ISSUE PAPER FOR THE SESSION:
Visioning an Architecture Capable of Realizing the Right to Health: Towards a Framework Convention on Global Health?

....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 Silverman Abella to the Empire Club of Toronto. “THE WORLD IS NOT UNFOLDING AS IT SHOULD: INTERNATIONAL JUSTICE IN CRISIS.” 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, Getting to Zero Strategy: 12

Introduction
In the second decade of the twenty first century, national and global responses to HIV have entered a different era. Implicitly, this is recognised in the UNAIDS 2011-2015 Strategy, Getting to Zero, which talks about a ‘new context’ and a ‘pivotal moment in the global response’.

Since the mid-1990s, realization of the right to the highest attainable standard of health has been interpreted to include the right to access ARV treatment and the protection of the human rights of people living with HIV. These have been two of the most powerful impulses that have shaped the global and national responses to the HIV epidemic. A growing acceptance of human rights (at least on paper), has influenced local, national and international responses.

Ironically, although criticized for its ‘verticality’ and ‘exceptionalism’, this urgent and human rights-based response to HIV has contributed to bringing about a renewed focus on other aspects of global health. It has spawned innovative new institutions such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), led to huge additional expenditure on health generally, and contributed to the creation of a global health activist movement. At the same time, it has starkly revealed the shortcomings of national and global systems that are meant to protect and advance health, as well as of responses to other health challenges.

These shortcomings now have to be overcome, for the sake of both the HIV and broader global health agenda. A tangible re-articulation of strategy and vision for UNAIDS and the human rights movement, one that goes beyond recognizing this new context to taking
action to address it, is necessary. Continuing with old tools and old strategies will hinder and make impossible the vision of universal access.

Some of these insights lie behind the decision of a number of organizations to form a Joint Learning and Action Initiative (JALI) on National and Global Responsibilities for Health. This initiative, which is at its nascent stages, aims to develop a campaign to identify consensus demands on steps that must be taken to fulfil the right to health as well as a set of proposals for a future UN Framework Convention on Global Health (FCGH). The rationale for this initiative is briefly set out below.

**Health as a national and shared responsibility**

Providing for a population’s 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. However, health is also a global ‘shared responsibility, involving equitable access to essential care and collective defence against transnational threats’ (WHO). As the Millennium Declaration states:

> we recognize that, in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to the entire world’s people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs.

There is also now an understanding that universal access to proper health care is not only a shared responsibility, but is also essential for development and the attainment and maintenance of a healthy and productive society. Yet this recognition rarely translates into action on the ground. For example, the recommendations of WHO Commissions such as the Commission on Macroeconomics and Health (2001) and the Commission on the Social Determinants of Health (2010) have not been implemented and seem unlikely to be except in a piecemeal and ad hoc fashion.

Unfortunately, the gap between rights rhetoric and health realities remains deep and wide. Health care remains inadequate for billions and even deteriorating in some parts of the world. The financial and human resources that are needed to create a sustainable and thriving health system are out of reach of many developing nations, and always will be if these nations are denied international assistance. Examples of the effects of this denial include:

- Although there have been improvements in health outcomes since the adoption of the Millennium Development Goals (MDGs) – such as a reduction in child mortality rates and the expansion of HIV treatment – the international community has not succeeded in significantly reducing health inequalities. In some large countries, including South Africa and China, inequalities have increased.

- High-profile diseases such as HIV, tuberculosis and malaria remain major health threats, as do neglected diseases. Easily treatable illnesses such as diarrhea, pneumonia and malaria are responsible for two thirds of child deaths in developing countries. According to the Global Alliance for Vaccines and Immunization (GAVI), 1.5 million children die per year in developing countries alone from preventable diseases despite the availability of vaccines.
Responses to preventable and treatable diseases in developing countries remain ‘silied’ or not integrated or complementary. 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. Instead, global health initiatives, including for HIV, have been multiple, overlapping, uncoordinated and even competing. Many well-funded and well-intended initiatives have lacked mechanisms of accountability, transparency and tend to focus on short-term results (Sridhar, 2010: 460).

As is evident with HIV, power imbalances allow donors to shift attention from one ‘fashionable disease’ to the next without focusing on building long-term national health stability (Sridhar, 2010: 460). Civil society advocacy organizations and NGOs in particular are threatened by this donor fickleness, and financing for civil society organisations is drying up despite the fact that civil society has been the engine of the AIDS response.

