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A Framework Convention on Global Health: Health for All, Justice for All

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A Framework Convention on Global Health Health for All, Justice for All

Lawrence O. Gostin, JD

HEALTH INEQUALITIES—THE inequitable distribution of disease and early death between the rich and poor—represent perhaps the most enduring and consequential global health challenge. Children born in sub-Saharan Africa are 20 times more likely to die in the first 5 years of life than children born in Europe or North America.¹ Childbearing women are nearly 140 times more likely to die in labor than women in high-income countries.² Overall, life expectancy in sub-Saharan Africa is 26 years shorter than in wealthy parts of the world.³ Collectively, health inequalities translate into nearly 20 million deaths every year—and have for at least the past 2 decades.⁴ This represents approximately one-third of global deaths, including millions of deaths related to inequalities within countries.⁵

Health inequalities have persisted despite substantially increased resources and innovative policies. For example, from 2000 to 2008, governments in sub-Saharan Africa doubled their health spending from an average of \$15 to \$41 per capita.⁶ International health assistance increased from less than \$6 billion annually in the early 1990s to \$10.5 billion in 2000, and then climbed to nearly \$26.9 billion in 2010.⁷

The Paris Declaration on Aid Effectiveness⁸ and the Accra Agenda for Action⁹ call for clearer targets and indicators of success, harmonization among partners, alignment with country strategies, and mutual accountability for measurable outcomes. The International Health Partnership seeks to put these principles into practice. The

Health inequalities represent perhaps the most consequential global health challenge and yet they persist despite increased funding and innovative programs. The United Nations is revising the Millennium Development Goals (MDGs) that will shape the world for many years to come. What would a transformative post-MDG framework for global health justice look like? A global coalition of civil society and academics—the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)—has formed an international campaign to advocate for a Framework Convention on Global Health (FCGH). Recently endorsed by the UN Secretary-General, the FCGH would reimagine global governance for health, offering a new post-MDG vision. This Special Communication describes the key modalities of an FCGH to illustrate how it would improve health and reduce inequalities. The modalities would include defining national responsibilities for the population's health; defining international responsibilities for reliable, sustainable funding; setting global health priorities; coordinating fragmented activities; reshaping global governance for health; and providing strong global health leadership through the World Health Organization.

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Global Fund to Fight AIDS, Tuberculosis and Malaria is driven by country demand and receives funding proposals from Country Coordinating Mechanisms, whose members include government, civil society, development partners, and the private sector. Bilateral programs, such as the US Global Health Initiative, have also embraced country ownership and health system strengthening.¹⁰

Yet even these innovative approaches and increased funding have failed to redress the inequitable burdens of disease and disability. The solutions to the fundamental challenge of health disparities cannot lie in maintaining the status quo. Although significant progress has been made on the health-related Millennium Development Goals (MDGs), many low- and middle-income countries are not on

track to meet their targets.¹¹ The United Nations is currently revising the MDGs, which will shape the health and development agenda for years to come. What would a transformative post-MDG framework for global health justice look like?

A global coalition of civil society and academics from the global South and North—the Joint Action and Learning Initiative on National and Global Responsibilities for Health (JALI)—has formed an international campaign to advocate for a Framework Convention on Global Health (FCGH).¹² Recently endorsed by the UN Secretary-General, the

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Box. The Framework Convention-Protocol Approach

Definition: A binding treaty using an incremental process whereby states negotiate a framework with key normative standards. More stringent obligations can be subsequently created through protocols. The Framework Convention on Global Health (FCGH) creates fair terms of international cooperation to solve the defining global health issues in a more systematic and integrated way.

Current Models: The Framework Convention-Protocol approach has become an essential strategy of transnational social movements to safeguard health and the environment. The Kyoto Protocol to the UN Framework Convention on Climate Change sets specific levels for greenhouse gas emissions. The WHO Framework Convention on Tobacco Control sets global standards for reducing the demand for and supply of tobacco.

Institutional Structures: The FCGH envisions linkages between existing institutional structures and newly created ones: the WHO Secretariat, the Conference of Parties (implementing FCGH duties and drafting protocols), an intergovernmental panel on global health (facilitating and evaluating scientific research on innovative solutions), and a high-level intersectorial consortium on global health (placing health on the agendas of multiple sectors).

