

FINAL DRAFT

Proposal for a global ‘Right to Health and Health Care Campaign’ to be launched by the People’s Health Movement. *December 2005*

We thus find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be considered both of these at the same time. This, I believe is the great drama of medicine at the start of this century. And this is the choice before all people of faith and good will in these dangerous times.

- Paul Farmer

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1. The context

1. The progressive weakening of public health systems, the growing privatisation of health care and the erosion of universal access to health care are phenomena seen across the globe as part of the process of liberalisation and capitalist globalisation. The health sector globally still seems to be dominated by vertical and technocentric approaches, often supported by ‘public-private partnerships’ active at several levels; nowadays these are the preferred modes of implementing health sector reform. There is thus an urgent need to replace this dominant discourse by a process aimed at universally achieving the ‘right to health and to health care’ as the main objective to achieve more equitable health care systems in both developing and developed countries. To counter and reverse the tide promoting ‘health care as a commodity’, there is a need to establish a global consensus on ‘health care as a right’, as well as to begin using (and fighting for) this right and for the respective enabling conditions that will strengthen public health as a public good in a lasting manner.

2. Human rights violations are not accidents; they are not random in distribution or effect; they are linked to social conditions that determine who will suffer abuse and who will be spared. In each local context, it is thus the socio-political forces at work that determine the risk of most forms of human rights violations.

3. Culture per-se does not explain human rights violations --it may, at worst, furnish an alibi. So, we do need to ground our understanding of human rights violations in the broader analyses of power and social inequality.

4. Human rights abuses and violations we witness every day somehow fail to draw on our deeper understanding of their social, economic and political determinants --this lending them a random appearance when, in fact, they are highly predictable. It is mostly the poor who are the victims and they have too little voice and no influence, let alone rights.

5. It is inequities of power that prevent the poor from accessing the opportunities they need to move out of poverty. Denying this, only serves the interests of the powerful. Structures and not just individuals must be changed if the world is to change.

The promotion of equity is the central ingredient for respecting human rights in health. Moreover, poverty --part and parcel of the global free-market system-- is the world's greatest killer.

6. In health, we have to consider poor (or lack of) access to health care as a violation of social and economic rights in general. Health thus offers a critical perspective on human rights that we cannot miss.

7. Since laws designed to protect human rights and the right to health (RTH) are mostly not applied, what additional measures have to be taken? This is what the Right to Health and Health Care Campaign (called RTH Campaign for short in this document) sets out to explore.

8. We think we must do something about these human rights violations; we must move beyond just doing good situation analyses. It is also not enough to improve the situation of the poor within the existing social relationships. Poverty demands that we build a different, more just social order. Rights are claimed through social action and the latter depends on how power is distributed and used to address health issues.

9. Human rights legislation alone --without enforcement mechanisms (triggered and controlled by the people)-- is not up to the task of relieving the immense suffering already at hand. Ultimately, laws are most often tied to the prevailing power relations. Rights are not equal to laws --they are realised through social action and by changing the prevailing power relations. Rights cannot be advanced but through the organised efforts of the state and of organized civil society.

10. If we stay in our ivory towers, human rights can reduce us to avid seminar attendants, without the urge to really take action. Knowing carries obligations --thus the proposed Campaign.

11. To work on behalf of the victims of violations of the RTH invariably means becoming deeply involved in pressing for social and economic rights.

12. The Right to Health is perhaps one of the least contested social right. But health advocacy has failed miserably so far. Somehow, public health must be linked to a return to social justice. Denial of care to those who do not pay is simply legitimised in the free-market system. Therefore, equity is actually the central challenge for the future of public health. The commodification of health care changes people from citizens with rights to consumers with (or without) purchasing power. This leaves those who are economically marginalised also

marginalised from accessing comprehensive health care. The issue of rights, the correlative public obligations and the way the latter are secured is thus critical.

13. We must protect those most likely to suffer the insults of structural violence. We have to embark on a process that roots-out the structural problems underlying widespread human rights violations. The Campaign here proposed by PHM is a step in that direction, i.e., it seeks the social transformations indispensable to resolve the inequities found in health.

2. The justification: Why a global RTH Campaign?

14. Nearly 150 countries around the world are parties to the International Covenant on Economic, Social and Cultural Rights. General Comment 14 (GC 14) of the Committee on Economic, Social and Cultural Rights (CESCR) adopted in the year 2000 elaborates on and clarifies the Right to Health by defining the content, the methods of operationalization, the violations and the suggested means to monitor the implementation of this right. GC14 is the most authoritative interpretation of international law relating to the right to health. , There is now a need to launch a global process of mobilization to actually implement the provisions of GC 14 in all ratifying countries. **This clearly calls for measures to operationalize the RTH and to review and recast all global and national health sector reform initiatives** in the light of the framework of health as a right (such as, for instance, recasting the reforms that are now being pursued to achieve the Millennium Development Goals).