In short, there seems to be evidence of a global will for health—as seen in the growing number of international declarations and covenants, regional agreements and national legislation that recognise access to health care services or provide services that determine health as a fundamental human right. But is there a way? How can this will be better organized and put into action?

**Situating HIV in this larger context**

For good reason, HIV and AIDS have occupied unprecedented global attention for a single disease. As a result, significant progress has been made, albeit not enough for the millions who have died. But despite the fact that nearly a million people will die of AIDS in East and Southern Africa in 2011, for a variety of political reasons, this attention will not continue. If AIDS is to attract the resources it still requires, it needs to become a central part of an advocacy movement to raise the response to global health as a whole to the peak levels of the AIDS response, and higher.

After a decade of advances in the numbers of people accessing ARV treatment and some breakthroughs in HIV prevention, the picture should be an optimistic one. But it is not. Increasingly it is governmental and structural constraints that account for the lack of progress (or even threaten progress), particularly the absence of good governance, violations of human rights, inadequate levels of funding on a domestic and international level, as well as the implementation of health care programs that are not based on a proper objective assessment of national health needs.

There have been repeat attempts to address these challenges through programmes such as the Accra Agenda for Action (2008), the Paris Declaration on Aid Effectiveness and the Millennium Development Goals. But these innovative approaches have not brought about the desired fundamental shifts in global health.

**The importance of the right to health**

It is not accidental that over the last 20 years there has been a growing recognition and development of understanding of health as a human right. Part of this was linked to the adoption of General Comment 14 by the UN Committee on Economic, Social and Cultural Rights in 2000. But before and after this, civil society activists also played a major part by continually pressing health as a right, and making specific demands on governments, the UN and the private sector that flow from this right. Reflecting this, there is now a growing body of international and domestic law that recognises or refers to the right to health.
There are also references to health as a right in many different conventions and declarations, the most recent being the 2010 UN General Assembly Resolution on the Human Right to Water and Sanitation.

Today it is well understood 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 education, information, safe drinking water, and adequate sanitation. This is particularly important for AIDS.

Further, it is now uncontroversial that the right to health gives rise to legal entitlements and obligations. Whilst this idea is resisted in a few parts of the world, notably the United States, 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.

International law recognises that the right to the highest attainable standard of health is subject to progressive realization. In other words, it is not a goal that can be achieved overnight. This said, countries must steadily and progressively address their health obligations, and – we would argue – do so in an increasingly coordinated and standardized manner.

**Sustaining an emergency response**

There have been many national and international movements for health in the past, but almost all of them have faltered at some point. The same could happen to HIV. But the response to HIV/AIDS thus far has set an example of the potential of health movements if they are coordinated, driven from below and rooted in rights and evidence.

There are several reasons why the response to HIV/AIDS stands out. The response 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 the UN, states, and the private sector.

Success was achieved through activism that expanded across the globe. HIV received global political recognition as an emergency in the late 1990s. The 2001 Declaration of Commitment was an enormous boost for the movement and the response. The HIV/AIDS movement made health (through AIDS) one of the preeminent moral and political issues of the last century and brought to the fore the notion that health is a human right. But it is also challenging this notion to mean something. It points to the inadequacy, at this point, of the ambiguous language in General Comment 14. Something more concrete and more directive is needed.

The question that has to be posed is where does UNAIDS go from here, and how? Except in broad strokes this is not answered in *Getting to Zero*.

Answering this question is necessary not only to maintain forward movement, but also to stall a reverse. As it is, in 2010/2011 a number of donor governments have cut back on their AIDS aid pledges and across the world cuts in health aid are taking place. Although the GFTAM achieved a larger financial replenishment than ever in October 2010, it was still less than the lowest need scenario, and not sufficient to reach targets of universal access. If anything a roll back is taking place. Emergencies such as climate change, food insecurity and terrorism are shuffling AIDS (and to some extent health) to the background of global priorities. With global health becoming less of a concern for many developed
states, UNAIDS needs to start thinking not just of its ‘own’ strategies but also of a strategy that could reinforce global health as a priority.

The rationale for a Framework Convention on Global Health
UNAIDS’ Getting to Zero strategy acknowledges that ‘recognizing financial constraints, the need to generate greater efficiency’ in the global health response to HIV/AIDS in particular, requires us ‘to radically reshape the global response’ (p 9). The question then becomes, how do we do so?

According to JALI’s advocates, the future of global health is based on mutual responsibility. The creation of a United Nations FCGH would prioritize health at a global level and embody the notion that on issues that cut across national boundaries, states do not have complete sovereignty. The recognition of universal human rights necessitates a greater degree of global governance and responsibility.