Advantages: The Framework Convention-Protocol approach is flexible, allowing states to agree to politically feasible obligations, saving contentious issues to later protocols. It enables a “bottom-up” process of social mobilization for health and health justice.

FCGH would reimagine global governance for health, offering a new post-MDG vision.¹³ Although creating a bold global health treaty is an enormous undertaking, it could begin as a “soft” non-binding instrument—something World Health Organization (WHO) Director-

General Margaret Chan has referred to as a “framework for global health.”¹⁴ The BOX describes the Framework Convention-Protocol approach and the TABLE lists key modalities of an FCGH.

Define States' Responsibilities for the Health of Their Own Populations

Too often, global health is framed as the quantity and quality of funding given by richer to poorer countries. However, this obscures the reality that states have primary responsibility for safeguarding the health of their populations. International human rights law—enshrined in the WHO Constitution¹⁵ and the Universal Declaration of Human Rights¹⁶—places duties on all states to progressively realize the right to health. An FCGH would bind states, within their capacity, to provide universal access to a comprehensive package of health services.

The current \$41 per capita of government health sector spending in sub-Saharan Africa—and only half that level in Southeast Asia⁶—is well below the minimum \$60 per capita that WHO estimates is required by 2015.¹⁷ These health expenditures as a proportion of total government spending are significantly lower than the global average (<10% compared with 14%).⁶ Yet African heads of state pledged in the 2001 Abuja Declaration to commit at least 15% of their budgets to the health sector,¹⁸ a pledge reaffirmed at their 2010 summit.¹⁹ At the present rate of increase, it will not be until 2039—nearly 4 decades after the Abuja Declaration—that average health sector spending among African countries will reach the 15% target.

A state's own health spending is influenced by international assistance, which accounts for 15% of total health expenditures in low-income countries on average and is as high as two-thirds in some countries.⁶ Unfortunately, developing countries often reduce their domestic health spending in response to increasing international assistance—the “substitution effect.”²⁰ If low-income countries spend roughly

\$0.50 to \$1 less for health for every dollar they receive—and if the outside funding is not aligned with national priorities—the overall result will be unsatisfactory.

Moreover, it is unrealistic to expect that affluent states will carry out their responsibilities if lower-income states do not provide necessary resources for health within their own economic constraints, and do so effectively. A firm international commitment placed on countries to make a clearly defined contribution to health services could convince wealthier countries to accept their mutual responsibilities. Agreement on minimum domestic responsibilities for health would enable all countries to better understand and honor their obligations.

Define International Responsibilities to Provide Sustainable Funding

The duty of states should not be limited to caring for their own people but should also extend to fostering a functioning, interdependent global community, in which health is a matter of common concern. Increased globalization has compelled states to understand the need for collective action, as evidenced by WHO's International Health Regulations.²¹ However, state responsibilities extend far beyond rapidly spreading infectious diseases to encompass building health capacity in low-income states.

The Current Paradigm of “Health Aid” Is Untenable. “Global health” is often viewed in a constricted way, focused principally on health assistance provided by wealthy states to the poor, in a donor-recipient relationship.²² Framing global health as “health aid,” however, suggests that the world is divided between states that give and those that receive, whereas, in fact, they are equal partners. Collaboration among countries, both as neighbors and across continents, should be about reducing shared risks and advancing common interests, affirming mutual responsibilities for human well-being, and building capacity collectively.

The concept of “aid” both presupposes and imposes an inherently unequal relationship, in which one side is a benefactor and the other reliant. This leads high-income states and foundations to view their funding as “charity,” which is largely discretionary. It also means that donors have the sole authority to choose the amount and objectives of funded programs, without regard to the host countries’ priorities. International funding, therefore, is not predictable, scalable to needs, or sustainable in the long term.

Conceptualizing international funding as “aid” masks the deeper truth that health is a globally shared responsibility, reflecting mutual risks and vulnerabilities—an obligation of health justice that demands a fair allocation of burdens and benefits. International funding should be seen as a partnership designed to achieve the communal objective of safeguarding health and narrowing inequalities.