15. There are a host of reasons to adopt the Right to Health approach as the basis for the strategy of our People's Health Movement. Among them is the fact that the Basic Human Needs Approach (has) never delivered. Other, as valid, justifications are: a) health care has become increasingly commodified, b) the Human Rights-based Approach (HRBAP) is the new UN policy, c) HR principles are enshrined-in and backed-by international and often national law, and d) the People's Health Movement (PHM) is founded on the principles of the right to health and to equitable access to health care services at all levels with no discrimination.

16. But why do we need a **global** campaign on the Right to Health? We live in a rapidly changing world where massive, trans-national financial forces actively influence economic and political decisions, while the influence of nation-states is progressively shrinking. It is in this context that we must view the dire global crisis of health systems. The latter is symptomatic of much that is wrong with the neo-liberal model of global restructuring. This process is unchecked by either national or global mechanisms of social regulation and redistribution, so it cannot but produce a deep crisis of all publicly-financed social systems. In this context, while we continue to struggle for the Right to Health as a basic human right at various levels, right now there is growing recognition of the need for a **global initiative** to address health system issues in a rights-based framework. At least three reasons can be pointed out as to why, today, such a coordinated global effort has become essential:

A. Financial transactions are increasingly globalized, leading to such transactions effectively escaping the taxation mechanisms of national governments. While traditionally national governments have regulated and taxed financial transactions within countries for purposes of redistribution and social welfare, there are hardly any corresponding mechanisms for global taxation and social redistribution at the international level. Due to neoliberal policies that restrict the revenue of the state, it is not an accident that national governments find themselves increasingly unable to finance comprehensive welfare and health security systems. Today, there is an urgent need to: a) put in place global principles, norms and mechanisms of effective taxation

and redistribution of the resources being generated through global financial transactions, and b) better finance health and social security systems. This is only possible through a globally coordinated effort, thus the Global Campaign.

- B. Also take into account the increasingly globalized characteristics of labor, with legal and 'illegal' migrants, with refugees, and large scale redistribution of labor around the world. There is thus a need to establish universal norms (while retaining space for nationally decided adaptations), regarding minimum standards of essential health services that must be ensured irrespective of country of origin, to all persons of all nationalities in all countries. This will eventually reduce the practice of capital to outsource work to countries with the least health and social security protection, (and hence the lowest labor costs), and will eventually ensure that essential health care is made available to all, including migrants, who must be assured health care irrespective of the 'legality' of their status. Similar considerations apply to the issue of medical personnel and health care workers whose distribution must be based on need rather than on the ability of richer countries to pay more for human resources from poorer countries. Only globally applicable norms and mechanisms, based on the recognition of health as a right, will adequately address this growing problem.
- C. There is also a growing worldwide need for solidarity in and mutual learning from our struggles, so as to strengthen our efforts in the various countries and regions. There is a related need to challenge the dominant global discourse of '*Health care as a commodity*' and '*safety nets for those left outside the existing packages of benefits*' that result from health services being increasingly marketized and from governments retreating from the provision of health care, limiting their role to supporting said 'safety nets' or other kinds of reduced public health services 'for the poor'. We need to counter this with a strong '*Health care as a human right*' strategy that unequivocally asserts the central role of the state and public health systems, and their responsibility to provide health services for all. This is key to influence the powerful global institutions and initiatives that aggressively shape health policies today, especially in developing countries. A global campaign will thus also strengthen and support governments that are currently providing universal access systems, and will cite them as examples, fostering popular support for such systems within and beyond countries.

3. The Right to Health: A holistic overview of its components and tasks for the global health movement

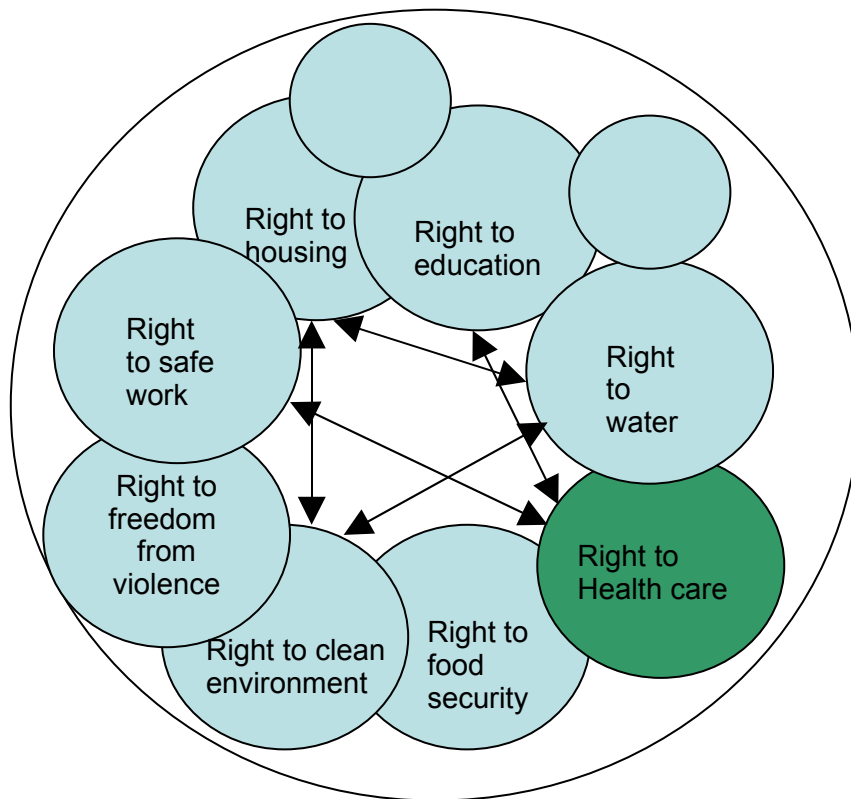
17. PHM struggles for and demands the respect of all aspects of the right to health. This has been defined as the '*right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*' (General Comment 14, CESCR).

