Chapter Two: Health and the Inequality of Poverty: Towards a Right-based Convention on Global Health

By *Mark Heywood*
Created *2008/02/29 - 4:19pm*
29 February, 2008 - 16:19 ? Mark Heywood

Introduction:

This article continues the argument that there is a political reason for deteriorating public health. However, whilst declining health can be partly attributed to political neglect it is not its direct cause. Rather, it is the growth of socio-economic inequalities that are coming about as a result of changed patterns of production and economic growth, combined with human insecurity, that is putting millions of people at risk of ill health and disease. Tackling this requires (a) that health strategies do more to examine inequality1, and (b) that advocacy for health begins to include robust political advocacy against inequality.

The article tries to justify this hypothesis by looking at some of the drivers of the HIV epidemic in South Africa. Initially drawing on the evidence that links higher risk of HIV infection to inequality I argue that health promotion will be self-defeating if it ignores the link between social and economic inequality and poor health. The currency of such an approach is borne out by people like Paul Farmer who asks rhetorically whether we can address ill health:

> ?without addressing social forces, including racism, pollution, poor housing, and poverty, that shape their course in both individuals and populations??2

In a similar vein Daniel Becker, a Brazilian health activist, asks: ?How much good does it do to treat people?s illnesses, only to send them back to the conditions that made them sick??3

The road to health requires that civil society (of all hues) identify and challenge those governmental policies which cause and reinforce inequality -- even whilst they alleviate some poverty. It also requires that pro-poor organizations of civil society pro-poor, including political parties, begin to understand health. Finally it necessitates acceptance of the importance of using the state?s legal and moral power and resources to ensure that government?s carry out their positive duties to protect and promote health, obligations that they have voluntarily accepted under national and international law. This requires community mobilisation to reclaim the national state as a democratic instrument that can deliver on poor people?s needs. One of the most effective ways to do this will be through stepping up campaigns for human right to health both nationally and internationally.

Health without Equality?

Research conducted in a number of developed countries has demonstrated that inequality, rather than just wealth, is a social determinant of health. This is seen to be the case even when the inequality is between people who, comparable to third world standards of living, are socially secure. Thus, Daniels et al point out that ?the relationship between economic development and health is not fixed, and that the health achievement of nations is mediated by processes other than wealth.?4 Put simply a country may simultaneously be gaining in wealth, and failing in health.
Most, but not all, of the research on which the findings of writers such as Amatya Sen and others are based is drawn from developed countries. However, it is logical to say that when the economic and political policies that are pursued by developing countries contribute to a growth in social inequality, this will have negative consequences for health. This would explain why countries such as China or South Africa, which are experiencing rapid economic growth,

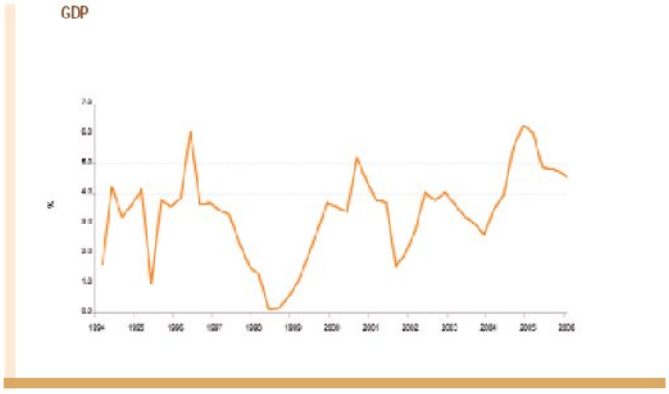
simultaneously witness declining population health.

Put another way, economic policies that widen inequality between the monied and the poor and between the poor and even poorer, fuel both disease and ill health.
Research bears this out. So does empirical evidence that is starting to emerge in South Africa.

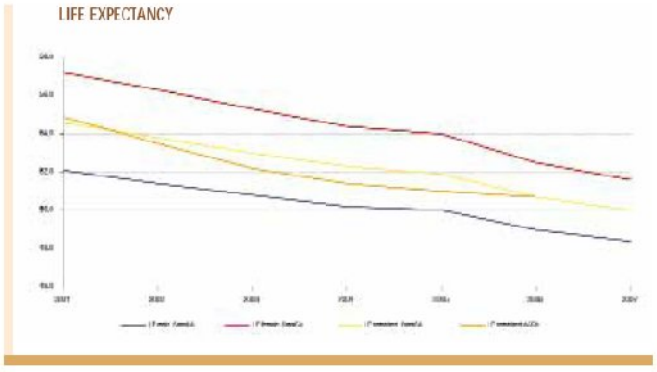
In 2007 a report published by the South African government found ?widening income inequality, particularly between more and less skilled black workers?. 5 The report added that inequality was not being overcome by ?the beneficial impact of social grants and some job expansion?. Significantly, it also noticed that:

> Inequality between races has declined, while inequality within race groups has grown. In 1993, 61 per cent of inequality was between race groups, however, by 2006 inequality between race groups had declined to 40 per cent. Over the same period, inequality within race groups has become much more prominent.

