Where Are Rights? Where Is Responsibility? Who Acts for Global Public Health?

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An inherent tension that exists between rights and responsibility is particularly acute with regard to access to health and health care services. Despite decades of rights advocacy and acceptance, promoted and solidified in the public health arena by advances in access to public health services, these questions remain largely unanswered: *Whose and which rights are to be protected? Who bears or which entities bear responsibility for ensuring those rights? Who acts—and how—for global public health?* This article explores these questions by analyzing the response and the responsibility to respond to the HIV/AIDS epidemic in South Africa and to Ebola in West Africa.

The tension between rights and responsibility is not new. Three broad shifts have taken place pertaining to their allocation—and assumption—notably since the 1990s. First, roughly since the Peace of Westphalia in 1648, responsibility—though not individual human rights—for territorial and, eventually, corporal security lay with the sovereign state. Second, from about the 1960s, the language of human rights entered the discourse in relation to a sovereign state's responsibility, eventually coming to encompass the ideas and ideals of human security. The independent international Commission on Human Security formulated the latter as "vital freedom" and defined them as "protecting people from severe and pervasive threats, both national and societal, and empowering individuals and communities to develop the capabilities for making informed choices and acting on their own behalf."[1] The onus for creating conditions conducive to such freedom continued to reside with the sovereign state.

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Significant change, however, has since occurred in *who* exercises responsibility. It coincided with the so-called unipolar moment following the fall of the Berlin Wall, the collapse of the Soviet Union and the end of the Cold War, and the emergence of human security, notably in the 1994 United Nation's (UN) Development Programme's *Human Development Report*, whose second chapter is appropriately entitled "New Dimensions of Human Security."[2] Although state sovereignty continues to be the building block of local, national, and international relations and global governance, its real power to enact responsibilities and assume accountability for the provision of the rights of its citizens has arguably waned—not uniformly but almost regardless of whether the state in question is considered consolidated, fragile, or failing/failed. Consequently, the ostensibly sovereign state is *ultimately* responsible for the traditional territorial security and physical security of the populace within its borders. In addition, it is accountable for both of these securitizations both internally and externally (i.e., within the international community of states). However, the same state is increasingly confronted with nonstate actors (NSA) that both demand its action and assume some of its functional responsibility—but not state (-citizen) accountability. As such, the state-centric international governance system is characterized less by power relationships between sovereign states than by a diffusion of power between states and NSAs.

Who determines and who decides whose and which rights are to be protected? Who bears or which entities bear responsibility for ensuring those rights? Who acts—and how—for global public health? Where does the power lie?

To illuminate the trajectory of rights along the (fragmented) alignment of global responsibility for public health, this article looks first at the case for health rights and responsibilities; second, at the case of HIV/AIDS response in South Africa; and third, at the ongoing interventions with regard to the Ebola epidemic. Finally, it seeks to draw these disparate arguments and insights together to propose possible solutions for harnessing rights and responsibilities in a way that would guarantee their protection and implementation.

The Schism between Rights and Responsibilities: How Did We Get Here?

What are the origins of the schism between the allocation of rights and responsibilities? What is it attributable to? This article argues that the increasing disconnect—the diffusion between state and nonstate assumption of responsibility for rights—has come in shifts. This diffusion is a symptom of the dynamic relationship between changes in the global ordering of responsibilities and accountabilities over time.

Relevant for the argument here are those changes in the articulation and allocation of responsibility and accountabilities within the time frame from the end of World War II through 2014. Conceptually, this span includes the sweeping shifts in global order identified by James Rosenau's concept of "governance without government" thesis first

wrought in his book of the same title, through Stephen Krasner's assertion of sovereignty as "organized hypocrisy," to what this article calls "disorganized hypocrisy."[3] Rosenau maintained that a number of governance "regimes" would form to tackle specific issues in the international realm. To a large extent, he has been proven correct: if NSAs are included, then a plethora of organizations exists dedicated to treating HIV/AIDS, providing water and sanitation, and even administering public transportation in municipalities around the world. However, these are not "regimes" in the sense that they have a central organizational structure, that their interventions are legally binding, or that any mechanisms are in place to ensure the continuation of their work if and when they opt out. Krasner hypothesized that states, as the central building block of government and governance, were not omnipotent in their sovereignty.[4] Concurring, I hypothesize further that states nonetheless remain the key organizing entity in a global order increasingly characterized by actors acting outside the state system.