([http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En?OpenDocument](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument))

18. This right includes both the *right to all the underlying determinants of health besides health care* (such as water, food security, housing, sanitation, education, a safe and healthy working and living environment, etc.), and the *right to health care* (i.e., the right to the entire spectrum of preventive, curative and rehabilitative services plus health education and promotive activities carried out with the primary objective of improving health).

19. The global health movement has an important role to play regarding both of the above components of the Right to Health.

20. The diagram below shows the main components of the RTH and some of its interrelationships:



21. We reiterate that there is no ambiguity on the issue that *PHM* takes as its overall perspective and goal the defence and promotion of the **Right to Health** as a whole. However, in practice, this suggests two types of **tasks for the global health movement**:

3a. Tackling the right to all the underlying determinants of health

22. Supporting and even co-initiating, campaigns or initiatives addressing key health determinants (e.g., campaigns for water, for food security, or for housing) is important and justified by itself. There are initiatives already working on behalf of these rights, not necessarily spearheaded by health activists. We contend that the focal points for each of these initiatives should be the organizations with the most experience and commitment to that particular issue (e.g., water food security, housing, the environment). This recognition places an obligation on health activists to actively support and strengthen such initiatives to the best of their capacity, though not necessarily to take up the responsibility of primary leadership of such groups. When liaising with these groups, *PHM* will bring-in the health perspective into their campaigns.

23. Health activists should view their involvement in such initiatives related to health determinants as additional. In practice, the constituents, the leadership and the plans of each of these initiatives are most often autonomous of each other, despite their shared relevance to health and the RTH.

24. An additional important role that has to be played by *PHM* activists is to help document violations of the Right to the underlying determinants of Health. It is for them to demonstrate the health consequences of such violations (e.g., showing how denial of food security leads to

worsening malnutrition, increased morbidity and mortality). Health-based arguments can indeed significantly strengthen the demands of claim holders to tackle these determinants from a RTH perspective.

3b. Strengthening the Right to Health Care

25. We argue that the global health movement has a primary and unquestionable responsibility to take the lead on this. The urgent need for action within the health care sector has already been pointed out. We are all witnesses to the often catastrophic consequences of the lack of economic access to adequate health care and the poverty trap that leads to avoidable morbidity and mortality.

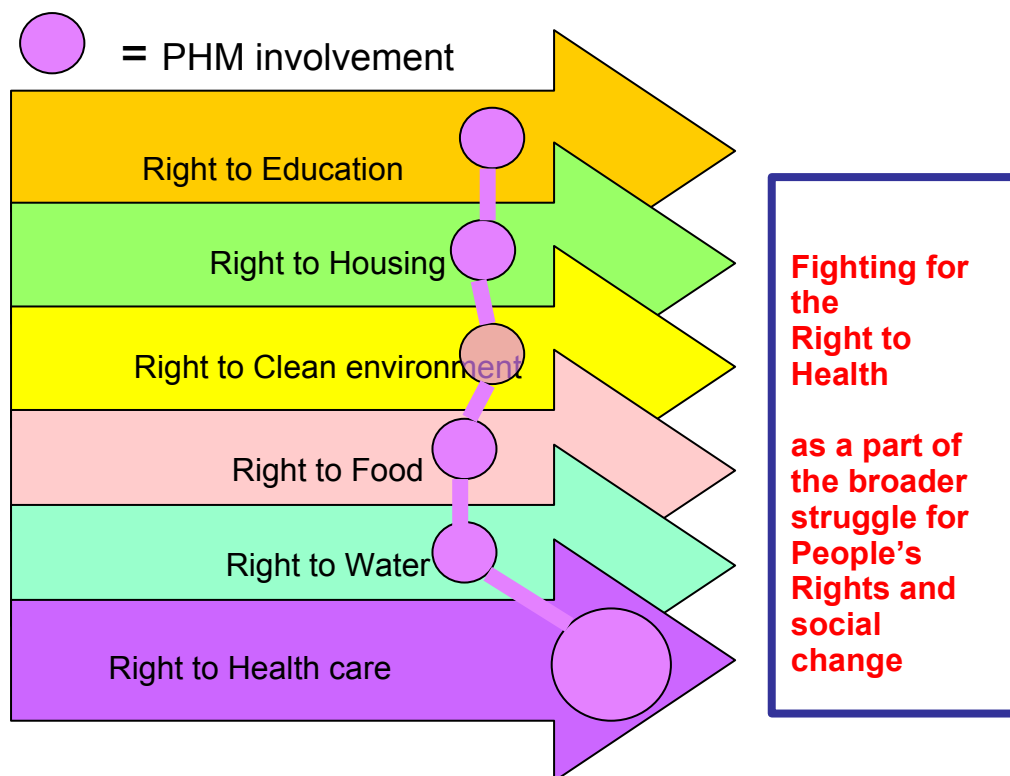
Given the above, we suggest the following **overall strategy for PHM:**