A causal link between inequality and poor health would explain what otherwise would appears to be an inexplicable contradiction about the new South Africa: the country is experiencing progress with key economic indicators (see GDP growth in the table below), and even with many of its social ones (houses are being built, sanitation improved etc). 6



But it is simultaneously experiencing a growing disease burden and, as illustrated below, significantly declining life expectancy. 7



The explanation for this would seem to be the growth in inequality not just between rich and poor, but also within ?the poors?. Inequality, rather than just ?extreme poverty? - as has been claimed many times by South African President Thabo Mbeki8 - is a major driver of declining ill health generally and HIV particularly.
This suggests that by itself a strategy that promotes economic growth and seeks to use selective cash transfers (child support grants, foster grants etc) for poverty alleviation will not be an effective HIV prevention strategy, as has frequently been claimed by Mbeki and his acolytes.
Whilst there is a dispute about the depth and breadth of poverty in South Africa even the Presidency concedes that inequality has grown.9 There are fewer people classified as living in absolute poverty but more very poor people live side-by-side with less poor people in urban formal and informal settlements all over the country. This growth in proximal inequality creates an immediate vulnerability to disease, however distant its political causes. What do we mean by this?

People?s experience of poverty is not uniform. Poverty (like wealth) is layered, with gender and disability in particular being associated with deeper degrees of poverty.10 For much of the twentieth century women were healthier than men, with longer life expectancies, lower vulnerability to diseases like TB etc. But this appears to be changing, especially in the ?new economies?.

In South Africa the fact that women and girls experience deeper social and economic disadvantage than men and boys, is thought to explain their consistently earlier and higher rates of HIV infection and mortality. In many communities girls and young women, who are the least equal of poor people, adopt survival strategies that are not necessary for others.11 Sex becomes a commodity they can exchange in return for a degree of social security (or greater equality).12 This is obtained from men who may be only slightly less poor (because they live in the same community), but whose access to income is linked to their gender, limited access to the economy and often slightly older age.

The links between inequality, gender and ill health are well supported by research. Historically the migrant labour system, and its enforcement by apartheid laws, penned millions of women into rural areas. Today migrancy ? although of a different sort -- remains a major risk for disease.13 However, the situation has become even more complex. Mark Hunter, for example, has argued that in the post apartheid years changes to the South African economy have created ?a changing political economy of sex?.

> ?It is clear that most African women today are no longer waiting in rural areas to be infected by their migrant partners, the pattern of infection described convincingly in the 1940s for syphilis and often evoked uncritically in the contemporary period.?14

Women are as poor as they were under apartheid but more mobile, making them much more the active agents of their own vulnerability.

Social instability means that awareness of HIV, when it is not accompanied by access to income, a dependable justice system that can prosecute domestic violence and rape and support services for women and girls, will be insufficient to reduce risk behaviour.

On the other hand, as Catherine Campbell has pointed out, poor men are also not immune to behaviors that are directly influenced by their marginalization and inequality. She draws attention to how:

> ?Frequent and unprotected sex with multiple partners may often be one of the few ways in which men can act out their masculinity. This might be the case particularly in situations where men, at best, work in difficult conditions over which they have little control or, at worst, have little access to jobs and money.?15

From the above it should be clear that in post-apartheid South Africa poverty, inequality, migration and sex form the locus of a risk to health and well-being. The theatre where this risk is acted out are the communities where people live, but their behaviours (or choices) are being heavily influenced by social, economic and political policies devised and implemented at a national level. To be effective public health strategies must therefore address both national and local issues.

Let me illustrate this with the case of HIV where the vicious circle that must be broken can be summarized as follows. For many people, vulnerability to HIV starts by being driven by external factors (inherited disadvantage together with contemporary political and economic policies that exacerbate inequality). However, once this risk has translated into HIV infection, then actual poor health, caused by HIV, provides its own internal motor to the cycle of inequality. Thereafter unless people have access to health care services that provide treatment and care, illness adds to pre-existing deprivation. Being sick incapacitates people, creates new needs and diverts household resources. HIV infection becomes not just a symptom, but an agent, of inequality. It must therefore be challenged on two levels: *directly* through traditional public health campaigns to diagnose, prevent and treat HIV and *politically* through challenges to the policies that create, or fail to alleviate, the risk.