Set a Fair Level of Global Health Assistance. The Commission on Macroeconomics and Health calculated that high-income countries should allocate 0.1% of gross national income to official development assistance (ODA) for health.^{23,24} In 2009, ODA for health from wealthier countries was 0.045% of gross national income, or half of what is required by this measure.²⁵ The High Level Taskforce on Innovative International Financing for Health Systems similarly determined that total annual health spending in low-income countries would have to more than double to meet the MDG targets.²⁶

Yet the international community is not projected to meet these funding levels, and with austerity budgets in many high-income countries, international development resources are unlikely to grow.²⁷ For example, a shortfall in contributions led the Global Fund to cancel its Round 11 and postpone funding for new activities until 2014.²⁸ The United States is also well behind pace in achieving the Global Health Initiative spending targets of \$63 billion from 2009 through 2014.²⁹

Ensure the Long-term Reliability of Funding. Although the volume of international funding for global health

Table. Objectives and Modalities of a Framework Convention on Global Health (FCGH)

Objective	FCGH Modalities
Define state responsibilities for the health of their domestic populations	Establish domestic funding targets covering health care, public health, and social determinants of health, with timelines for compliance.
Define international responsibilities to provide sustainable funding	Establish a global health financing framework to ensure reliable funding. Equitably apportion responsibilities according to resource capacities and health needs.
Define the right to health to meet health needs and reduce global health disparities	Establish agreed-upon definitions for “universal coverage” and “health equity.” Strengthen commitments under WHO codes of practice and global strategies, such as reducing health worker recruitment in developing countries with personnel shortages.
Ensure policies in key domains (eg, trade, agriculture, environment) to promote health and health equity	States commit to a health-in-all-policies approach. WHO charged with engaging with and coordinating multiple sectors.
Create innovative financing mechanisms for health	States commit to innovative financing for health, such as taxes on financial transactions, unhealthy foods, and alcoholic beverages.
Improve empirical monitoring of progress and setbacks in implementing the right to health	Establish standardized methods of data gathering and benchmarks for measuring progress on health outcomes and health equity.
Promote sound models of global governance for health	States commit to “good governance” (eg, transparency, engagement, accountability). WHO to lead health-focused multisectoral consortium.
Promote strong global health leadership	Strengthen WHO with sustainable funding, expertise to develop evidence-based innovative solutions, and normative authority to implement those solutions.

Abbreviation: WHO, World Health Organization.

certainly matters, long-term reliability is equally important. Financial assistance is typically provided in the form of grants with limited duration. The long-term viability of funding often depends on domestic politics in wealthy countries—from election and appropriation cycles to changing geopolitical interests and priorities.

Financial commitments, therefore, remain short term and conditional, with funding that is volatile and unreliable. Low-income states are “understandably reluctant to take the risk of relying on increased aid to finance the necessary scaling up of public expenditure.”³⁰ That does not mean they will refuse financial assistance that is available. However, the short-term nature of assistance makes states reluctant to invest in infrastructure, human resources, or recurrent costs, which poses obstacles to building high-quality health systems.

Financial assistance that is unreliable and contrary to the principle of mutual responsibility is an inefficient

expenditure of resources. This should be sufficient reason to consider a global agreement on norms that clarify national and global responsibilities for health, transforming ineffective short-term financial assistance into effective sustained funding. For example, an FCGH could structure international funding obligations with longer-term horizons, consistent with national health priorities.

Set Global Health Priorities to Improve Health and Reduce Inequalities

The problem facing poor countries is not simply insufficient financing, but also skewed priorities. Currently, a significant amount of funding is directed toward “specific diseases or narrowly perceived national security interests” placed high on the global health agenda by a small number of wealthy donors.³¹ Typically, a few high-profile infectious diseases are prioritized. For example, WHO’s 2010-2011 extrabudgetary funding was primarily for infectious dis-

eases (65%), with negligible allocations for noncommunicable diseases and injuries.³² Yet, noncommunicable diseases account for 63% of all deaths worldwide, and injuries account for 17% of the global burden of morbidity among adults.³³

In priority setting, a stronger cooperative approach should be taken among funding partners in defining and advancing developing country health agendas. Funding, both domestic and global, should more accurately reflect health needs within low-income countries. To maximize health and well-being, greater precedence should be given to the major determinants of health: public health services to meet human needs, well-functioning health systems, and socioeconomic conditions.

