EDITORIAL

The Human Rights Discourse in Health (19 key statements)

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Food for a flagrantly violated thought

A. Meaning of the human rights discourse in health:

1. The revived interest in a HR-based approach to development and to our work in health is well justified and an advantage over our current approach. Human Rights (HR) - and the Right to Health - have a particular concern about those who are disadvantaged, marginal and living in poverty.

2. Widespread unsatisfied health needs - primarily of the poor who lack economic access to health services (and are now faced with widespread fee-for-service charges) - represent flagrant violations of the rights of a majority of people. This is to be seen in good part as a failure of beneficiaries themselves to act as empowered claim holders placing their demands from a power base that can force non-performing duty bearers (individuals and organizations) to provide the services and resources needed to reverse those violations.

3. We have become quite good at doing detailed Situation Analyses of unfulfilled needs and entitlements. But these only list and sometimes characterize the multiple violations of the right to health. So these represent diagnoses only.

4. To get something done about these violations we have to further embark in Capacity Analyses that look at who is supposed to do what about each of the violations we document (and why they are not doing much or anything). Capacity Analysis has also been called Accountability Analysis, because seeking accountability provides claim holders with the opportunity to understand how duty bearers have discharged their obligation and provides duty bearers with the opportunity to explain their conduct.

5. After carrying out these capacity analyses, we have to - in an organized way, through proactive community mobilization - embark with the beneficiaries in doing-something-about-those-violations, knowing exactly who in health needs to be approached/confronted and with what specific demands.

6. All unfulfilled needs and entitlements, by definition, cause some kind of harm (by omission). But the satisfaction of basic needs is not always seen as a legal obligation by most decision makers - though perhaps seen as a moral obligation. But moral obligations have not been sufficient to satisfy the numerous unfulfilled needs of the poor in the last 40 years (or more) of Northern-led development; much less will they be sufficient to revert the violation of rights.

7. Unfulfilled-needs-and-entitlements do not bind duty bearers. Violations-of-human (people's)-rights, on the other hand, DO bind duty bearers legally under international law and, among other, under the Constitution of the World Health Organization (WHO). Most countries have signed the respective UN Human Rights Covenants - and this is the most important... We are now demanding duty bearers to legally uphold the health contents of what has been signed by their respective countries and has now been sanctioned by the international community.

8. There is thus now a growing body of Moreover, the Constitutions of over 100 countries include the respect of health-related rights; courts around the world are already adjudicating cases involving the right to health. international HR law and practice to help us identify the specific interventions and policies that are needed to achieve HR goals in health. Therefore, the

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challenge now is to bring the Right to Health to actually bear upon local, national and international policy making processes and bodies. It is to be noted that proactively influencing policy making in health does not depend on winning related HR court cases; the policy-influencing-approach is not a soft option; it calls for forceful social mobilization: It is not about listening to the powerless and marginal; it is for the latter to be empowered to demand accountability for key structural changes not occurring. The court-based and the policy-based approaches are thus mutually reinforcing and both should be used in our struggle; we thus need to promote both. What is now left is to implement all these practices that operationalize the right to health at the community, at national and international level. This, by addressing issues of poverty, discrimination and stigma particularly in relation to gender issues, children, racism, HIV/AIDS and mental health. [a]

9. All this represents an important quantum jump in our prospects to achieve some of the changes we want to see being implemented in health and in society.

10. It needs to be emphasized here that reaching the SDGs also will have to pass through breaking the poverty syndrome behind pretty much all the indicators of the SDGs. In our case, looking at these goals only through the prism of the right to health will only advance our cause in the health indicators (goals), i.e., a very partial victory. Many are calling for specific 'contributions of the right to health to poverty reduction. [a] We rather see it the other way around: "how-will-poverty-reduction-contribute-to-the-right-to-health". (Or, at best, we see it both ways, but not the former way alone). We are NOT seeking pro-poor health policies! We are seeking "pro-health-poverty-reduction-policies".

11. The HR cause gives us the possibility to advance our political agenda towards equity, towards the indispensable structural changes that need to be made for health and other social services to receive the resources they need to reverse the corresponding rights currently being violated.

12. We now can face duty bearers accusing them of violating international law. And that is a tactical advantage. We can now demand structural changes under the wing of international law. Our challenge now is to spread the word about this so that, in alliance with claim holders, we can muster the power to give a new direction and greater momentum to our struggle.

B. How to strengthen the HR-based approach in our work in health:

13. The more specific challenge we face is to incorporate the HR-based approach into the Health-For-All-Now agenda. The popularization of what the HR discourse means, as characterized above in a very simplified way, is step one. We need to do this first with our strategic allies in bilateral, multilateral and non-governmental organizations. Several of them were tried: In the 1990s, UNICEF has taken the lead among UN agencies to set the course of what needs to be done to apply the HR-based approach in development planning; CARE has made substantial advances in adopting a HR-based approach in its operations worldwide. Because most international, governmental and non-governmental development agencies have not yet re-visioned and re-missioned themselves to adopt a HR-based approach, there is much we can learn from the two experiences cited here - followed by much we can (and need to) do.

14. In step two, it will be for these allies to then bring the new concepts to their colleagues and peers, as well as to a host of different health workers in their respective workplaces and then to community leaders in the areas where they work.

15. The incorporation of capacity analyses to identify and characterize duty bearers that are not doing what needs to be done will, from now on, be key to our work. This process is in itself empowering for us and for the claim holders we work with.

16. Both in steps one and two, it has to be emphasized that there is no hierarchy of HR; there are no 'competing rights'. All rights are universal and inclusive, so we have to work for their fulfillment in all areas; that is why looking at Health-for-All as part of our struggle for the drastic reduction of poverty is crucial.

[a] Statement by Paul Hunt, Special Rapporteur on the Right to Health, Commission on Human Rights, 59th session, March-April, 2003, Geneva.

17. The neoliberal development paradigm tries to fragment the social reality into sectors allowing partial small victories to be hailed as successes alas with absolutely no sustainability. If the system that causes all the symptoms and signs that come with poverty is not fixed, small victories in health, in education or any other sector are just deceiving us. For example, the emphasis on trade that globalization fosters is not going to benefit the poor unless we specifically build-in fair trade rules AND mechanisms of distribution of the benefits of trade to the lowest income quartile. Or, an example from the health sector would be: We have seen Herculean efforts and resources being poured into the Expanded Program of Immunization; who could fault that when it saves lives? But saves lives for how long? Until the child saved from dying from one of the six immunizable diseases, because s/he is malnourished and lives in a poor and contaminated environment, falls prey to a pneumonia or a diarrheal episode for which we do not have a vaccine yet... Who are we fooling here?

18. What is highlighted here is that we cannot let the forces of status-quo hijack the concept of HR in health. Any partial/sectoral interpretation of this concept is ultimately dishonest. HR is about a more equitable distribution of resources in society and health is one of many entry points to achieve this goal. Human beings are born with a right to health and society has to proactively make the investments to prevent totally preventable ill-health and malnutrition and to treat those affected by the diseases of poverty. Focusing our efforts in anything short of this is a job half done, more so if we do not arrive at such a situation through the empowerment of claim holders themselves to relentlessly demand that the needed changes are implemented. This is not a task for an avant-garde only: it is a mass mobilization task.

19. We are not saying that all this is easy, or fast, or that there are no small victories on the road to achieving our main objectives. But the focus has to remain on the big picture....do not miss the forest!