If you consider that ill-health often robs poor people of their capacity to be politically active because they are made

further ?unfree? by illness, this is clearly a challenge.16 But TAC?s sustained and visible community mobilization for AIDS treatment has shown that it is possible (I will explore this more in the next chapter).

The Role of Government and Uses of the State

Because of these connections there is a growing need for health activism to become enmeshed with political activism and vice versa.

In the present global political context, where revolutions in communication have created growing awareness of a range of social issues from climate change to health, and where there can be immediate access to information, there should be growing opportunity for such links to be established.

Unease about the post-1990 phase of globalisation has created a new theatre for social justice activists. It has spawned institutions such as the World Social Forum and the People?s Health Movement. But despite this health remains isolated in from campaigns for equality and justice. The way in which demands for equity and opportunity for good health could be used to mobilize around other social ills, and better other aspects of the lives of poor people, is still largely overlooked.17

Ill health seems to be regarded by the left primarily as the *consequence* of poverty and inequality, rather than equally as a *contributor* to it. As a result it is rare to find health advocacy at the centre of the campaigns and programmes of pro-poor and social justice organizations. In recent decades, socialist parties, trade unions and social movements have rarely shown any sign that they appreciate how integral health is to dignity and development. Consequently very few have prioritized and aggressively implemented health programmes and platforms ? and the duty of the state in this regard has been forgotten.

Unfortunately there is also evidence that many political activists and analysts seize too quickly on those explanations for poor health that are nearest to hand and which offer grist to their mill about the ?inherent evils? of neo-liberalism and globalization.18 Of course, there are good reasons to draw attention to the negative consequences for health of structural adjustment, debt repayment and the World Trade Organisation?s (WTO) Agreement on Trade Related Aspects of Intellectual Property (TRIPS).

But this is an insufficient explanation for state failure, and if it is the only explanation then it is disarming. In my view declining health is not being caused by globalization alone, but by the *voluntary* retreat of the State from its social responsibilities ?sometimes using ?globalization? as a feint for its own omissions.

One consequence of the failure of activists to focus in a sophisticated way on state duties (and on developing alternative policies for governments) is to hand control over the debates about the need to prioritize population health to the very governments and institutions whose policies did the most to begin the reverse of post-colonial health gains in a number of countries ? the United States, the World Bank and the IMF.

Albeit not representative of the lowest income countries, South Africa nevertheless gives ammunition to my argument. Since the advent of democracy South Africa has reduced its external debt to 33.5% of GDP (down from 43.5% in 1994) and avoided taking loans from either the World Bank or IMF19. Relative to other developing countries, its debt burden is not significant, and certainly does not impede social spending.

But despite this, between 1996 and 2000, under an economic policy known as the Growth Employment and Redistribution Strategy (GEAR), the ANC government voluntarily imposed arbitrary limits on public spending on health with profound consequences. Today, even in a period of a more expansionary fiscal policy, the Minister of Health refuses to accurately establish the country?s health needs, so that she can properly quantify its human resource or budgetary needs.20

Similarly, despite the fierce rhetoric leveled by the Thabo Mbeki, the ANC, ? and other developing countries -- against pharmaceutical company profiteering from medicines, the government has declined to use the flexibilities negotiated,

in November 2001, under the TRIPS agreement to issue, or even threaten, compulsory licenses on essential medicines.

For these reasons it is arguable that the political determinants of the health crisis lie as much with the refusal of developing country governments (particularly the so-called emerging economies) to use the State?s resources or legal authority to prioritise health in public policy, as with globalisation.

The problem is that most developing country governments are unwilling to act reasonably or systematically to fulfill states? duties in relation to the right to health, despite reams of lip-service to international human rights covenants and national constitutions.

The approach to health adopted by the ANC serves, once again, as an example. In its broad strokes the ANC?s health policy has always been rights-based, pro-poor and progressive. The 1955 Freedom Charter, for example, stated:

> ?A preventative health scheme shall be run by the state. Free medical care and hospitalization shall be provided for all, with special care for mothers and young children. The aged, the orphans, the disabled and the sick shall be cared for by the state.? 21

However, during the years when the ANC was banned (1960 ? 1990) and its leadership in exile or prison, a disconnect developed between those working on and campaigning for population health in South Africa and those in exile. Consequently, as Leslie London demonstrates, most of the thinking, experimentation and vision-making around health that took place came internally from:

> ?those health organizations campaigning for civil and political rights (for example, against detention without trial) were also the same groups simultaneously devising policies for primary health care in post-apartheid South Africa, lobbying for a national health service, and joining with civil organizations campaigning for better housing.?22

After the ANC was unbanned in 1990 the gap between internal and external thinking about South Africa?s health policy began to be bridged. The main planks and promises of a post apartheid health system were reflected in the ANC?s *Reconstruction and Development Programme* which was developed before the first democratic election.23 This was followed by a broad consultative process that, in 1994, produced the ANC?s National Plan for Health (NPH).24 The NPH was detailed and far-sighted on paper, and by 1997 had been translated into a government white paper. Unfortunately though the strategy lacked a plan for implementation and underestimated the opposition it would encounter. As a result, although a raft of pro-poor laws and policies on health have been passed,25 they have all been poorly implemented.