That is, states are assumed to be capable of meeting three tenets of human security: (1) ensuring the territorial and physical security of citizens; (2) protecting lives and livelihoods through basic economic stability, health, and welfare; and (3) bearing accountability internally and to the international community.[5] The onus for guaranteeing these obligations remains with the state even when functional implementation lies with NSAs. As long as such obligations could be coordinated by the state, the latter remained the definitive agent.

However, the continued rise of NSAs represents a fundamental shift in the nature, not just the organization, of sovereignty as pertaining to both territorial and human security. Here the term *disorganized hypocrisy* refers to the current state of affairs in which many actors are "in on" the action of addressing—even providing—provisions of security and human security but are beyond the realm of state government as well as international or global governance. The critical difference today is that, instead of shoring up states' lack of capacity, NSAs have contributed to the fragmentation of their power—including their ability to guarantee traditional and human security:

> NGOs' [nongovernmental organizations'] role and influence have exploded in the last half-decade. Their financial resources and—often more important—their expertise, approximate and sometimes exceed those of smaller governments and of international organizations. "We have less money and fewer resources than Amnesty International, and we are the arm of the U.N. for human rights," noted Ibrahima Fall, head of the U.N. Centre for Human Rights, in 1993. "This is clearly ridiculous." Today NGOs deliver more official development assistance than the entire U.N. system (excluding the World Bank and the International Monetary Fund). In many countries they are delivering the services—in urban and rural community development, education, and health care—that faltering governments can no longer manage.[6]

Three examples briefly cited here illustrate this accelerating fragmentation. First, the International Campaign to Ban Landmines, championed by Lady Di (Princess Diana): pictures of maimed children ignited global public outrage, fueling the 1996 Ottawa Treaty in which the Canadian government promoted the concept of human security.

Second, the transnational alliance between the US Act-Up and the South African Treatment Action Campaign to advocate for HIV/AIDS treatment on the part of the state: here, too, images of children (born with HIV in refugee camps in Cambodia) helped prompt Richard Holbrooke, the US ambassador to the UN, to bring the issue of the pandemic to the Security Council. Third, the Global Witness campaign to ban "blood diamonds," whose sale filled the coffers of fighters in the brutal civil wars in Sierra Leone and Liberia: American consumers seeking diamonds for marriage proposals, as well as diamond houses such as DeBeers and jewelers such as Tiffany & Company, joined the effort that resulted in the Kimberly Process to certify nonconflict (nonblood) diamonds. Working around and yet on the state, these three examples illustrate the translocation of power in inter*national* relations: from the state itself, to alliances of NGOs or NSAs, to state-NGO/NSA-market actors. The fact of these extra-state actors leveraging influence upon the state—over, under, and around the state–is arguably contributing to a remaking of the state from a provider of human security to a regulator thereof. This transformation is changing the nature but not the scope of state responsibility.[7] If the state is not capable of providing but is charged with guaranteeing citizens' rights, who decides whose rights and where the responsibility lies? What does the reallocation of rights and responsibilities mean for health and, specifically, for health in Africa?

Whose Rights?

The revolution of human security and rights-based development lies in their universalism. States become the bastions not only of ultimate responsibility for the extent of the provision of rights for what is possible within their capacities but also, arguably, for the highest standard internationally. President Franklin D. Roosevelt's now-famous "Four Freedoms Speech" of 1941 preceded the call for human security in the 1994 UN Development Programme and again in the 2003 publication of the report "Human Security Now" by the Commission on Human Security.[8] From the very beginning of the post–World War II period, Article 1 of the UN Charter, and Article 25 of the UN Universal Declaration of Human Rights encoded the principles of human security, including emphasis on the right to health: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care . . . and the right to security in the event of . . . sickness, [and] disability. . . . Motherhood and childhood are entitled to special care and assistance."[9]

The centrality of health among global policy priorities is reiterated in the constitution of the World Health Organization (WHO) in 1948; the International Covenant on Economic, Social and Cultural Rights; the 1994 United Nations Development Program; and the adoption of the International Health Regulations (IHR) in 1969 and most recently updated in 2005. These agreements have transformed normative ideas into principles of action.[10] Yet real implementation lags, lost in the opaque realm between theoretical and practical responsibility.