Public Health Services to Meet Human Needs. Far-reaching health benefits would come from meeting such timeless human health needs as clean water and adequate nutrition, sanitation and sewage, vector abatement, and tobacco control.³⁴ Countries that have significantly improved health outcomes have done so primarily through sanitary reform, such as running water, functioning lavatories, a hygienic environment, and control of vermin (eg, rats, cockroaches, mosquitoes, lice). Regulatory reforms to ensure safe and nutritious food, occupational health and safety, and reductions in use of tobacco and alcohol create conditions in which the population can be healthy.

Health System Strengthening. The WHO has set out the essential building blocks of a well-functioning health system: accessible health services, a well-trained health workforce, information systems, and essential vaccines and medicines.³⁵ A financing system that consistently allocates sufficient funds for universal access to affordable services would meet a full range of medical needs, including primary, emergency, and specialized care.

Socioeconomic Conditions. Socioeconomic status remains a vital underlying determinant of health. People who receive high-quality education, employment, housing, and social or in-

come support lead healthier and safer lives than those who lack these critical services. Reducing poverty, promoting gender equality, and narrowing socioeconomic inequalities are essential to achieve better health for the world's population.⁵ It is for this reason that governments should adopt a "health-in-all policies" approach, ensuring that all decisions are made with an eye to achieving optimal population health.³⁶

Coordinate Fragmented Global Health Activities

Multiple actors now occupy the field of global health. The deluge of initiatives, often focusing on specific diseases, includes more than 40 bilateral donors, 26 UN agencies, 20 global and regional funds, and 90 global health initiatives,³⁷ not including the proliferation of aid organizations, religious missions, and volunteers.³⁸

The increasingly crowded landscape has resulted in fragmentation, duplication, and reduced programmatic efficiency. Developing countries "face a bewildering array of global agencies from which to elicit support," leaving health ministries overburdened with "writing proposals and reports for donors whose interests, activities, and processes sometimes overlap, but often differ."³⁹

The encroachment of international actors on capable local actors hinders country ownership and control. Well-funded entities that operate AIDS clinics or other state-of-the-art facilities are able to offer more lucrative salaries and better working conditions than local providers. This can drain public or private initiatives in the host country, making it more difficult to provide sustainable services.

The governance system needs to foster effective partnerships and coordinate initiatives to create synergies and avoid destructive competition at all levels—international, national, and local.⁴⁰ Most importantly, developing countries must take "ownership" through exercising effective leadership, setting their own strategies, and coordinating activities. International

partners should align behind these objectives, use local systems, and share information to avoid duplication.

Better coordination and a shared sense of priorities should augment, not detract from, the diversity of approaches that arises from the proliferation of global health actors. These include civil society, with its ability to mobilize social action, advocate for the poor, and hold public officials accountable; the private sector, with its ability to develop innovative drugs and vaccines, market nourishing food, and build safer and healthier places to work; and foundations, with their willingness to fund imaginative solutions to critical global health challenges and satisfy unmet needs. Thus, harnessing the creativity and resources of multiple partners is an essential global health strategy that must be facilitated through an international agreement.

Reshape Global Governance for Health

Global governance for health (the subject of a *Lancet/University of Oslo/Harvard Global Health Institute commission*⁴¹) is the collection of rules, norms, institutions, and processes that shape the health of the world's population. Governance strategies aim to organize divergent stakeholders and manage social, economic, and political affairs to improve global health and narrow inequalities.^{42,43} This does not require top-down, "command and control" rules, but rather wise influence and direction to better address the key determinants of health and ensure programmatic effectiveness.

Global governance for health differs from the more conventional concept of global health governance, which principally concerns the role of the health sector. Global governance for health includes the health sector but also captures multiple domains that influence health, such as agriculture, development, foreign policy, human rights, trade, and the environment. For example, burdening low-income countries with long-term debt or requiring reductions in government expendi-

tures as a loan condition can weaken domestic health systems. World Trade Organization rules protecting intellectual property similarly can render essential vaccines and medicines unaffordable. For example, an FCGH could require states and international organizations to show that loan conditions or trade rules are not detrimental to the public's health.