Among the arguments for the FCGH are:

- **Maintaining momentum after the MDGs:** The centrality of HIV to the achievement of MDGs 4, 5 and 6 means that for the next five years there is already in place a framework that should be used to hold states and the UN to existing commitments to the prioritization of HIV. But, particularly in a period of global economic and political uncertainty, the creation of a coherent health framework could be a motor for improvements in global health during the post-MDG period.

- **Clarifying roles and responsibilities:** Success or failure in a concerted effort to enforce the right to health by creating a framework capable of its delivery will determine ‘how the next phase of treatment is delivered and the strength of our collective commitment to human rights and gender equality’ (Getting to Zero p 21). Developing this framework is a way to get different role-players within health engaging each other, and to set about a 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.

- **Empowering civil society:** It is important to note that a FCGH is not envisaged as 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 (which is what the JALI partners intend), could also empower civil society organisations, health professionals and citizens in their own campaigns for governments to provide for adequate national standards of health.

- **Creating a global compact and shared consensus:** By creating a global international support system, enduring national health systems could be developed to meet basic survival needs and reduce 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. Finally, one of the greatest benefits of a framework convention is that it could develop a shared humanitarian consensus on global health (Gostin and Lawrence, 2007: 227).
It is for these reasons, among others, that the JALI collaboration is proposing the development of a coherent global health governance framework for the post-MDG period, as well as seeking to identify short term proposals and demands that can build new partnerships around health and AIDS.

The UNAIDS Getting to Zero strategy seems, in a non specific way, to anticipate the JALI arguments. It states that ‘effective partnerships are fundamental to a successful and sustainable HIV response’ as ‘partnerships give voice to the people infected and affected by HIV, act as a catalytic force for change and provide accountability for political commitments’ (p 28). However, UNAIDS also acknowledges that within a changing political and economic environment, new and innovative ways are needed for working within these partnerships. It also recognises that a renewed effort is required to encourage the commitment of the global North to support the global South (p. 28). According to UNAIDS this form of ‘global compact ‘can serve to promote the ‘pursuit of solidarity, equity and human dignity beyond the AIDS response’ (p 28). UNAIDS has acknowledged that in order to support countries in protecting human rights in the context of health as well as HIV/AIDS, we need to create a more ‘coordinated global effort’ (p 40).

Doubts and questions
Of course, the FCGH 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. They are right.
- Others question the value of an 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.

All of these arguments contain some truth. But significantly, the UN has already set precedents for such an agreement. The UN Framework Convention on Climate Change (UNFCCC) has established a binding agreement which has been adopted by 169 countries, while the UN Convention on the Rights of Persons with Disabilities has been regarded as a significant breakthrough in the development of global health law and governance (Lord et al, 2010: 565). The Framework Convention on Tobacco Control is another example.

Finally, it must be stated strongly that it is not intended that a FCGH will be brought into existence by governments or the UN alone. It is intended that a civil society led partnership be built, including the AIDS movement, using universal access to HIV goods and services as the driver for broader health reforms. This partnership will embrace research, advocacy and engagement. In the context of envisaged WHO reform, UNAIDS would do well to engage in this debate and clarify and concretize its own vision.

Potential recommendations
- UNAIDS should meet with the key advocates for a FCGH.
- UNAIDS should have an internal discussion about whether a FCGH would assist it to meet its own targets and objectives.
- UNAIDS should have a discussion on potential health strategies post-MDGs.
- UNAIDS should discuss the potential benefits/risks of a FCGH.
Questions for discussion by the Reference Group

- Has the global response to HIV peaked and, if yes, why?
- Civil society has driven the response to HIV since the mid 1980s. What was its vision then? What is its vision now? Can civil society overcome the political obstacles to further successful organization in countries of Eastern Europe, China and parts of Africa?
- Is a FCGH a possible next step for post-2015? Would it create a new vision that can re-inspire different partners involved in global health? Could it encourage different actors 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? (Some recommended suggestions to consider would be a contemporary statement of the duties arising from the right to health; a timeframe for progressive realization of the right to health; agreed norms for the provision of health services at a national level and 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?
- Do members of the RG agree with the approach suggested?
- What follow up should the RG agree to undertake on this issue?

Additional readings


This issue paper was prepared by Mark Heywood and Varsha Lalla (SECTION27) to facilitate discussion at the Reference Group's March 2011 meeting.

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