

A Global Framework Convention on Health - Would it Help Developing Countries to Fulfill their Duties on the Right to Health? A South African Perspective

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It is arguable that the delivery of global health has reached an impasse. This is evident not only in unresolved debates that are raging about where to allocate health aid or how to sustain and expand funding for AIDS treatment,¹ but also in challenges facing national health systems that are incapable of purely domestic resolution. But there is some irony and much opportunity in this situation. Not only have the last 20 years seen an unprecedented growth in funding for health, mainly through funding for AIDS, but there have also been a range of initiatives and ideas² that have generated better knowledge not only of the determinants of health,³ but also of how to attain it.⁴ Scientists, public health experts and activists have created a store of intellectual knowledge, technology and ideas which, if properly and fairly deployed, might provide the opportunity to re-launch tangible progress towards the progressive realization of the right to health on a global scale.

It is in this context that Professor Lawrence Gostin and now a growing band of fellow travelers have floated the idea of a Global Framework Convention on Health (FCGH)⁵. Gostin summarizes the FCGH as:

[A] global health governance scheme that incorporates a bottom-up strategy that strives to do the following: build capacity, so that all countries have enduring and effective health systems; set priorities, so that international assistance is directed to meeting basic survival needs; engage stakeholders, so that a wide variety of state and non-state participants can contribute their resources and expertise; coordinate activities, so that programs among the proliferating number of participants operating around the world are harmonized; and evaluate and monitor progress, to ensure that goals are met and promises kept.⁶

This article aims to support this proposal, but to do so from two slightly different perspectives. First of all, we will argue from a South African perspective that national experience in attempting to fulfill the right to health supports the need for an international framework. Second, we suggest that this framework is not just a matter of good choice or even of justice, but of a direct legal duty that falls on those states that have consented to operate within the international human rights framework by ratifying key treaties such as the International Covenant on Economic Social and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). States can either accept this duty or face with growing pressure from those who believe in global social justice to find lasting solutions to the terrible inequities in global health standards.

How would a global agreement benefit national delivery?

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Functioning health care services depend first and foremost on whether governments take the right to health seriously and care about the health of the poor. Sadly, many do not. In many countries government officials and the rich are content to utilize private profit driven health services, while leaving the poor to fend for themselves in an underfunded public sector. Because of this, poor people often spend catastrophic amounts of money 'out of pocket' on accessing private care before falling back on the public health system. In Brazil, India, and South Africa social movements are developing to demand greater state responsibility for health. In this context, there are some who fear that a FCGH could have the negative effect of relieving states from pressure to fund and deliver health care services. But in fact the opposite could be the case. A FCGH would signal the prioritization of health at a global level and embody the principle that whilst states have sovereignty over purely domestic matters, on issues that cut across national boundaries, or implicate universal human rights, there will be a greater degree of global governance and responsibility.

In campaigning for a FCGH it is important that civil society be a driver of the process, showing both ownership and commitment to its success. Amongst many major transnational organizations working on health, such as Médecins Sans Frontières or Health-Gap,⁷ there is currently a high degree of introspection about how to move forward to secure the right to health, and particularly how to sustain and expand the substantial increase in global expenditure on in health in recent years. However, much of thought and activism is spent protesting the 'backlash,' rather than channeling legitimate demands into a forward looking framework that would/should increase both efficiencies and equity, thereby silencing some of the critics of the global AIDS movement. Civil society should begin to debate this idea and its current proponents should actively seek to draw civil society into the discussion at an early stage. A global agreement stitched up behind the backs of civil society will fail because citizen activism, popular mobilization around health and an acceptance of state's accountability to their populace and to each other is essential to success.