In my view, the ANC should have argued that the legally binding obligations it assumed under South Africa?s much vaunted Constitution, and the democratic mandate it acquired over the South African state and its resources, required it to act radically to improve public health. It could also have used the state more effectively as a bulwark against national and international institutions, policies and laws that undermine health. The international backlash that gathered as a result of the 1998 - 2001 litigation brought by the Pharmaceutical Manufacturers Association (PMA) against the SA government demonstrated the sympathy such an approach would gain internationally. Bold but reasonable measures to advance health would have had the backing of the South African constitution, international law, and a led to a strong moral surge in support of health protection and promotion.

But the ANC leadership chose not to do this, focusing instead on other ?priorities? and the mistaken assumption that economic development would trickle down improved health.

As a result social, political and economic policies have had a negative effect on population health, and have not been countered by aggressive health programmes or, except on the issue of HIV, aggressive health advocacy.

The deteriorating health status of the poorest people of South Africa has become clearer and clearer in the last few years. One would have thought that, in the face of the evidence of crumbling health and rising disease related mortality, the ANC would have endorsed a proposal made in May 2007 by former Deputy Health Minister,

Nozizwe Madlala-Routledge, to instigate a systematic review of health policy.[26] But instead of being taken seriously the proposal contributed to her dismissal by President Mbeki in August 2007. It was even described by the Minister of Health?s spokesperson, Sibani Mngadi, as a proposal:

> ?to call in the World Bank to review the national health system. Those familiar with the programmes championed by the World Bank in the rest of our continent will understand that this would have meant the end of such policies as free healthcare for pregnant and lactating women, children under five years and people with disabilities.?[27]

In keeping with its obliviousness to health, the 5-yearly policy review process undertaken by the ANC in 2007 was also a missed opportunity to revitalize its commitment to health. For example, although the ANC?s Policy Discussion Document on Social Transformation, says ?Education and health must be prioritised as the core elements of social transformation? it does not say why or how.[28] The links between poverty, homelessness, joblessness, inferior education and ill health are missing. Consequently, the resolutions on health that were adopted by the ANC?s 52nd National Congress in December 2007 are lack-lustre and without depth.[29]

Where does this leave us?

Human Rights and State Duties

For those who are committed to public health and social justice a debate about the possibility of using ?the human rights approach? as a way to impress (and if necessary compel) government?s to fulfill their duties is overdue.

In a May 2007 article criticizing Amnesty International?s campaign for the Right to Health[30], *The Economist* wrote provocatively that:

> ?Food, jobs and housing are certainly necessities. But no useful purpose is served by calling them ?rights?. When a government locks someone up without a fair trial, the victim, perpetrator and remedy are fairly clear. This clarity seldom applies to social and economic ?rights?. It is hard enough to determine whether such a right has been infringed, let alone who should provide a remedy or how.?[31]

The *Economist* was being mischievous. But similar thoughts are articulated elsewhere.[32] What the article does draw attention to is the need to try to agree on a definition of the content of crucial socio-economic rights (in order to know ?when a right has been infringed?) *and* to link this to the demand for the strengthening of democratic institutions, including legal systems, that are meant to be accessible to people ?remedy? violations of human rights.

Intellectual fellow travelers of *The Economist* would probably not dispute that the major international human rights covenants, and the General Comments of the Committee on Economic Social and Cultural Rights interpreting these covenants, support the principle that if people starve in a country that has a grain surplus (like India) or die of AIDS within proximity of under-utilised private health care facilities (as they do in South Africa), ?a human right has been infringed?.[33] But they would go on to argue that such a finding is essentially moral rather than legal, and therefore of little remedial value.

There was a time when this was true. However in the last few decade human rights have become more than just ?pious wishes?. Today there is now a growing body of domestic law on the right to health and state duties. Thus, according to H Hogerzeil et al, ?more than 150 countries have become State parties to the ICESCR, and 83 have signed regional treaties. More than 100 countries have incorporated the right to health in their national constitution.? In addition, in the last fifteen years in low and middle income countries, there have been at least 71 legal cases around access to treatment, 59 of which were successful.[34]

In these countries, at least, the justiciability of the right to health no longer seems to be about the ability of a court to determine whether a right has been infringed (as claimed by the *Economist*). Rather, the problem revolves around how a court can meaningfully remedy infringements of the right to health and ensure the enforcement of orders made by the Court. It also about how to persuade states to comply with positive duties in the first place ? duties they have explicitly assented to through the ratification of international human rights Covenants, Treaties and Declarations such as the 2001 UNGASS Declaration of Commitment on HIV.