Thus, the International Covenant on Economic, Social and Cultural Rights—as well as the Convention against the Elimination of Discrimination Against Women, the Convention on the Rights of the Child, and the World Trade Organization's Doha Declaration on "Trade-Related Aspects of Intellectual Property Rights," which allows for the production of generic versions of essential medicines under certain conditions before patent protection runs out—appears to provide an *implicit* obligation on the part of states to improve health and to establish and secure health as a human (security) right. However—and crucially—none of them prescribes an *explicit* obligation.

Similarly, the IHRs emphasize the universal and expanding right of each individual citizen (of the world) to the highest standard of health. In fact, the IHRs, having gone into effect in 2007, require their 196 signatory state parties to "develop public health capacities to detect and respond to public health emergencies of international concern (PHEIC), with states required to cooperate in building these capacities. However, the regulations do not provide incentives, sanction states for failing to cooperate, or allocate responsibility."[11] No specific or enforceable obligation to ensure that individuals attain physical and mental health and no guidelines for how the state's obligations are to be discharged exist.[12] This situation obviously creates problems for the implementation of the right to health within the remit of a state's responsibility to provide (human) security. The consequences are particularly obvious with regard to states' responses to threats to human security of health. Two of these are HIV/AIDS and the Ebola epidemics.

Whose Responsibility?

The (inter)national system based on sovereign states continues to operate under the assumption that "governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[13] Critically, "while only States are parties to the Covenant, and thus ultimately accountable for compliance with it, all members of society—individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector—have responsibilities regarding the realization of the right to health."[14] As Milli Lake notes with regard to judicial processes in the Congo, "The *de facto* assumption of power by these diverse sets of actors has created opportunities through which nonstate actors can enter and influence juridical processes by engaging in tasks normally reserved for representatives of the sovereign government. These activities would not be possible in contexts where the state had greater reach."[15] This exacerbates the problem of responsibility because merely counting the number of convictions of a prioritized crime or the number of people inquiring about health treatments and antiretroviral medications for HIV, for example, "tells us little about the dynamics of power" that determine the necessary response to the problem (including the problem definition) at hand.[16] Lake notes that "on a broader scale, it could also be argued that the involvement of international actors in micro-level governance activities in DR [Democratic Republic of] Congo has served not to build capacity but in

fact to further relieve the Congolese state of its responsibilities to provide basic goods and services to its citizens." Indeed, because there is a litany of "international and domestic organizations ready to engage in this work, there may be little incentive for the central government to re-invest its own time and resources into developing a functional state apparatus."[17]

Such developments actively undermine the state's sovereignty and capacity to exercise responsibility, leading to absurdities such as Indonesia's claim to "viral sovereignty"—the idea that viruses belong to the state in which they originate. It was invoked to prevent and delay sharing data and samples of H1N1 influenza also due to the anticipated costs of being branded a state of contagion amidst exclusion from research and treatment benefits. Indonesia's was an ill-fated attempt by the state to seize control over information pertaining to the outbreak, its domestic response, and its interdependence sovereignty—notably its ability to regulate any potential medical interventions and possible patents created externally and sold (back) to Indonesia.

These examples all iterate the theory and practical reality in the still state-centric international system that

> there are roles that only the state—at least among today's polities—can perform. States are the only nonvoluntary political unit, the one that can impose order and is invested with the power to tax. . . . Moreover, it may be that only the nation-state can meet crucial social needs that markets do not value. Providing a modicum of job security, avoiding higher unemployment, preserving a livable environment and a stable climate, and protecting consumer health and safety are but a few of the tasks that could be left dangling in a world of expanding markets and retreating states.[18]

Assuming then the necessary vitality of a responsible sovereign state to the guarantee of access to rights, notably health rights, and admitting the increasing roles played by NSAs in the same arena, what is the current status quo? What does it mean?