Should the principle of a FCGH be accepted there will of course need to be intense negotiation about its content. It is not the aim of this article to anticipate that debate. However, in broad strokes we can say that a global agreement would make it possible to at least set global norms and standards in the most common areas of health delivery, and perhaps (in a similar fashion to the envisaged agreement on climate change) timeframes for the achievement of these standards. Some areas on which standards could be set include:

- Duties of states to support each other in order to achieve the right to health, and to manage exceptional health crises;
- Recommended levels of domestic public sector expenditure on health services;
- A definition of the essential health services that should be available to all the population;
- Minimum staffing norms for the delivery of effective and quality essential health services;
- Minimum conditions of employment for health care workers;
- Core health services that should be provided by a health system;
- Principles of equal access and non-discrimination in access to health care services;
- Rights of migrants to health care services; and
- Measures that states agree not to take that hinder other states' capacity to realize the right to health.

A FCGH would provide benefits by both requiring states to pull-up to a global standard and permitting a universal push-down on states to fulfill their duties under human rights law. It would

assist health activists by setting standards against which citizens are able to measure their governments. In the same way that it is necessary for states to take measures that narrow the inequality between public and private health care at a national level, a FCGH could help narrow inequalities on a global scale. By doing so it would lessen the movement of people either seeking health care across national boundaries, or seeking to provide health care services in greener pastures.

South Africa as a crucible

South Africa is a crucible where all the challenges that face national and global health express themselves on a stage where the government is under a direct constitutional obligation to constantly improve the accessibility of health services. As such, the South African experience is a useful yard stick to measure the potential value that would be added by a radical rearrangement of the architecture of global health that aims to achieve greater sustainability, transparency, predictability, and unified norms and standards in delivering the right to the highest attainable standard of physical and mental health. This, it seems is the objective of a FCGH.

South Africa is a new democracy. Its legal architecture is based upon the conception of human rights and responsibilities that became dominant in the mid-1990s, and influenced the legal frameworks adopted by many countries emerging from different forms of dictatorship. Within that framework, in the early 1990s, the drafters of South Africa's Constitution decided to make 'the right of access to health-care services' for everyone, justiciable alongside other socio-economic rights, including rights which are direct determinants of health.⁸ Indeed in one section of its Constitution, section 27, the Constitution's drafters, placed a basket of rights related to health, including sufficient food, water, social security – and ordered that these rights be 'progressively realized' 'within available resources' by 'reasonable legislative and other measures'. On either side of the right to health it placed the right to housing (section 26) and the right to basic education (section 28) – rights that are also not unrelated to health.

These are not abstract or only dimly relevant entitlements, because South Africa (like many other developing nations) faces a simultaneous crisis of population health and a crisis of health systems. This is described in detail in a 2009 special edition of the *Lancet*.⁹ But in summary, South Africa is home to nearly six million people with HIV, all of whom are legally entitled to have access to anti-retroviral treatment (ART) when they require it. It has one of the worst tuberculosis (TB) epidemics in the world, which has spawned both multidrug-resistant (MDR-TB) and extensively drug-resistance (XDR-TB) strains. There is malaria in parts of the country, generalized malnutrition and obesity, as well as a growing burden of non-communicable diseases. In early 2009 cholera spilled over from neighboring Zimbabwe and a few years before that typhoid was detected in a township not far from Johannesburg. Car accidents, smoking, and a very high level of inter-personal violence add to the demand for health-care services. And, as if this were not enough, South Africa's health-care services must provide for an uncounted number of undocumented migrants (estimated to be as high as four million people) whom public health, morality, and law require have access to care.

South Africa is trying to deal with its health challenges. In 2010-11, there is an ongoing campaign to persuade fifteen million people to test voluntarily for HIV; a budget has been allocated for an

additional 500,000 people per year to commence antiretroviral treatment (ART); there are mass immunization campaigns. In addition, a commitment has been made to introduce a system of National Health Insurance (NHI) within the next five years that will guarantee to all people an essential package of health care services funded by a single health insurance system.

But the question is, should the duty to fulfill the right to health in this context be South Africa's alone? And if it is, will the 'highest attainable' standard of health that is achievable with South Africa's 'available resources' (which are insufficient) and competing socioeconomic priorities (which are huge) be sufficient to protect and improve public health? One forecast of the cost of providing a basic benefit package of health services to all under a system of NHI suggests that it would immediately cost twice the current amount that is spent on the public health system in South Africa. To fund it would require a dedicated payroll tax of 17% to supplement what the government currently provides for health through general tax revenue. From these figures it would appear that 'basic health' for all the population is unaffordable.¹⁰ But what will be the cost to global health if South Africa, and countries like it, are unable to provide basic health care services, left to muddle along alone or worse, fail to overcome the challenges of HIV prevention and treatment?