States Have a Responsibility of "Good Governance." Public officials, who have the power to allocate resources and make policy, owe a duty of *stewardship*—an obligation to act in the interests of the population they serve. Good governance is *trustworthy*, in that it is avoids corruption, such as public officials personally benefiting or diverting funds from their intended purposes. It is *transparent*, in that institutional processes and decision making are open and intelligible. It is *deliberative*, in that public officials meaningfully engage stakeholders, giving them the right to provide genuine input into policy making. Good governance is also *accountable*, in that political leaders give reasons for decisions and take responsibility for successes or failures, and the public can change the direction of policies. Good governance enables government to formulate and implement effective programs, manage resources competently, and provide high-quality health services.

Despite the importance of good governance, the World Bank finds that health is a highly corrupt sector in many developing countries.⁴⁴ Health care professionals engage in corrupt practices by leaking funds, diverting drugs or supplies, demanding off-the-books payments, and bribing public officials for accreditation or licenses. A vicious cycle of graft can occur, as corrupt countries tend to perform poorly and then become even more reliant on foreign assistance.

Governance Strategies Must Influence Multiple Sectors. The global governance system must be capable of exerting influence in multiple regimes that affect health. Intellectual property affects access to essential medicines, trade in services affects health worker migration, and climate change affects food,

disease vectors, and natural disasters. Human rights law covers socioeconomic determinants of health, while humanitarian law protects civilians caught in armed conflict.

An effective global health leader such as WHO needs to be at the table in major forums advocating for health with a powerful voice. However, this has not occurred. Global Health Watch, for example, reported that rich states use their funding leverage to pressure WHO "to steer clear of macroeconomics and trade . . . and to avoid such terminology as 'the right to health'."⁴⁵

An FCGH could enhance WHO's influence by creating a high-level intersectoral consortium on global health composed of senior leaders of global institutions, such as the World Trade Organization, International Monetary Fund, World Bank, and Food and Agriculture Organization. Convened by WHO, the consortium's objective would be to ensure a sustained, high-level focus on health within multiple regimes.

Provide Strong Global Health Leadership

Given the proliferation of global health actors and the manifold influences on health from numerous sectors, exercising global health leadership is a daunting task. However, the difficulties should not mask the imperative of strong leadership. In a complex and splintered world, there is no substitute for leadership. Without strong leadership, the current response to global health challenges has been ad hoc and fragmented. Without a global health advocate with economic and political clout, other regimes have dominated the global agenda, notably intellectual property and trade.

The WHO has the unique legitimacy to assume leadership, with its constitution granting broad normative power "to act as the directing and coordinating authority on international health."¹⁵ Although WHO is an admirable organization, it has failed to live up to expectations in its leadership role.⁴⁶ The WHO, moreover, is currently undergoing a major structural re-

form amid a budget deficit of more than \$300 million, with 300 headquarter staff members (>10% of personnel) losing their jobs.⁴⁷

The solution is not to marginalize WHO but rather to strengthen the agency so that it can fulfill its constitutional responsibilities. To enhance its role as an authoritative technical agency, the FCGH would charge WHO with convening an intergovernmental panel on global health—modeled on the successful intergovernmental panel on climate change. The panel would provide ongoing scientific analysis and recommend innovative solutions to improve health and reduce inequalities. To enhance WHO's normative authority, the FCGH would strengthen commitments under WHO codes of practice (eg, the international recruitment of health workers) and global strategies (eg, diet and physical activity, and the harmful use of alcohol).

If the bold vision of a Framework Convention on Global Health does become a reality, WHO must be at the center of global governance for health, providing evidence-based innovative solutions, steering the health sector, influencing multiple sectors, and becoming a passionate voice for "health for all, justice for all."