A. 26. Regarding the tacking the right to all the underlying determinants of health, PHM country circles would continue to strengthen and expand their involvement in various concerned initiatives within their countries and regions. PHM may even decide to co-initiate or support a specific international campaign on a particular health determinant (e.g., the Right to Water). There should be an ongoing analysis of the interrelatedness between various health determinants so as to enable PHM and its circles to develop integrated and holistic strategies. PHM is, for example, already actively involved in the work of the Commission on the Social Determinants of Health of WHO.

27. However, given the wide diversity of determinants and the existence of other initiatives already active around each of these, it is not strategically possible for the global health movement to launch a single campaign encompassing all health determinants on a global scale –although, we reiterate, participation in various initiatives is an important overall task.

B. 28. Along with this, we suggest PHM focuses on a **Global Right to Health and Health Care campaign**. The Campaign will concentrate on strengthening the Right to Health Care since we argue that PHM has a primary responsibility regarding this issue. However, during this campaign, the documenting of violations will not be restricted to those in the sphere of health care, but will encompass denouncing violations of health rights related to the various determinants of health. The Global Right to Health and Health Care Campaign will focus on tasks in which PHM (along with partners in the global health movement) can take the lead and primary responsibility.

29. These two types of activities should be combined as part of a holistic and comprehensive approach to the Right to Health. This strategy does not reflect any judgement on the relative importance of health care vs. the underlying and basic determinants of people’s health; it is rather a question of a strategic choice, The overall perspective about how the global health movement should approach the Right to Health is depicted in the following diagram:



4. What does the RTH imply and what is the added value of adopting the human rights-based approach (HRBAP) to tackle it?

30. In every development process, there are two types of actors: **claim holders and duty bearers**. When the State does not respect human rights, claim holders have to demand their rights from the duty bearers in government. If they do not do it, it is in part their fault. One can thus say that it is also the duty of those of us who are aware of human rights (and who have an interest in the outcome of the conflict, but are not directly involved in it) to generate awareness about the bases of these rights, in partnership with the marginalized and underserved groups we work with.

31. The RTH is thus violated, when the poor, the marginalized and the discriminated, as claim holders, do not have the capacity to effectively demand (claim) their rights; rights are also violated because duty bearers do not have the capacity or the will to fulfil their obligations (technically called ‘correlative duties’).

32. Therefore, in the HRBAP one has to carry out two types of analyses: a) **situation analyses** in which one determines the causes of the problems placing them in a hierarchical causality chain of immediate, underlying and basic causes or determinants, and b) **capacity analyses** in which one determines who are the individuals/institutions that bear the duty to do something about the above causes calling them then to fulfil their duties as per their country’s obligations as signatory of the UN HR covenants. (Herein lies the call for HR activists to carry out rights awareness work, i.e., to educate and inform the broader society about what these rights mean).

33. These two types of analyses have to be carried out with the representatives of the local community and the beneficiaries of the health system so that the rights being violated can be

identified jointly and those responsible can be also jointly confronted --for them to do something about the problems identified.

34. Note that, as a PHM ultimate goal, we do NOT look for health policies that favor the poor... We seek significant poverty reduction policies that directly address the social determinants of the inequitable distribution of resources we see globally; we also seek to end the existing violations to the RTH. The Campaign for the RTH gives PHM the possibility of advancing its political agenda that strives for equity and thus strives for structural changes that will do away with the social, economic and political determinants of health. The challenge is to now disseminate these concepts to a wider public.

35. As PHM, we are no longer going to go to beg for changes to be implemented; we are now going to demand them based on existing international law already in force in most of the countries where we work. Disseminating this concept is in itself empowering and is part and parcel of this Campaign. Note that people in countries that have not ratified these covenants do have the same rights. Their problem is that their governments have not made a commitment to honor them. The Campaign will also work in non-ratifying countries.

36. We seek to overcome the culture of silence and apathy about the HR violations in health we all know are happening. This, because HR and the RTH will never be given to poor, marginalized, discriminated and indigenous persons. Repeat: **rights are never given, they have to be fought for!** And this is what the RTH Campaign will attempt to do.

37. As regards the added value of adopting a HRABP, several advantages come to mind: a) A RTH Campaign has a big social mobilization potential --and this is an indispensable part of any campaign, b) as said, the HR approach is backed by international legislation, c) the RTH approach demands --from a position of strength-- that decision-makers take responsibility, d) HR imply correlative duties that are universal and indivisible (there is no such a thing as 'basic rights'), and e) the HR approach is focused on processes that lead to outcomes (just setting goals, like the MDGs, is thus not sufficient in the HRBAP).