The international dimensions of providing health care at a national level

It is important to recognize that the high burden of disease (and the (in)ability to counter it) that is experienced by developing countries is usually not just a reflection of poor domestic governance, local conditions and corruption. It often has historical determinants that go back centuries.

In Africa, a century of colonialism, neo-colonialism, and then the prerogatives of the cold war (a war essentially between the USSR and the USA) diverted emerging economies and societies from 'normal' patterns of development and impoverished them materially, socially, and intellectually.¹¹ In South Africa *apartheid* not only created a lop-sided and skewed health system, which disadvantaged people on the grounds of race, but it also explains the epidemiology of diseases such as TB and patterns of HIV infection. For example, the fabulous wealth that was accumulated and exported through gold mining had amongst its social costs an epidemic of sexually transmitted diseases that helped HIV quickly acquire epidemic proportions once it established itself in the late 1980s.¹² TB was an occupational disease of the mining industry that began to be controlled before HIV, but has now exploded because of HIV. TB and HIV are now South Africa's greatest and most expensive health challenges.

But in addition to the geo-political determinants of health status in South Africa, there are more contemporary international challenges that make national health an issue that can only be protected by global agreements. Several stand out:

An international but unequal market for human resources

Over the last few decades, developed countries have not invested sufficiently in expanding or replenishing their health work forces. For a combination of reasons, there is an overall shortage of nurses and doctors in countries such as the United States and United Kingdom. One research report estimates that the United States alone will be short of 800,000 nurses by 2020.¹³ The 'solution' has been the active recruitment of health workers from developing countries. This pull has found a ready

market amongst health professionals who, independent of the lure of nurse recruiters, are being pushed out of their domestic health systems by poor salaries and conditions that often make the practice of medicine intolerable and impossible. The result is evident in countries such as South Africa, where high vacancy rates for doctors, nurses, pharmacists and dentists contrast sharply with the number of those professionals practicing abroad.¹⁴

But the issue here is not just that the developed world 'owes' developing countries for its poaching activities, but that the health workforce is one area that would benefit from global planning and estimates of need. Further, even if poaching was stopped, insufficient resources to cover the cost of employing sufficient health professionals would still result in human resource shortages. Put simply, many developing countries can just not afford to employ sufficient health professionals even if they are in sufficient supply. There is no national solution to this conundrum.

The prohibitive cost of essential medicines

The high cost of essential medicines presents a similar dilemma, one that has been the subject of much activism in the last decade. Whilst work to improve the social determinants of health is essential and 'prevention better than cure,' there are hundreds of millions of people worldwide, including an estimated 33.4 million people infected with HIV¹⁵ for whom medicines are essential to life. In 2008 two million people died of AIDS. Permitting preventable illness and death amongst these people exacerbates the determinants of ill health, perpetuating problems into future generations as, for example, when orphans grow up in income insecure families.

But as we have seen demonstrated with AIDS, medicines and medical technologies are not cheap; further, new challenges lie ahead with the affordability of second line regimens for millions on AIDS treatment or better regimens for people commencing treatment. In meeting this need states have to confront forces that are beyond their control including profit-dictated research agendas, currency fluctuations, the disjuncture between developed and developing country markets and the high cost of pharmaceutical ingredients, research and development. This powerless dependency is not something that can be overcome at a national level, even with use of flexibilities permitted since 2001 under the World Trade Organization agreement on Trade Related Aspects of Intellectual Property (TRIPS)¹⁶.

Who pays for migrants and refugees?