Diffuse Power: Disorganized Hypocrisy

If sovereign states were omnipotent and omnipresent in the territories under their ostensible control and purview, such reordering would not be necessary. States alone would carry and wield their responsibility and accountability, both internal and external, to guarantee security and human security within their borders. However, this is not the case. In terms of external geopolitics, each state is—and has always been—influenced and affected by its neighbors both near and far. According to Paul Farmer, "Enforcing rights is another matter altogether, since it is often the signatory states themselves who are responsible for rights violations, from torture to neglect of the public sector." Indeed, "health and human rights needs a legal framework to impose on national governments, true, but who is responsible?"[19] This is evidenced in the period under review during which (national) state sovereignty was exported to most of the world while it was also purposefully corralled. It occurred through the geopolitical East-West conflict as well as through issue-specific governance regimes. Its circumscription was further entrenched through

the asymmetric establishment of institutions of global governance, including the UN, and the proliferation of NSAs, whose organized assumption of responsibility and accountability for human security is unclear at best and nonexistent at worst. Consequently, the centrality of the state is rapidly becoming more conceptual than actual, the result of which is disorganized hypocrisy, with very real implications. The contemporary consequences of this disorganized hypocrisy pertain particularly to transnational threats to human security posed by disease outbreaks (notably HIV/AIDS and Ebola) as well as the immediate and the attendant responses to financial crises (such as cutting health care provisions) and crime syndicates (including the mafia or the Islamic State).

The next section and its two subsections compare the two brief case studies—the global response to HIV/AIDS and Ebola. They illustrate the hypothesis of sovereignty today as disorganized hypocrisy and delve into an analytical discussion of what might be done about *diffuse sovereignty*.

Global Health Governance: Who Does It? (Re)defining the Roles of Actors—State and Nonstate

The current architecture of global governance, including governance for health, rests on the presumption that governments of states are the entities responsible for human—at least citizen—rights. Fulfilling this right to health requires a state to possess the necessary means for individuals to access health care.[20] But whether that means that the state has to provide health care beyond access—and to what extent it is obligated to provide it—remains unclear. That is, a gap exists. Indeed, into that gap step myriad NSAs that take on some functional responsibility in addressing the epidemic but do not assume the final guarantee for HIV/AIDS response or broader public health vested in the state.

Tracing the trajectory of the local emergence of global responses to HIV/AIDS and Ebola reveals the fragmentation of the global order into disorganized hypocrisy. As both pandemics make abundantly clear, no global governance regime for human security exists. Furthermore, given the gaps in an international global system based on the responsibilities of ostensibly sovereign states—without formal, functioning, mandatory capacities—it is not surprising that additional actors have entered the fray. As both cases here illustrate, NSAs have taken the lead in responding to HIV/AIDS and Ebola.

HIV/AIDS

Regarding the global response to HIV/AIDS over a 30-year period, NSAs have been able to (1) raise the alarm and goad states—initially wealthy and relatively unaffected (notably the United States and Europe)—into springing into action on behalf of their infected populations; (2) perform a triage role in the worst-affected states, predominantly in sub-Saharan Africa, caring for and eventually treating the ill;[21] and (3) pressure the

states whose populations suffered the most to accept the final responsibility and accountability for the provision of life-long treatments on an ever-greater scale. These events happened in a number of phases. First, NSAs, both local and global, offered care for HIV-infected persons. Second, as treatments became available, local and global NSAs lobbied for access to them, even going to get them on occasion.[22] Such actions were reinforced by international and multilateral organizations like the Joint UN Program on HIV/AIDS; political statements such as the 2000 UN Security Council Resolution 1308 and the 2006 and 2011 UN General Assembly political declarations on HIV/AIDS; bilateral agreements (e.g., the US President's Emergency Fund for AIDS Relief, launched in 2003); and philanthropic activities (notably by the Bill and Melinda Gates Foundation). The HIV/AIDS response advocated by these organizations was further cemented by tenders for anti-HIV medications, which effectively locked recipient states such as South Africa and Uganda into agreeing to provide a particular kind of HIV/AIDS response ad infinitum. Finally, in accepting the prescriptions of this course, South Africa, for example, rose to the occasion to honor chapter 2 of its constitution to bear responsibility for the health of its population. It seemed to illustrate the lasting power and authority as well as the vested responsibility and accountability for human security on the part of the state.