5. Focus of the Campaign

38. The Campaign will, in its first phase, focus on the 'Right to Health Care' as an urgent response to the weakening health systems in many countries. The issue of access to quality health care can be importantly acted-upon from within the health sector. This requires broadening our vision of health care to a vision that, as in Alma Ata, includes preventive, curative and rehabilitative health services, as well as health promotion services, e.g., nutrition, quality drinking water and sanitation, health education, health information systems. Specific important aspects of this Right such as women's and children's right to health care, mental health rights, HIV and AIDS-affected persons health care rights, workers' health rights, the right to essential drugs, etc. need to (and will) be woven into the Campaign, bringing diverse branches of the global health movement into a broad coalition that strengthens universal access to health care.

39. At the same time, PHM will denounce and act upon adverse existing and new policies that are having negative impacts on the Right to Health (such as the privatization of services, the weakening of universal access systems, vertical programmes that fragment health systems, the current 90/10 gap in research funding, the unjust international trade regimes --to name just but a few). These policies, and violations of key health determinants, will be identified at the country level and will be taken up as part of the proposed Campaign.

6. The three phases of the Campaign

40. To move towards implementing the Campaign process, we here propose the following sequence of activities:

I. Preparatory phase (early to mid 2006)

The following will be attempted:

1. Creation of a broad consensus on the Campaign idea, involving as many as possible coalitions and networks so as to engage them in the Campaign giving them the option to develop the concept further. In each country, identified groups will be invited to become part of the Campaign. At global level, a '**Core Campaign Steering Group**' of about 6-8 organizations will be formed; members will have to be driven by the vision and be willing to help coordinate the Campaign globally, as well as willing to commit their staff's quality time to travel internationally over the next two years (early 2006 to early 2008). This team will actively support a host of regional organizers and will lead the international networking work, plus the upfront fund-raising and advocacy work for the Campaign. To support this team, a global campaign secretariat (of about three to four persons) will need to be formed to give guidance to the campaign.
2. Identification of specific (existing PHM or newly associated) groups that will take *regional responsibilities* and work as regional convenors, in order to convene Campaign activities in all regions of the world. If possible, at least one consultation within each region to discuss the campaign will have to be held. (Current PHM regions are: Europe, Africa, Eastern Mediterranean, South Asia, South East Asia and Pacific, Latin America and the Caribbean, and North America; this can be modified in accordance with the most logical grouping, without allowing an impractical atomization of regions).
3. Identification of short and long-term sources of funding for the various aspects of the Campaign, at regional and global level plus the development of a budget..
4. Reaching of a clear understanding with key global strategic allies --such as WHO and the Special Rapporteur on the Right to Health-- to ensure their active involvement in the Campaign throughout the process. An agreed-upon mechanism for regular consultation with allies will be set up.
5. Completion of guidelines for the preparation of papers depicting 'The State of the Right to Health' in each country. (Early 2006)
6. Contribution to the discussion and planning of the next (2007) edition of the Global Health Watch that could incorporate analyses and suggested lines of action to achieve the 'Right to Health' at global and regional level.

41. This phase will culminate in a restricted consultation of the Campaign Steering Group in the first quarter of 2006 in which the developments so far will be reviewed and plans made for the next phase of the Campaign.

II. Documentation and analysis phase (last three quarters of 2006).

During this period, country, regional and a global report will be prepared as follows:

42. Country papers or reports on the Status of the Right to Health Care (clearly distinct from reports on the status of health of a population!) will be completed in the countries of at least two regions; in the other regions, the process will be started and brought to as an advanced stage as possible. Not all countries may be able to prepare these reports with comparable

levels of detail, much depending on the capacities of the respective PHM circles and the actual availability of information. Whenever possible, these papers will also suggest possible solutions to the major problems described). [It is here noted that PHM does not see these (or any) reports as an end; rather, the processes launched that mobilize civil society to produce these reports is the real end].

1. Options are as follows:
 - **Full blown Country Reports:** These will be the most extensive and will analyse all or most aspects of the health care system in the country and report on their current status with facts and figures, documenting why and how General Comment 14 has (not) been fulfilled five years after its adoption (within the framework of a ‘progressive realization of the right to health’).
 - **Country Status Papers:** These will be less detailed and may not cover all components of the health sector, but will be based on country level information and statistics that bring out major health care system gaps.
 - **Country Overviews:** These will only contain a listing of major issues of concern from the Right to Health perspective (e.g., declining health budgets, unregulated privatization, imposition of user fees, dismantling of the social security system). Some facts and figures will be presented. These country overviews will be prepared where detailed and reliable country level information is not available or the local group’s capacity is limited.

43. The aim is that about 35-45 countries will prepare these country reports or status papers – aiming at a minimum of 4 in each region.