Finally, there is the reality of the health needs and rights of non-national populations who in some countries may number millions of people. Again, South Africa helps illustrate the point. South Africa is the destination for millions of people fleeing from sites of conflict or social breakdown in the African continent. In addition, many people come illegally to South Africa precisely because of the accessibility of basic health care services that are non-existent in their country of origin. In Zimbabwe, for example, maternal mortality more than quadrupled from 1990 to 2007, to 725 mothers' deaths per 100,000 live births. In 1994, 80 percent of Zimbabwean children received all their basic vaccines; by 2007, only 53 percent did. The collapse of social services, including health, is one of the factors explaining the exodus from Zimbabwe – transferring responsibility for the provision of basic health care services onto another government.¹⁷ The South African constitution says that "everyone" has a right to have access to health care services, and it would be immoral and unjust to deny health to millions of undocumented migrants (although this often happens in practice

as a result of resource shortages and xenophobia amongst South Africa health workers). The question, however, is who should have responsibility for the cost of providing these services, particularly in a country that is already unable to meet its 'own' needs?

At this point in the argument, therefore, it should be evident that there is, as Gostin et al., repeatedly argue, a moral duty on the countries of the world to share responsibility for international challenges that are experienced within national jurisdictions. However given that morality is not the primary driver of foreign policy or development aid, we go further and argue that there is today also a legal duty to establish an effective framework for delivery of the right to health.

The Legal Duty: The Reach of the ICESCR?

At an international level there are a plethora of declarations either on health generally,¹⁸ diseases specifically,¹⁹ or on socioeconomic conditions that influence health status, most notably the Millennium Declaration that encompasses the Millennium Development Goals (MDGs).²⁰ Furthermore, the Universal Declaration for Human Rights (UDHR), in article 22 encourages international co-operation in realizing economic, social and cultural rights whilst article 25, provides for a standard of living adequate for health which includes food, housing, medical care and necessary social services.²¹

These declarations are often easily made by states because they are not legally binding. However that does not mean that they are of no legal consequence. Indeed, it has been argued that, read together, they create customary international law that has become binding even on states such as the USA that may not be signatory to some of these agreements.²² This argument is strengthened when the declarations are read alongside other measures, including legislation, that are being taken by a growing number of states to recognize, respect, protect and fulfill the right to health. This fact is crucial when we try to determine whether the ICESCR (which we discuss more fully below) binds states that have not ratified it. Particularly important here is the United States, which, whilst the largest global provider of health aid, is able to do so entirely at its own discretion, rather than within any framework of rights and duties. Because of the economic size of the US even a 'small' slowing or diversion of health funds can have a disastrous effect on recipient countries or – to be more accurate – recipient people.

The ICESCR is meant to give legal effect to the UDHR. Because the UDHR is seen as customary international law, it is therefore arguable that the ICESCR has effect even on states that have not ratified it. This case is further strengthened when it is read within the context of all other declarations dealing with health in general or diseases such as HIV specifically.²³

For example, by 2010, 160 States had ratified the ICESCR, including many developed countries, although not the United States.²⁴ Even more states have ratified the CRC and the CEDAW. Alongside this we should note the international trend to include the right to health within national constitutions²⁵ as well as a broad body of jurisprudence reflecting on different aspects of the duties that arise from this right. The question is: what does all this mean?

Customary international law on the right to health

We would argue that read together, and having now become a part of customary international law, this body of law creates a positive obligation on states to cooperate on health and to establish efficient and effective institutional forms that would enhance this cooperation. The ICESCR is explicit on this and the fact that the majority of the world's nations have ratified it shows a consensus regarding a particular practice. It states:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. (Article 2.1)

And that:

The States Parties to the present Covenant agree that international action for the achievement of the rights recognized in the present Covenant includes such methods as the conclusion of conventions, the adoption of recommendations, the furnishing of technical assistance and the holding of regional meetings and technical meetings for the purpose of consultation and study organized in conjunction with the Governments concerned (Article 23).

The ICESCR entered into force in 1976, 34 years ago. That was a very different world in terms of global health. It is true that it may not have envisaged a FCGH – but if that is not to be the form of international cooperation what should be? Because the fact of the matter is that – despite the existence of the World Health Organization (WHO) – there is agreement that current forms of cooperation are often ineffective, insufficient and incapable of achieving progressive realization of the right to health.