Human rights can assist with this. Like the notion of the ?rule of law? human rights have been evoked for several centuries. However, both have been buzz words of the post 1990 World Bank-IMF-EU-USA facilitated ?democratization? of states in Africa, Asia, Latin America and Eastern Europe. Predictably this gives rise to suspicion. But the fact that human rights and rule of law have been packaged as part of the neo-liberal ?development? agenda does not make either concept fundamentally neo-liberal. Debates about human rights have gone through many permutations. But, at heart, advocacy for human rights was borne out of injustice and was intended to correct it.

Today it is possible for civil society organizations to draw ever greater attention to human rights violations. Ironically this has been assisted by globalization and the possibility to globalize the local through access to the internet. This strengthens our ability to more effectively assert that government?s have positive duties to respect, protect, promote and fulfill these rights.

This could therefore be an era of opportunity for human rights advocacy for the protection and promotion of health. However, many academic writers on health appear to be in a quandary on this issue. Most academics either ignore human rights, are skeptical about them, or advance wishful-thinking based theory with no guide about the how. David Fidler, for example, worries whether human rights will become ?a morally compelling but politically ignored mantra, as perhaps has been the fate of the global human rights strategy on HIV/AIDS.?35 Aginam says we should ?de-emphasise justiciability and stress human dignity, indivisibility and the interdependence of all human rights.?36

Then, most recently Lawrence Gostin, one of the architects of the human rights approach in relation to HIV/AIDS,37 questions the value of human rights as a means to protect and improve health (as opposed to being just a powerful discourse). 38 In an important article arguing for a ?Global Framework Convention on Health?, Gostin laments that the WHO has ?shied from [human rights based] rule making? and seen ?itself principally as a scientific, technical agency.? 39 He does not mention that the WHO was set up with one objective: ?the attainment by all people of the highest possible level of health?, or that its third principle was that ?The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.?40

But what Gostin and others miss is that in the period of (what academics who like to confuse ordinary people call) ?post-Westphalianism? (meaning simply the period of the rise of multi lateral institutions under the auspices of the UN) is that during the ?cold war? the human rights principles that underlay bodies like the WHO were sacrificed to the politics and horse-trading of governments. As a result, in the words of Gregg Gonsalves, UN bodies saw themselves:

> ?MOST critically as responsible to their member states, NOT those that live within those states. This for me is a fundamental misunderstanding of UN agencies, who are ?meta-state? actors, they aren?t independent agencies on health (e.g. WHO) etc, but agents of member states and thus doing the bidding of the states that govern them.?41

It therefore not surprising that eventually in a dramatically changed political, social and epidemiological environment ?social activists ? turned to the language of human rights to articulate their aspirations for global health.?42

However, Gostin and others get snared in a web of codas that makes it hard to see the wood for the trees. He worries that ?recasting the problem of extremely poor health as a human rights violation does not help.? He is concerned that the theories of justice that are entrenched by human rights cannot help either because under international human rights law states? duties are first of all to their own populations.

He says:

> ?States may owe their citizens basic health protection by reason of a social compact. However, positing such a relationship among different countries and regions is much more complex.?43

He thus struggles to find a ground in law or human rights to his support his argument that rich governments need to

accept that they have a duty towards the health of poor countries. Strangely, he overlooks the finding of the Committee on Economic, Social and Cultural Rights that:

> ?in accordance with Articles 55 and 56 of the Charter of the United Nations, with well-established principles of international law, and with the provisions of the Covenant itself, *international cooperation for development and thus for the realization of economic, social and cultural rights is an obligation of all States. It is particularly incumbent upon those States which are in a position to assist others in this regard.*?44 (my emphasis)

Finally, like others45 he laments that the right to health is ?progressively realizable?. The fact that state?s duties are tied to ?available resources? leaves violator states with a large and legally ambiguous area in which to justify their omissions.

The argument of Gostin and others boils down to a plea that on the basis of morality and enlightened self interest rich states should be beneficent and accept a duty to assist poor states to attain a threshold of service provision in areas such as health. This approach ends up resting heavily on a dependence on a fickle global charity, rather than global responsibility/duty or encouraging citizens to demand their rights to health and hold governments to account.