The state remained the focal point of advocacy and action. The myth of its sovereignty reinforced the notion of its ultimate responsibility for and accountability to the populace within its borders. Nonetheless, there is little escaping the fact that the states charged with the ultimate response to HIV/AIDS had precious little room for maneuver, and their agency constrained from above, horizontally, and below.[23]

Ebola

Similarly, the currently raging Ebola pandemic is putting enormous pressure on the worst-affected states—Guinea, Liberia, and Sierra Leone—from below, horizontally, and above. This case highlights both similarities to and differences with the trajectory of the HIV/AIDS response. A response here might be characterized as even more urgent than that to HIV/AIDS (whose incubation period is measured in years, not days). These worst-affected states, by their own accounting and the standards of sovereign statehood that continue to govern the analysis of a functioning global order, are incapable of mounting an adequate response—too little is being done from all directions. Liberia has pleaded for outside help, effectively declaring its lack of sovereignty.

NSAs, notably the commendable Medécins Sans Frontières (Doctors without Borders), are overwhelmed. In an unprecedented war cry, MSF has asked for military intervention to stem the tide of the pandemic. Samaritan's Purse, another humanitarian aid organization responding to the Ebola epidemic in Liberia (two of whose volunteers were evacuated to the United States upon testing positive to the virus), voiced concern that states had left NGOs to fend off such a security threat.

In an attempt to undergird NSAs and the most afflicted and affected states, the UN Security Council unanimously passed Resolution 2177 on 18 September 2014. The resolution declared Ebola an international emergency, concluding that the pandemic's spread could reverse peacekeeping and development gains. It "called on member *states* to deploy medical assets, expand public education, and end travel bans . . . [but] left unclear the exact duties required of states" (emphasis added).[24] The resolution triggered the UN Mission for Ebola Emergency Response.[25] The UN Humanitarian Air Relief service is also flying medical supplies to the worst-affected region.

Where are the states? Three hundred Cuban doctors have arrived in Sierra Leone, and about half that number are expected from China. The United States and the European Union are building makeshift hospitals and isolation wards, but neither is sending delegations of medical personnel although some volunteers are headed to the region.

The state-centric stalwarts of the global order—international and multilateral institutions from the UN to the WHO—have done little. It took the WHO five months to declare an international health emergency (from the first identified case on 25 March 2015 until 8 August 2015). Since then, it has publicly abdicated its role as a response coordinator, declaring itself "only" a "technical agency." It is supporting the training of the Cuban doctors in Sierra Leone.

No one seems to be in charge. No one—no NSA, state, or international/multinational organization—is in a position of authority. None is sovereign over the situation. None is either responsible or accountable for the human security of the persons most affected. Power is diffused. Sovereignty is not only disorganized but also increasingly hypothetical. And yet. . . .

The default guarantor of human security then remains the obviously not-quite sovereign state. The HIV/AIDS response revealed the weaknesses in this arrangement—even if from the contemporary perspective it appears that the most-affected states are able to muster the financial and human capacity to contain that pandemic. With regard to the current Ebola crisis, despite the obvious fragility of the states involved, the state-centric global order remains. It does so despite the fact that it appears patently unable to guarantee the human security of an increasing number of people. No plausible alternative arrangement has emerged. How might that change?

Conclusions: Spanning Schisms, Containing Complexity

Assuming that the hypothesis of disorganized sovereignty proposed here proves viable, the question becomes, what does it mean? To guarantee human security, one must assure that the responsibility and accountability for the components thereof be allocated somewhere. Mechanisms to trigger action for such a guarantee need to be found.[26]

The world needs a multilateral framework that can provide both rapid responses to emergencies and long-term capacity building that targets the underlying deficiencies in

infrastructure, expertise, and funding in these weak states. Otherwise, they will remain weak links in global public health. As Terje Tvedt, a Norwegian expert on nonprofit organizations, argues, such failed states are better served by intergovernmental organizations representing sovereign nations.[27]

The case studies above primarily reveal two aspects of the current global order: (1) that it continues to rest on assumptions of the theory of ultimate state sovereignty, and (2) that these same assumptions are simultaneously undermined by the presence and the power diffusion of elements of sovereignty by multinational/international actors and organizations, as well as by NSAs, each at the local, national, and global levels. The inherent contradiction in these two positions is intensified in their conceptual and technical manifestations. That is, where, if not with the state, could responsibility and accountability for human security conceivably lie?

The state system is here to stay for the moment. Yet, considerable weaknesses characterize it at both the national and the international levels. In an attempt to recognize the rights demands placed upon it, despite its weaknesses, and to engage the responsibility of the international community, *The Responsibility to Protect* report of 2001 sought to erect a global response to cases of genocide, war crimes, and crimes against humanity.[28] Put forward by the International Commission on Intervention and State Sovereignty, it has so far failed on two fronts: it has not garnered a global conceptual consensus about when to intervene, and it lacks automatic mechanisms to compel those viably capable of doing so to respond.