In this respect, General Comment 14 of the Committee on Economic Social and Cultural Rights (CESCR), on the right to health, is instructive. It states at paragraph 38 that:

In its General Comment No. 3, the Committee drew attention to the obligation of all States parties to take steps, individually and through international assistance and cooperation, especially economic and technical, towards the full realization of the rights recognized in the Covenant, such as the right to health. 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 recognize the essential role of international cooperation and comply with their commitment to take joint and separate action to achieve the full realization of the right to health.²⁶

The role of the WHO?

There are several paths that those who advocate for a FCGH could follow. State members of the WHO can point to Articles 2(k) and 19 of its Constitution which empowers the health assembly “to adopt conventions or agreements with respect to any matter within the competence of the

organization.”²⁷ This is a path that states like South Africa, with an unsustainable disease burden, and an immediate interest in improved global collaboration on health should seriously consider.

But this is also an issue where pressure and advocacy from below will be vital. AIDS activism contributed directly to the creation of the Global Fund on AIDS, TB and Malaria (GFATM), the WHO’s “3x5” initiative, and reductions in drug prices. Outside of AIDS, citizen activism woke up other dormant health campaigns and issues, which saw what can be achieved by mobilization around health. In 2010 civil society sees and justifiably fears a push-back by developed country governments on their commitments to HIV.²⁸ Members of civil society in countries where the right to health is firmly embedded in the law, and whose government’s have ratified international covenants, could argue before courts at a national level that their state’s failure to work to establish effective mechanisms for international cooperation - including financing - on health is a failure to take all available and reasonable measures or to utilize available resources to realize the right to health. We urge them to consider doing so.

Of course some may argue that this is legal conjecture, and untested. That being the case, the best thing to do is to test it.

Conclusion

A FCGH is a moral, legal, political and public health imperative. After the many Commissions, Declarations, and institutional innovations of the last 20 years it is the logical next step for the promotion of the right to health.

The increased investment in and prioritization of global health during this period owes a great deal to AIDS activism, which used demonstration, litigation and relentless advocacy to raise awareness of health and shamed governments into increasing resources for health. But arguments about justice, anger and advocacy may now prove insufficient on their own to compel states to tackle the objective and material barriers that face the realization of the right to health: these are financial resources, state accountability, a lack of planning and prioritization partly although not entirely due to unpredictable financing flows. Consequently the AIDS movement has reached a natural impasse, in some ways the victim of its own success.

In this situation, civil society needs to fight for an objectively determined and agreed standard for global and national health, one that is not dependent on the vagaries and subjective priorities of different political administrations in the USA, Canada and EU. Although there is much reference to the financial constraints faced by governments in this period, the reality is that resources for health are not that scarce if they are measured against the overall availability of resources in the globe. Rather resources for health are becoming more scarce because of subjective decisions that have been taken by government leaders of developed countries, concerning the lives of people with no part or power or place in the decision making process. A FCGH that broadly sets out national and international duties towards health, health challenges and their cost, would make people of poor countries less prone to shifting first world priorities.

Such an agreement should explicitly accept that attaining the right to health is both a national and a global responsibility and should be based on:

- Recognizing duties arising from the Universal Declaration of Human Rights and its Covenants;
- Recognizing that the determinants of health are international as much as they are national and that the containment of disease depends upon co-operation, not just in emergencies such as SARS, H1N1 or HIV, but continually;
- That not all states have the same resources to meet their duties to realize the right to health, and that this creates a positive duty on developed countries to both fund health care in developing countries and a negative duty to desist from policies and practices that negatively infringe on the right to health in developing countries; and
- But linked to this it is important to demand greater accountability and transparency in funding health by developing country governments and costed minimum standards for the provision of health care.

In coming months and years there will be intense debates about universal access and how to achieve the MDGs. The question of a global machinery and framework for delivering health should be made part of these discussions by a coalition of governments, academics and health and social justice activists. To return to the language of politics and hope in South Africa: *Ke Nako*. Now is the time!

Endnotes:

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