And finally the wheel come full circle and we find our way back to developing country governments where Gostin implies there is limited agency, capability and capacity to improve public health, But this is only partially true. His argument about lack of resources and capacity to provide for health is certainly valid in some of the world?s poorest and most indebted states. But it does not apply to several key emerging economies where the problem is firstly a lack of governmental will to provide health care services, rather than ?available resources? or capacity.

In these countries the question is whether civil society is able to exert the necessary pressure, supported by international opinion and law, to force governments to do more to address public health. Admittedly, community mobilization for the human right to health will be difficult in countries which continue to suppress democracy and fundamental human rights such as China46, Pakistan and Zimbabwe47. However, in countries such as South Africa, India and Brazil, which have populations numbering hundreds of millions and a high burden of disease, the right to health can be pursued through a social mobilization that also targets the institutions of the democratic state, such as the courts, human rights commissions etc.

UN Framework Convention on Global Health

Prematurely writing off the legal and political force of using human rights (in various ways) to compel governments to take measures to make health care available, accessible, acceptable and of good quality undermines Gostin?s main (and important) argument about the need (arguably the duty under international law) to establish a United Nations Framework Convention on Global Health (FCGH). Indeed, the strongest argument for such a Convention lies in the fact that many States? cannot or are not meeting their national duties as set out in documents such as CESCR General Comment 14 on the right to health. An international agreement has become necessary to set vital health standards and regulate the growing inequalities in the production and distribution of health care.

The human resource crisis is a telling example. Based on CESCR General Comments 3 and 14 it is arguable that in accordance with international human rights law the right to health creates a duty on states to begin to develop and co-ordinate a global plan for the production and equitable distribution of sufficient health care workers48. At a minimum it requires an international agreement on standards of remuneration of health care workers, as one way to remove the lure that pulls many health workers away from developing countries. This is necessary because experience has already demonstrated that good intentions, or even voluntary bi-lateral agreements such as that entered into between Britain and South Africa in 2003,49 are not enough on their own to alter the global health market?s pull of health care workers out of developing countries, into industrialized countries where health workers earn much more and work in much better conditions.50 Indeed, a recent research report, quotes official estimates that by 2020 the United States will have a shortage of 800,000 nurses.51 The effect of this ?market? (when left unregulated) is to make the realisation of the right to health impossible in developing countries ? and ironically even more dependent on aid for health.

Some people will reply by saying that the capacity to produce and sustain a health work force is primarily a national duty. This is undoubtedly true. But if a FCGH included standards on health care remuneration, conditions of employment etc, this would boost national efforts to retain health workers, and allow better planning for local production.

Although this might sound radical, it could also formalise an international benchmark for the minimum required expenditure on health per person per annum in order for a state to be able to meet basic health needs ? perhaps at around $100.52
The aim of a FCGH should be to collate existing norms and agreements on State duties in relation to health and transform them into standards; to examine the plethora of soft law that exists in order to determine and set standards regarding the ?minimum core content? of the right to health 53 and thereby elaborate on what positive and negative duties the right to health places on governments and other actors, including multi-national corporations.54

Most importantly, from my perspective, a FCGH would empower civil society and the health professions in their struggle with their own governments for national standards in health, in a way that the health related Millennium Development Goals (MDGs) are structurally incapable of doing because they are set around vertical targets, rather than standards or systems.

Significantly, as Gostin points out, there are precedents for such definitive agreements ? although few that are explicitly based on human rights, and some that deliberately overlook them. The WTO TRIPS agreement, for example, sets a global standard for intellectual property protection, but is silent on its impact on health or human rights. The UN Framework Convention on Climate Change (UNFCCC) (despite having its Kyoto protocol undermined by the United States) can, to its credit, claim to have established a binding agreement which by December 2006 had been adopted by 169 countries.

In the realm of health, the Framework Convention on Tobacco Control (FCTC) is described by the WHO as ?a binding international legal instrument which establishes broad commitments and a general system of governance for an issue area.?55
However, because of the political neglect of health (as explained in chapter one), it seems unlikely that a FCGH will be brought into existence if left to governments alone. Pressure for such a Convention needs to come from below, from the populations who most need it and the organizations and campaigns that try to represent their needs.

In view of this, in the next chapter, I will look at the experience of the Treatment Action Campaign (TAC) in South Africa, and argue that it is emerging as an example of what can be achieved at a national and local level by using a combination of human rights advocacy, social mobilization and law to advance the struggle for better health. I will also argue that, if its achievements are to be sustained over years to come, the globalized nature of some of the major determinants of health necessitates international regulation.