A similar lack of automatic-response triggers has hampered global response to the Ebola outbreak. No mechanism exists to compel an intervention. Even UN Security Council Resolution 2177 only "calls on" member states that deploy personnel to the worst-affected countries to provide medical evacuation should the need arise. No provision compels such deployment or the deployment of urgently needed medical personnel (in accordance with the above). Affected national states are left largely to cope on their own, with a smattering of support from NSAs.

Conceivably, some approaches could overcome this schism. On the conceptual level, "containing complexity" for the allocation of responsibility and accountability for human security is necessary. Furthermore, on the technical level, doing so is contingent upon the necessity and willingness of states to formally share sovereignty, the institution of legal mechanisms to delegate sovereignty, and the creation of conditions and attendant mechanisms by which sovereignty is returned to the states. The purpose and goal here are to acknowledge the durability of the current state system, with the caveat that no state is sovereign, and to reapportion the diffuse power in the global order not only to provide for human security on an ad hoc and short-term basis but also to guarantee its provision over the long term. The following proposal, consisting of three conceptual positions and four technical solutions as applied to (inter)national health agencies, seeks to allow such a realignment of rights and responsibilities to work.

First, explicit acknowledgement of the preeminence of the state as the guarantor of human security is necessary. Given the plethora of NSAs operating at the local, national,

international, and global levels, curtailing or terminating their work is unlikely to be either possible or useful. However, having them register at the state and international levels might add some transparency to their activities while enabling a host state to determine where and how to negotiate the allocation of its (meager) resources.

Second, as evidenced in the Ebola response, (weak) states asking for or acceding to assistance should formally be in the position of power with regard to whom they petition, for what, and for how long; moreover, those states, NSAs, and multinational or international organizations receiving requests should not be able to decline but should be compelled to meet the demand and coordinate their actions. Such shared or delegated sovereignty would offer a way to shore up the provision of human security while clearly delineating the lines of responsibility and accountability. A plausible precedent for doing so might be the current Ebola response taking shape under the UN secretary-general.

Third, states (overly) reliant on or sharing or delegating some of their sovereignty to other states or NSAs must have a mechanism through which to reclaim it. This provision might also prove useful in the event of the abuse of shared or delegated sovereignty by NSAs that fail to meet their obligations or that actively circumvent the state above, horizontally, or below which they are operating.

Beyond these conceptual options are four technical solutions to a global reordering of human security for health. With the lessons from the HIV/AIDS and Ebola responses fresh in mind, it is vital that one internationally recognized and legitimate organization serve as the notification center for declaring and providing information on an international health emergency. This entity need not be the WHO, whose international authority and legitimacy in the aftermath of its curtailed HIV/AIDS response and its abdication with regard to Ebola are severely compromised.[29] The WHO, however, could serve as an information portal (competing with *Wikipedia*, whose site has apparently taken the lead as a source of information on the Ebola pandemic), much as it releases respected guidelines on HIV/AIDS treatment.

Second, once an international health emergency has been declared, mandated actions are necessary. Currently only voluntary ones exist—not a solution and certainly not a sustainable one. Making this clear are the following: NSAs that can pick and choose where they serve, under what policies, and for how long; a lack of protocols or the provision of protective gear to fight Ebola; and a dearth of deployment of medical personnel, also in the case of Ebola. In emergencies, all of the following conditions should also be mandated: if and when treatments are available, if they are produced and who produces them, and who pays and how much.

Third, health emergencies do not erupt without some forewarning. Zoonoses (diseases that cross over from animals to infect human beings) such as HIV and Ebola have long been predicted. Preparing for them involves health as well as educational, financial, and governance structures. In terms of predicting and reacting to the next such outbreak, the US-led Global Health Security Initiative, proposals for a Universal Health Systems Fund and Universal Health Insurance, and revamped IHRs outfitted with adequate national and international financing as well as incentives and sanctions are absolutely vital.

Fourth, contingencies to health are also determinants of health. In the long term, technical interventions for health must take into account food security and economic security—and vice versa.