2. A **Global Health Watch Report chapter on the Right to Health** could then be drafted; it will focus on how specific governments, as well as the various global agencies and actors are infringing or opposing the Right to Health in different ways (e.g., the WTO through its patent regimes, the WB, the IMF and other international agencies through their lending and granting procedures; the MDGs focusing on outputs that foster vertical approaches rather than emphasizing human rights-based processes). It will also focus on the minimum obligations developed countries have to contribute to health care development in poorer countries, to stop the northward migration of health professionals and other such issues.

44. This phase will culminate with the concrete planning of Regional Assemblies on the Right to Health in all seven or eight regions of the world: Dates, venues, financial arrangements, major agenda contents and organising agencies will be identified and given concrete mandates. For this, a pre-planning meeting to finalise the program of these regional assemblies may be held at the end of 2006.

III. **Regional Assemblies and subsequent action phase** (after the World Health Assembly of May 2007)

45. The following is proposed:

1. One assembly in each of the seven regions will be held sequentially thereafter. These assemblies would be called by PHM, with involvement of the UN Special Rapporteur on the Right to Health and WHO, and will be attended by national health officials, national human rights committees and PHM, as well as other health and human rights activists. Plans will be made to have health workers and beneficiaries represented in these meetings as well. Available country reports/country performance report cards on the Right to Health will be presented

and discussed. This will be complemented by a regional analysis paper in each region, dealing with how international macro factors and global agencies are affecting the Right to Health in the region. These assemblies will attract wide global media coverage as much as coverage by the media within each country involved should also be assured. Action plans to implement the Right to Health will be drawn, discussed and presented in the second half of the assemblies.

2. This series of regional assemblies may culminate in some kind of a resolution being proposed for adoption at, say, the World Health Assembly in Geneva in 2008. Such a resolution will call for time-bound, progressive implementation of the Right to Health. This will include demanding governments to progressively incorporate RTH principles and standards into their national laws. Further, the resolution will put in place mechanisms for monitoring and redressal of this right in all countries of the world; it will appeal for an end to all forms of violations of this right based on the clearly defined standards in the CESCR's General Comment 14. PHM partner organizations will also use this as a concrete opportunity to draw-in many more organizations into the network, to dialogue with their country governments, to engage with NGOs, and national human rights bodies so as to build a consensus on the need to end violations of health rights in their various forms, as well as to reverse policies responsible for such violations.
3. Finalisation of the Global Health Watch report on the Right to Health is envisioned for April 2007. The same could include summaries of all the regional analysis papers and a one-page standardized abstracts of the available country Right to Health reports.
4. Preparation of a '**Global Action Plan on the Right to Health Care**'. Such a document will, with facts and figures, convincingly show how quality essential health care services could be made available NOW to every human being on earth, provided certain key reallocation of priorities and resources are enacted (transferred from rich to poor countries, for example). The plan will call for trade and patent regimes to be changed to benefit countries that have been impoverished, as well as call for internal and external changes to be made in relevant economic policies so as to allow an increased flow of resources to the social sector, and allowing for a more rational reorganization of national health systems. These global recommendations will be accompanied by practical recommendations for the countries in each region. These may be appended as a compendium of specific recommendations for individual countries to consider and take-up. The latter will form the basis of a Concrete Agenda to achieve the goals set out in the PHM's People's Charter for Health.
5. Governments will be lobbied to accept the major points suggested during the regional assemblies and the 2008 World Health Assembly will be asked to adopt a '**Declaration on the Right to Health for All**' for implementation by member countries, The same will have time-bound, specific and monitorable benchmarks and will contain the basic principles of a more bottom-up health sector reform. Some of the primary shifts likely to be demanded will be to move: from a vertical focus on programs to a comprehensive health systems approach; from the existing commercialized and privatized health care sector, to universal access through publicly managed health systems; from a meagre flow of health resources from rich to poor countries to a more dependable, long-term flow of such resources -- including the issues of patents, development assistance and the brain drain in the sector. The aim will be to foster more effective community involvement and monitoring in health to operationalize the Right to Health. Universal Access to Comprehensive Health Care will be endorsed as an overarching principle, together

with a related call for definitive changes in the global trade and patents regime as it affects health. Additionally, calls will be made for a global redistribution of resources to finance basic health care. A shift in policies of all the international agencies working in the health sector will be demanded so that they progressively move towards a human rights-based approach to health planning.

7. Organizational collaboration foreseen

46. Launching a RTH campaign will involve organizational work, making alliances, spreading relevant ad-hoc information, carrying out extensive education, denouncing and monitoring of the unfair health care delivery systems with a view to propose and see-through concrete needed reforms.