ENDS

1 In October 2007 the Council of Science editors organized a global theme issue on poverty and human development in which science journals throughout the world published articles on this subject. See www.councilscienceeditors.org/globalthemeisue.cfm

2 P Farmer, ?Structural Violence and Clinical Medicine?, *Plos Medicine*, October 2006, Vol 3

3 Daniel Becker, Centro de Promoção da Saúde (CEDAPS) Health, Equity and Social Determinants, presentation to the University of Nijmegen, 23 May 2007.

4 Daniels N, Kennedy B, Kawachi I. Health and Inequality, or, Why Justice is Good for Our Health? (p 67) in S Anand, F Peter, A Sen, *Public Health, Ethics and Equity*, Oxford University Press, 204.

5 The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007,

6 Ibid

7 Ibid,

8 See T Mbeki, Speech at the Opening Session of the Thirteenth International AIDS Conference, July 2000, www.anc.org.za/show.php?doc=ancdocs/history/mbeki/2000/tm0709.hml

9 See ANC Today, Volume 7:45, Nov 2007: ? the rate of improvement of income for the poor has not matched that of the rich, and thus while income poverty is declining, inequality has not been reduced.?

10 The association between disability and poverty has not been properly studied or quantified in South Africa.

11 It is important to note that by ?survival? I do not mean solely ensuring access to food, but also access to other commodities and resources that define modern living, and which very poor people see all around them, but lack money to acquire.

12 Research recently conducted in Swaziland and Botswana bears this out. Weiser SD, Leiter K, Bangsberg DR, Butler LM, Percy-de Korte F, et al, Food Insufficiency Is Associated with High-Risk Sexual Behavior among Women in Botswana and Swaziland*PLoS Medicine* Vol. 4, No. 10, e260 doi:10.1371/journal.pmed.0040260

13 See Mark Lurie?s "Migration and HIV/AIDS in Southern Africa: A Review" *South African Journal of Science* 96 (2000).

14 M Hunter, The Changing Political Economy of Sex in South Africa: The Significance of Unemployment and Inequalities to the Scale of the AIDS pandemic, *Social Science and Medicine* 64 (2007) 689-700.

15 C Campbell, *Letting Them Die, How HIV/AIDS Prevention Programmes Often Fail*, The International African Institute, 2003, 184.

16 Amatya Sen has described ill-health as a form of ?unfreedom?. However, as far as I know there is no research looking at actual levels of population morbidity, how many hours of avoidable labour this adds to the lives of carers, and what impact this has on human capacity to protest its condition etc.

17 In a chapter in xxxxx there evidence is provided to show how re-distributive economic policies have a positive outcome on health (See Sen et al). However, as I show in the next chapter of this article, campaigns for health sometimes also bring about economic and social redistributions.

18 South African economist Patrick Bond is a case in point. In 2003 he questioned TAC?s ability to compel the SA Government to introduce a national anti-retroviral treatment programme, something that happened later in the same year. In a mea culpa (Z Net Daily Commentaries, *Can Victory on AIDS Medicines Catalyse Wider Change?*, Dec 1 2003) he nonetheless concludes: ?Such socio-economic human rights can be won, in my view, only through deglobalisation, namely the delinking of countries and regions of the world from the bureaucratic straightjackets designed in Washington and Geneva-structural adjustment, TRIPs, etc-on behalf of corporate interests.?

19 The Presidency, Republic of South Africa, *Development Indicators Mid Term Review*, 2007, p 10.

20 See address by the Minister of Health to the SA Human Rights Commission, 30 May 2007. In response to a presentation made by the AIDS Law Project arguing that health budgeting is arbitrary and not based on a determination of health needs (see www.alp.org.za), she asks:

> ?do we need to get into an exercise, which will be very expensive and costly, of determining for all these areas and others the extent and the resource requirements of the backlogs, in order to determine needs based budget for the realisation of the rights in the Constitution??

She does not answer her own question.

21www.anc.og.za/show.php?doc=ancdocs/history/charter.html

22 L London, **Health and Human Rights: What Can Ten Years of Democracy in South Africa Tell Us?***Health and Human Rights, An International Journal*, Vol 8 no 1, January 2006.

23 ANC, Reconstruction and Development Programme, www.anc.org.za/rdp/rdp2#2.12

24 ANC, A National Health Plan for South Africa, May 1994, www.anc.org.za/ancdocs/policy/health.htm

25 Hassim A, Heywood M, Berger J, *Health and Democracy: A Guide to Human Rights, Health Law and Policy in Post-apartheid South Africa*, Siber Ink, 2007 available at www.alp.org.za

26 In an internal memorandum, May 2007, the Deputy Minister wrote of ?the urgent need to pay attention to the increasing burden of disease as well as poor health indicators, despite the growing investment in and resourcing of the health system. There is an increase in both communicable and non-communicable diseases and the demand for quality public health services remains significantly high.?