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REFERENCES

1. UNICEF. *Levels and Trends in Child Mortality, Report 2011*. http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf. Accessed April 24, 2012.
2. World Health Organization. *Trends in Maternal*

- Mortality: 1990 to 2008*. <http://www.who.int/reproductivehealth/publications/monitoring/9789241500265/en/index.html>. 2010. Accessed April 23, 2012.
3. United Nations Development Program. *Human Development Report 2011: Sustainability and Equity: A Better Future for All*. http://hdr.undp.org/en/media/HDR_2011_EN_Complete.pdf. Accessed April 24, 2012.
 4. Garay J. Global health (GH)=GH equity=GH Justice=Global Social Justice: The Opportunities of Joining EU and US Forces Together. <http://eucenter.berkeley.edu/newsletter/winter12/garay.html>. 2012. Accessed April 26, 2012.
 5. World Health Organization. *Commission on Social Determinants of Health: Final Report*. Geneva, Switzerland: WHO; 2008. http://www.who.int/social_determinants/thecommission/finalreport/en/index.html. Accessed April 24, 2012.
 6. World Health Organization. *World Health Statistics 2011*. Geneva, Switzerland: World Health Organization; 2011.
 7. Institute for Health Metrics and Evaluation. *Financing Global Health 2010: Development Assistance and Country Spending in Economic Uncertainty*. Seattle: University of Washington; 2010.
 8. Paris Declaration on Aid Effectiveness. *Ownership, Harmonisation, Alignment, Results and Mutual Accountability*. Paris, France: Organization for Economic Cooperation and Development; 2005.
 9. Accra Agenda for Action. Organization for Economic Cooperation and Development. 2008. http://www.oecd.org/document/3/0,3343,en_2649_33721_41297219_1_1_1_1,00.html. Accessed April 25, 2012.
 10. Gostin LO, Mok EA. The president's global health initiative. *JAMA*. 2010;304(7):789-790.
 11. *The Millennium Development Goals Report 2011*. New York, NY: United Nations; 2011. http://www.un.org/millenniumgoals/11_MDG%20Report_EN.pdf. Accessed April 24, 2012.
 12. Gostin LO, Friedman EA, Ooms G, et al. The Joint Action and Learning Initiative: towards a global agreement on national and global responsibilities for health. *PLoS Med*. 2011;8(5):e1001031. <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001031>. Accessed April 25, 2012.
 13. UN Secretary General. Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS: Uniting for Universal Access: Towards Zero New HIV Infections, Zero Discrimination and Zero AIDS-Related Deaths: Rep. of the Secretary-General, UN Doc A/65/797. March 28, 2011.
 14. WHO Reforms for a Healthy Future: Report by the Director-General, EBSS/2/2. http://apps.who.int/gb/ebwha/pdf_files/EBSS/EBSS2_2-en.pdf. October 15, 2011. Accessed April 26, 2012.
 15. Constitution of the World Health Organization. http://www.who.int/governance/eb/who_constitution_en.pdf. April 7, 1948. Updated October 2006.
 16. Universal Declaration of Human Rights. <http://www.un.org/en/documents/udhr/>. December 10, 1948. Accessed April 22, 2012.
 17. World Health Organization. *The World Health Report: Health Systems Financing—The Path to Universal Coverage*. Geneva, Switzerland: World Health Organization; 2010. <http://www.who.int/whr/2010/en/index.html>. Accessed April 23, 2012.
 18. Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Organization of the African Union Doc. OAU/SPS/ABUJA/3. April 24-27, 2001.
 19. Actions on Maternal, Newborn and Child Health and Development in Africa by 2015, African Union Assembly/AU/Decl.1 (XV). July 25-27, 2010.
 20. Lu C, Schneider MT, Gubbins P, Leach-Kemon K, Jamison D, Murray CJ. Public financing of health in developing countries: a cross-national systematic analysis. *Lancet*. 2010;375(9723):1375-1387.
 21. International Health Regulations <http://www.who.int/ihr/en/>. 2005. Accessed April 20, 2012.
 22. Stuckler D, McKee M. Five metaphors about global-health policy. *Lancet*. 2008;372(9633):95-97.
 23. WHO Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva, Switzerland: World Health Organization; 2001.
 24. Africa Steering Group. *Achieving the Millennium Development Goals in Africa: Recommendations of the MDG Africa Steering Group, June 2008*. New York, NY: United Nations; 2008.