As this article has striven to show, the current arrangement to guarantee rights via responsibilities relies on a state system that is fracturing. It is up to the actors, both state and nonstate, as constitutive agents of the international community, to realign rights with responsibilities. More research on the allocation and interplay of rights and responsibilities, as well as constructive solutions for their realignment, is necessary.

Notes

1. Sadako Ogata and Johan Cels, "Human Security—Protecting and Empowering the People," *Global Governance* 9, no. 3 (July–September 2003): 274.

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3. James N. Rosenau and Ernst-Otto Czempiel, eds., *Governance without Government: Order and Change in World Politics* (Cambridge, UK: Cambridge University Press, 1992); and Stephen D. Krasner, *Sovereignty: Organized Hypocrisy* (Princeton, NJ: Princeton University Press, 1999).

4. See Krasner, *Sovereignty*, 8–9, 42.

5. Vittorio Hösle, *Morals and Politics*, trans. Steven Rendall (Notre Dame, IN: University of Notre Dame Press, 2004); and Thomas Risse, "Paradoxien der Souveränität: Die konstitutive Norm, auf der die heutige Staatenwelt gründet—dass nämlich Staaten souverän sind—gilt uneingeschränkt nicht mehr. Was heisst das?," *Internationale Politik*, July/August 2007, 40–47.

6. Jessica T. Mathews, "Power Shift," *Foreign Affairs* 76, no. 1 (January/February 1997), https://www.foreignaffairs.com/articles/1997-01-01/power-shift.

7. See Laurence Jarvik, "NGOs: A 'New Class' in International Relations," *Orbis: Journal of World Affairs* 51, no. 2 (Spring 2007): 217–38; and Mathews, "Power Shift."

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10. "International Covenant on Economic, Social and Cultural Rights" (1966), Article 12, accessed 22 June 2015, http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx.

11. Lawrence O. Gostin and Eric A. Friedman, "Ebola: A Crisis in Global Health Leadership," *Lancet* 384, no. 9951 (11 October 2014): 1323.

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13. "Constitution of the World Health Organization" (1946), 1, accessed 22 June 2015, http://www.who.int/governance/eb/who_constitution_en.pdf.

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15. Milli Lake, "Organizing Hypocrisy: Providing Legal Accountability for Human Rights Violations in Areas of Limited Statehood," *International Studies Quarterly* 58, no. 3 (September 2014): 519.

16. Ibid., 523.

17. Ibid., 524.

18. Mathews, "Power Shift."

19. Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2003), 11.

20. See "Constitution of the World Health Organization" (1946), 1; and World Health Organization, *International Health Regulations (2005)*.

21. Notably with treatments and antiretroviral cocktails developed and patented in pharmaceutical powerhouses in the global North and West (mostly in the United States, Britain, France, and Israel) until India in the 2000s became the "world's pharmacy" by providing generic, often innovatively recombined, medications at a fraction of the initial cost.

22. See the Treatment Action Campaign, accessed 22 June 2015, http://www.tac.org.za.

23. The case of Uganda is starker. When the initial incarnation of the President's Emergency Fund for AIDS Relief required states to earmark 33.3 percent of funding for abstinence-only HIV prevention programs, President Yoweri Museveni of Uganda drastically changed his political message of "zero-grazing." The result was both a funding increase and a rise in HIV incidence.

24. Gostin and Friedman, "Ebola: A Crisis in Global Health Leadership," 1324.

25. "Ebola: What Lessons for the International Health Regulations?," *Lancet* 384, no. 9951 (11 October 2014): 1321, http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61697-4.pdf.

26. The 2001 concept of the "responsibility to protect" as an attempt to force the assumption and action of the global community in cases of genocide or crimes against humanity has failed to be effective.

27. Cited in Jarvik, "NGOs: A 'New Class,'" 217–38.

28. See International Commission on Intervention and State Sovereignty, *The Responsibility to Protect* (Ottawa, ON, Canada: International Development Research Centre, December 2001), http://responsibilitytoprotect.org/ICISS%20Report.pdf.

29. See Stewart M. Patrick and Daniel Chardell, "Course Correction: WHO Reform after Ebola," *Internationalist* (blog), Council on Foreign Relations, 27 January 2015, http://blogs.cfr.org/patrick/2015/01/27/course-correction-who-reform-after-ebola/.

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