances and inequities through programmes such as the Accra Agenda for Action (2008), the Paris Declaration on Aid Effectiveness, the Millennium Development Goals and most recently the UN General Assembly Resolution on Global Health and Foreign Policy. But these initiatives are often unknown to ordinary citizens, flawed in both design and implementation, and unsurprisingly have not brought about the desired fundamental shifts in global health. Neither are they far-reaching enough.

One can only conclude that whilst there might be evidence of a will for health, there is disagreement on a way. Or perhaps the truth is more cynical, there is a way but it is blocked by a combination of vested interests and the very structures, including the WHO, by which health is supposed to be protected and fulfilled.

So what is to be done?

The importance of campaigning for action on the right to health:

Over many decades health activists of all hues have continually pressed for action that recognises that health is a human right. As a result there has been a growing recognition and development of understanding of health as a human right. This starts with the 1978 Alma Ata Declaration and is boosted by the adoption of General Comment 14 by the UN Committee on Economic, Social and Cultural Rights in 2000. On the issue of international co-operation General Comment 14 states clearly that:

“In the spirit of article 56 of the Charter of the United Nations, the specific provisions of the Covenant (articles 12, 2.1, 22 and 23) and the Alma-Ata Declaration on primary health care, States parties should recognise the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realisation of the right to health.” (par 38)

And:

“Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible and provide the necessary aid when required.”

In the wake of General Comment 14 an extensive body of international and domestic law has developed that recognises or refers to the right to health. There are also references to health as a right in the plethora of UN Conventions and Declarations, the most recent being the July 2010 UN General Assembly Resolution on the 'Human Right to Water and Sanitation' (see annexure).

But what do all these references to human rights mean? Are they just part of a lazy UN language that seem to be used precisely because they are not seen as being actionable? Or can they be enforced in small or large ways? Who determines what resources are available or what are essential health facilities? As we contemplate the future response to HIV/AIDS and global health generally, we believe that national movements for health should develop mobilisation strategies that take advantage of these developments, particularly the fact that it is now accepted that:

- the right to the highest attainable standard of health encompasses not just medical care but also access to the underlying determinants of health such as adequate education, information, safe drinking water and adequate sanitation.
- the right to health gives legal entitlements to citizens and obligations to states.³
- the right to the highest attainable standard of health is subject to progressive realisation. This means countries must continually and measurably address their health obligations and do so in an increasingly coordinated and standardised manner.
- As seen most clearly in the Framework Convention on Tobacco Control (FCTC) it is now accepted that states have rights 'to protect public health' against private powers, particularly where this is necessary to realise or protect human rights.

These are the pluses available to movements for health.

On the downside it is important to note the inadequacy, at this point, of the ambiguous language in General Comment 14. Similarly, the dispersal of reference to the right to health across so many conventions makes it difficult to interpret or utilise. For rights to have utility and a mobilising power, they need to be understandable and accessible.

³ Of course this idea is resisted in a few parts of the world, notably the United States and China. But under different conditions and legal frameworks, many jurisdictions have started to define the nature of the right and the duty/obligations that a government and private players, such as multi-national corporations, have towards it.

How would a Framework Convention on the Right to Health assist?

When it comes to the right to health the threads need to be pulled together. Something more concrete and more directive is needed. This is the context in which we believe that a FCRH could assist to simplify explanations of the ambit and duties created by the right to health and prioritise health at a global level. A FCRH would entrench the notion that on issues of fundamental human rights which cut across national boundaries, states have primary responsibility. But where it is objectively established that they cannot fulfil their duties to health, they should benefit from reliable and ongoing international assistance. As with issues such as torture, states should not have complete sovereignty over the extent to which they choose not to fulfil their obligations to realise the right to health.

Below are some arguments for and against a FCGH:

Arguments for:

- **Empowering civil society:** The FCRH that we envisage must not be yet another out-of-reach agreement, hanging in Swiss airspace, unknown and inaccessible to those who it claims as its *raison d'être*. The existence of a global standard and framework on health, particularly if it has come about as a result of a movement of health rights education and advocacy from below will empower civil society organisations, health professionals and citizens in local and national campaigns for governments to provide for adequate national standards of health.
- **Clarifying roles and responsibilities:** Developing a framework is a way to get different role-players within health engaging each other, and to set about the process of clarifying national and global responsibilities for health. The aim is not to supplant existing health movements but allow them to organise within a common framework and start to speak with a common organised voice at national and international level.
- **Maintaining momentum after the MDGs:** The centrality of health and HIV to the achievement of the MDGs means that until 2015 there is a framework in place that should be increasingly used to hold states and the UN to existing commitments. But,

particularly in a period of global economic and political uncertainty, the call for a coherent health framework could be a motor for advancing the right to health during the post-MDG period.