47. The United Nations Special Rapporteur on the Right to Health has already shown interest in the idea of this global Campaign. WHO has a division dealing with Ethics and Human Rights which will be approached, while there are persons in other divisions such as the Poverty and Health Policies Division that have already shown a willingness to support the Campaign. Given the need to shift the focus of WHO more towards a rights-based approach, and given its global potential to influence national health systems, WHO will need to be strongly influenced, and could be a potential collaborator in the proposed Campaign, for instance by taking a stronger stance against privatization. To start with, PHM has been a key actor in the launching of the Commission on the Social Determinants of Health (CSDH) of WHO which PHM sees having real potential in the fight for the RTH care. Most countries have National Human Rights Commissions or official bodies that can be involved, to varying extents, in monitoring the Right to Health. Human rights groups have the potential to take interest in and provide expertise on this issue, especially in the context of issues like access to care for HIV and AIDS-affected persons. The Campaign will support other similar ongoing HR campaigns led by other networks. Of course, present PHM member organizations will also need to take the lead within and among countries where they work thus involving a yet broader range of civil society organizations in our network, including women's organizations, coalitions of HIV and AIDS-affected persons, trade unions of health sector personnel, people's movements, etc.; in this sense the campaign would be led by PHM-and-partners.

8. A few conceptual and strategic points

48. Here are just a few summary points as an input for the discussion we want to foster; the list should grow with our partners' inputs:

- i)- The Campaign will initially focus on advocating for the Right to Health Care, while documenting violations of the Right to key health determinants thus drawing upon the wider Right to Health perspective.
- ii)- The Campaign will challenge the commoditization of health, asserting the inalienable role of the state in public health systems with the public at the center.
- iii)- The Campaign makes health rights operational, and thus requires demanding specific commitments and norms that provide measurable parameters for monitoring and for the enforcement of redressal mechanisms. (These absolutely need to be accompanied by active civil society and claim holders mobilization).
- iv)- The Campaign builds a broad strategic alliance involving various special health rights movements that already (or not yet) claim the Right to Health as a key human right.

- v)- The Campaign is deeply rooted in national initiatives and counters reluctant local duty bearers; yet it also addresses key global processes and counters powerful strategic opponents such as the IFIs and some bilateral donors.
- vi)- The Campaign vies for putting the RTH more at the center of attention in the health discourse, and engages major actors making them take an explicit stand on the Right to Health.
- vii)- For today, the Campaign represents a strategy of resistance (i.e., preventing a further weakening of public health systems) and, for tomorrow, it offers a whole new alternative vision (i.e., one of universal access to comprehensive health care plus the tackling of the key negative determinants of health), and
- viii)- The Campaign will be used to shift the discourse from the preoccupation with vertical programmes and privatisation-oriented measures to focusing more on widespread denial and violations of the Right to Health, on demanding a global consensus on the implementation of this right, and on asking that all programs, policies and measures now be critically evaluated according to the tenets of Health Rights (i.e., RTH impact assessments).
- ix)- The Campaign will join the movement towards the international acceptance that International Human Rights Law takes precedence over Trade Law (and WTO Trade Rules) thus strengthening developing countries in their fight to end unfair terms of trade that negatively impinge on the RTH.
- x)- The Campaign will speak the right language to the different sectors. The private sector will be approached to uphold the principles of the RTH; with governments, the emphasis will be on re-empowering the state to be able to meet its obligations towards the RTH.
- xi)- Whenever appropriate and advantageous, the Campaign will push for the use of the judicial system (courts) to facilitate redress for those whose rights have been violated.
- xii)- The Campaign will not just turn into a global lobby focused on WHO. If WHO does not get on board, PHM will denounce this fact and will work with other strategic allies.
- xiii)- Finally, it should not be construed that the Campaign is premised on a violations approach to rights; it will actually focus on that plus on policy advocacy, on raising awareness and educating; on establishing alliances and on mobilizing and empowering civil society.

9. Expected outcomes of the Campaign

49. In its work, the Campaign will use four broad approaches: Within them, we foresee the following scenario emerging from the Campaign: (not necessarily a complete list)

A) Documenting violations and facilitating redress of those violations

- i)- An ongoing analysis and critique of government and private sector performance on RTH issues.
- ii)- The formation of health ‘rights watch’ monitoring bodies --with PHM and civil society participation in several countries.
- iii)- The highlighting of key global processes that are infringing on the RTH Care (such as those depicted above plus the impact of structural adjustment and PRSPs on health budgets, as well as the misguided focus of official development assistance -- ODA).

B) Policy advocacy (denouncing and formulation of new policies) at national and international level

- iv)- The active and ongoing denouncing of old and new policies with negative impact on the RTH.
- v)- A recommitment to the principles of Alma Ata.
- vi)- The identification of the more concrete steps needed to actually operationalize health rights in all countries.
- vii)- The posting of concrete demands regarding global governance in front of global agencies like the WTO, the WB and the IMF that have an inordinate influence on the issues related to the RTH care.
- viii)-The placing of demands so that the MDGs or any other vertical approaches are realigned (or be the entry point) to processes that make health systems more equitable giving access to the neediest to comprehensive health care. This can only be done by defining and keeping track of time-bound, achievable RTH process goals at global and national level.
- ix)- The opposition to the unregulated, commercialized health care model and the return to the principle of ‘universal access to health care’ as a central goal, with a better paid, better motivated, well trained and accountable health manpower together with a truly active community involvement.
- x)- The preparation of a ‘Global Action Plan on The Right to Health’ which will broadly present, in facts and figures, how quality essential health services can be made available to every human being NOW by providing the basis for more proactive international advocacy campaigns, as well as the preparation of country and decentralised action plans on the Right to Health.