 25. Kates J, Wexler A, Valentine A. *Donor Funding for Health in Low- & Middle-Income Countries, 2002-2009*. Washington, DC: Kaiser Family Foundation; 2011. <http://www.kff.org/globalhealth/upload/7679-05.pdf>. Accessed April 26, 2012.
 26. Taskforce on Innovative International Financing for Health Systems. More money for health, and more health for the money. http://www.internationalhealthpartnership.net/CMS_files/documents/taskforce_report_EN.pdf. 2009. Accessed April 24, 2012.
 27. Leach-Kemon K, Chou DP, Schneider MT, et al. The global financial crisis has led to a slowdown in growth of funding to improve health in many developing countries. *Health Aff*. 2012. doi:10.1377/hlthaff.2011.1154.
 28. The Global Fund to Fight AIDS, Tuberculosis and Malaria. Modification of Grant Renewals and Transition to New Funding, 25th Board Meeting, Accra, Ghana, Nov. 21-22, 2011, Decision Point GF/B25/DP16. http://www.theglobalfund.org/documents/board/25/BM25_DecisionPoints_Report_en/. Accessed April 19, 2012.
 29. Epstein SB, Lawson ML, Resler TJ. State, Foreign Operations, and Related Programs: FY2012 Budget and Appropriations. Congressional Research Service. <http://fpc.state.gov/documents/organization/169056.pdf>. 2011. Accessed April 22, 2012.
 30. Foster M. *Fiscal Space and Sustainability: Towards a Solution for the Health Sector: Background Paper for the Third High-Level Forum on the Health MDGs*. Paris, France: World Health Organization and World Bank; 2005.
 31. Garrett L. Midway in the Journey: How to Promote Global Health. A Foreign Affairs Roundtable. <http://www.foreignaffairs.com/discussions/roundtables/how-to-promote-global-health>. 2007. Accessed April 22, 2012.
 32. World Health Organization. *Proposed Programme Budget 2010-2011*. Geneva, Switzerland: WHO; 2009. http://apps.who.int/gb/e/e_amtsp3.html. Accessed April 22, 2012.
 33. World Health Organization. *Global Status Report on Noncommunicable Diseases 2010*. Geneva, Switzerland: WHO; 2011. http://www.who.int/nmh/publications/ncd_report2010/en/. Accessed April 22, 2012.
 34. Bloland P, Simone P, Burkholder B, Slutsker L, De Cock KM. The role of public health institutions in global health system strengthening efforts: the US CDC's perspective. *PLoS Med*. 2012;9(4):e1001199.
 35. World Health Organization. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. Geneva, Switzerland: WHO; 2007. http://www.who.int/healthsystems/strategy/everybodys_business.pdf. Accessed April 22, 2012.
 36. Institute of Medicine. *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges*. Washington, DC: National Academies Press; 2011.
 37. McColl K. Europe told to deliver more aid for health. *Lancet*. 2008;371(9630):2072-2073.
 38. Marmot M. Working through the issues of global governance for health. *Lancet*. 2009;374:1231-1232.
 39. Bloom D. Governing global health. *Finance Dev*. 2007;44:31-35.
 40. Rosenberg ML, Hayes ES, McIntyre MH, et al. *Real Collaboration: What It Takes for Global Health to Succeed*. Berkeley: University of California Press; 2010.
 41. Ottersen OP, Frenk J, Horton R. *The Lancet*-University of Oslo Commission on Global Governance for Health, in collaboration with the Harvard Global Health Institute. *Lancet*. 2011;378(9803):1612-1613.
 42. Fidler DP. *The Challenges of Global Health Governance*. New York, NY: Council of Foreign Relations; May 2010.
 43. Buse K, Hein W, Drager N, eds. *Making Sense of Global Health Governance—A Policy Perspective*. Basingstoke, UK: Palgrave Macmillan; 2009.
 44. Vian T, Savedoff WD, Mathisen H, eds. *Anticorruption in the Health Sector: Strategies for Transparency and Accountability*. Sterling, VA: Kumarian Press; 2010.
 45. Johnson T; The World Health Organization. <http://www.cfr.org/public-health-threats/world-health-organization-/p20003>. August 10, 2009. Accessed April 22, 2012.
 46. Ruger JP, Yach D. The global role of the World Health Organization. *Global Health Governance*. <http://www.ghgj.org/ruger2.2rolewho.htm>. 2009. Accessed April 22, 2012.
 47. Sridhar D, Gostin LO. Reforming the World Health Organization. *JAMA*. 2011;305(15):1585-1586.