- **Creating a global compact and shared consensus:** By creating a global international support system, sustainable national health systems could be developed capable of meeting basic survival needs and reducing global health disparities. A global compact could enable developing countries to carry out their obligations to fulfil the right to health, by clarifying national and global responsibilities for health. The process of and campaign for a framework convention could develop a broader humanitarian consensus on the centrality of health to human dignity and equality.

Arguments against:

Of course, the FCRH idea encounters ready and reasonable scepticism.

- Some argue that the world's most powerful developed and developing countries would never permit such a binding agreement because of its resource implications.
- Others question the value of yet another international agreement, when the real obstacles to health care lie at a national level.
- Still more point to the litter of unfulfilled international commitments and declarations. For example, a study done by Palmer et al showed that ratification of primary human rights treaties was not significantly related to a positive change in national health. How would a FCRH be different from other international declarations, covenants or agreements?

Conclusion:

Over coming months we hope that there will be an expanding debate about the idea of a FCRH. This debate will explore pro and cons, pitfalls and possibilities. Its outcome or the ideas it will raise cannot be known in advance.

However, whatever is decided, it cannot be argued that the status quo is sufficient – particularly by those who believe that health is a human right. It is for these reasons that we highlight the need for a coherent global health governance framework and set of rules.

A more united, cross issue, cross country campaign for the right to health provides civil society with opportunities to change health policy nationally and globally through its tool of reasoned advocacy, social mobilisation and litigation. Although most UN Conventions have failed to deliver, a FCRH might take advantage of the fact that some international treaties ‘have been effectively used to reduce child labour, increase access to antiretroviral health care, promote care of people who are elderly and mentally ill, and improve the quality of public spaces’.

Finally, it must be stated as a matter of principle that a FCRH will never be brought about by the good will of governments alone. It requires that a civil society led partnership be built, including the AIDS movement, using the demand for universal access to HIV goods and services as the driver for tangible and measurable health reforms. This partnership must be united around its goals and must identify short term proposals and demand that test commitments to health and thereby build new partnerships around health and AIDS.

The question that should then be asked is not *why* we should have yet another global convention, but rather *how* can we create a campaign and an institution that can make health possible for the billions who remain deprived of this right.

Some Questions:

- Is a FCGH (a) necessary (b) possible? Could it create a new vision that can re-inspire different partners involved in global health? Could it encourage social justice activists working on health to engage each other and create an energized advocacy agenda that highlights and fills the fault lines in global health?
- What are the most compelling arguments for and against a FCGH?
- What would be the possible content of a FCGH?

- a contemporary statement of the duties arising from the right to health?
 - a timeframe for progressive realisation of the right to health?
 - agreed norms for the provision of health services at a national level
 - an agreement and mechanisms for areas on which international co-operation is absolutely essential, including human and financial resources for health?
- What has been the impact at the national level of comparable initiatives such as the Framework Convention on Climate Change and the Framework Convention on Tobacco Control?
- Where have past international treaties and conventions on health failed and how can a FCGH be different?

Please send your thoughts and comments to: lalla@section27.org.za

Some Readings:

Gostin, JD and Lawrence, O., 2007, Meeting the Survival Needs of the World's Least Healthy People: A Proposed Model for Global Health Governance, *Journal of the American Medical Association*, 298 (2): 225 – 228.

Gostin, JD et al., 2010, The Joint Action and Learning Initiative on National and Global Responsibilities for Health, *World Health Report Background Paper 53*.

Heywood, M., 2008, Chapter Two: Health and the Inequality of Poverty: Towards a Right-based Convention on Global Health, <http://www.tac.org.za/community/node/1980>.

Heywood, M and Shija, J., 2010 A Global Framework Convention on Health: Would it Help Developing Countries to Fulfil Their Duties on the Right to Health? A South African Perspective, *The Journal of Law, Medicine and Ethics*, 38 (3): 640 – 651.

Hunt, P et al., 2008, Health Systems and the Right to Health: an Assessment of 194 Countries, *The Lancet*, 372: 2047 – 2085.

Lord, J et al., 2010, Lessons from the Experience of UN Convention on the Rights of Persons with Disabilities: Addressing the Democratic Deficit in Global Health Governance, *The Journal of Law, Medicine and Ethics*, 38 (3): 640 – 651.

Sridhar, D., 2010, Seven Challenges in International Development Assistance for Health and Ways Forward, *The Journal of Law, Medicine and Ethics*, 38 (3): 459 -469.

Millennium Declaration: <http://www.un.org/millennium/declaration/ares552e.htm>

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