C) Raising awareness and education

- xi)- The education of health activists about the other (non-health) areas of intervention that are crucial to improve health.
- xii)- An increased awareness in civil society and an explicit recognition by states of the Right to Health Care at country level in a larger number of countries.
- xiii)- A clearer delineation of what ‘health rights’ are at both global and country level.
- xiv)- Bringing the RTH into the global health agenda and making it a reference point in the global health discourse.
- xv)- The completion of the Declaration on the ‘Right to Health for All’ that commits governments and international agencies to the goal of universal access to quality health care in a rights-based framework.

D) Establishing alliances and embarking in civil society mobilization

xvi)- The strengthening of community empowerment actions.[It is noted that PHM practices the right to participation in all aspects of its work as specifically prescribed in General Comment 14].

xvii)- An active involvement in health rights issues with national human rights commissions and other similar bodies in several countries.

xviii)- A concomitant call for the implementation of GC 14 clauses by the Special Rapporteur on the Right to Health, in a form that makes it easier for the Campaign to monitor and advocate for health rights.

xix)- The establishment of strong links among the different constituencies fighting for the right to health, i.e., women’s and reproductive health rights, children’s health rights,

the health rights of HIV and AIDS affected persons, mental health care rights, the health rights of disabled persons --all fighting within the same overarching framework of rights. All these will provide the basis for a 'grand alliance' between all the movements working for these specific rights so that all demand comprehensive, quality health care systems for all with special attention given to those that have special needs. PHM would be taking the lead in initiating this campaign, but various other networks would be encouraged to share the task of leading and taking forward the same.

50. Some shift in the focus of WHO towards the Human Rights-based Approach to Health will definitively be needed: a shift that puts universal access to public services at the center and that strengthens a group inside WHO that will continue to work and provide leadership on this work.

51. The strengthening and broadening of the PHM network in various countries across the globe will be both an outcome, and also an imperative to take the Movement forward around the common, broad rallying point of the Campaign.

10. What may be realistically achieved through the proposed process?

52. We have no illusion that systematically raising the issue of the 'Right to Health' will by itself lead to an actual complete implementation of this right in countries across the globe. The universal provision of even basic health care services involves major budgetary, operational and systemic changes; in addition to shifting to a rights-based framework, major political and legal reorientations are thus needed --and such major changes cannot be expected to happen in full in the near future, given the political economy of health care in most countries of the world today.

53. However, we can expect and can work on a number of more achievable objectives that can take us towards the larger Human Rights goal. Some of these 'achievable' to be considered in our Campaign are: a) the explicit recognition of the Right to Health Care at country level, b) the formation, in some countries, of health rights monitoring bodies with PHM and civil society participation, c) a clearer delineation of health rights at both global and country level, d) the shifting of the focus of WHO towards health rights/universal access systems and the strengthening of groups within WHO that will work along these lines, e) the bringing of the Right to Health Care more into the global agenda thus making it a central reference point in the global health discourse, and f), the strengthening of the PHM network in as many countries as possible so that all its members work around a common and broad rallying point, along with building partnerships with other networks.

11. Organization of PHM-and-partners and of the Campaign: an iterative process to strengthen both

54. An obvious and valid response to the suggested Campaign may be that 'the internal development of PHM is uneven in different countries and that, in many countries, existing PHM circles are not in a position to take up such a demanding activity'. While accepting this situation, we also need to recognize that PHM country circles --which were formed during or after our first Assembly (PHA1), need to move beyond discussions to develop forceful, shared advocacy activities; this is crucial if they are to develop further and to draw-in more groups into our movement. There is now a need to develop and carry out shared and more effective advocacy actions at country level. These are to be directed at engaging both claim-holder groups and decision-makers (duty-bearers) in an effort to bring about needed changes

in the existing (and often deteriorating) situation. A Right to Health and Health Care Campaign can be such a catalyst and unifying process bringing together existing and new PHM circles, as well as involving new partner groups and networks. The campaign has the potential to give space to new organizations and networks, which have so far not been active in PHM. *In this sense, it can be seen as a campaign that will be developed by PHM-and-partners.* By engaging in this Campaign, PHM will not fall into the game of just increasing membership; it will rather build on network members' active participation and giving them a sense of purpose, belonging and coherence...the membership will then follow.

55. All this can work towards specific country-level advocacy objectives that have the potential to strengthen and expand the global health movement's internal organization while developing new partnerships around a common activity. Assessing the campaign's viability will start by ascertaining the existence of a minimum critical mass of PHM-and-partners strength and power in a substantial number of countries; this will determine the ultimate feasibility of the proposed approach. Our appeal is for such a process to start as early as possible. During PHA2 (July 2005), through a series of discussions, conceptual aspects of the campaign were debated, and a basic consensus on taking such an initiative forward was obtained. We now have to make use of the momentum achieved at PHA2 to work out, crystallise and plan the future courses of action of the Campaign --understanding that each country will move at its best (individual) pace.

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