27 S Mngadi, Nozizwe: sublime or sub-prime? *Mail and Guardian*, 21 August 2007.

28 African National Congress, Policy Discussion Document, Social Transformation, 2007 www.anc.org.za .

29www.anc.org.za/ancdocs/history/conf/conference52/resolutions-f/html

30 See: Amnesty International, Human Rights for Human Dignity, A Primer on Economic, Social and Cultural Rights, 2006 www.amnesty.org

31*The Economist*, March 24, 2007.

32 See: A Neier, Social and Economic Rights: a Critique: www.wcl.american.edu/hrbrief/13/2**neier**.pdf. Neier claims that the socio-economic rights in the SA Constitution and Universal Declaration of Human rights ?get [us] into territory that is unmanageable through the judicial process and that intrudes fundamentally into an area where the democratic process ought to prevail.? But this claim entirely misses the dialectical relationship that should exist in a democracy between legal systems and politics. The two should be part of a continuum and a process for ensuring accountability.

33 Articles 2, 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) deal with duties of States to assist each other and the rights to ?adequate food? and the ?highest attainable standard of physical and mental heath? See: www.ohchr.org/english/law.index.htm

34 Hogerzeil, H et al, Is Access to Essential Medicines as Part of the Right to Health Enforceable Through the Courts, *The Lancet*, Vol 368 July 22, 2006 www.thelancet.com. These cases were in Argentina, Bolivia, Brazil, Columbia, Costa Rica, Ecuador, India, Nigeria, Panama, San Salvador, South Africa and Venezuela.

35 D Fidler,

36 O Aginam, Global Health Governance International Law and Public Health in a Divided World, University of Toronto Press, 2005, 36.

37 L Gostin, Z Lazzarini, Human Rights and Public Health in the AIDS Epidemic, Oxford University Press, 1997.

38 Gostin, L. Meeting the Survival Needs of the World?s Least Health People, A Proposed Model for Global Health Governance, *JAMA*, July 11 2007, Vol 289, 2, 225-228.

39 In an earlier draft of the same article Gostin says the following of the WHO:

> ?The WHO was founded in 1948 as a normative institution, but its potential has never been realized. The WHO constitution empowers the agency to adopt conventions, which unlike normal treaties affirmatively require states to take action within 18 months. The WHO also possesses quasi-legislative powers to adopt regulations. WHO regulations, unlike most international law, are binding on member states unless they proactively opt out. But despite WHO?s impressive normative powers, modern international health law is remarkably thin with only one significant regulation and one treaty advanced in its 60 years of existence.?

40 Constitution of the WHO.

41 G Gonsalves, private communication, 22 February 2008.

42 Gostin

43 Gostin, L. Why Rich Countries Should Care about the World?s Least Healthy People, *JAMA*, 2007 Vol 298:1, 89-92.

44 Office of the High Commissioner on Human Rights, The Nature of States Parties Obligations (Art 2, para 1)

CESCR General Comment 3, paragraph 14.

45 See Obinan, p39

46 In a chapter in a forthcoming book L Jacobs (*Between Cultural Relativism and Uniform International Compliance: An Empirical Framework for Judging China?s Human Rights Performance*) points out how whilst China now recognises rights it makes them non-justiciable: ?rights are not inherent to the human condition, but are rather specific benefits conferred and enforced at the discretion of the state.? In fact, China is extremely sensitive about human rights activism around health as witnessed in its prohibition of a meeting that was due to take place on HIV and law in August 2007 (China bans AIDS rights meeting, Group Says, *Reuters News*, 27 July 2007).

47 See for example the report of the International Bar Association (IBA) issued on Zimbabwe in November 2007.

48 General Comment 14 of the Committee on Economic, Social and Cultural Rights, ?The Right to the Highest Attainable Standard of Health?. Paragraph 12(a) states: 12.

> The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:
> (a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-relatedbuildings, trained medical and professional personnel receiving domestically competitive salaries,and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

49 See Memorandum of Understanding the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Republic of South Africa on the Reciprocal Educational Exchange of Health Care Concepts and Personnel, 2003. SA Ministry of Health press statement, 26 October 2007, ?EU Urged to Consider Ethics of Recruiting from developing countries?, www.doh.gov.za

50 See D Mcfarlane, Africa Staffs the West, *Mail and Guardian*, 28 October 2007, www.mg.co.za

- ?Nearly 235 000 professionals left South Africa between 1987 and 1997. Since 1997, the brain drain has cost the country $7,8-billion, according to the Paris-based Institute for Research and Development.
- Arabic African countries annually lose 50% of their doctors, 23% of engineers and 15% of scientists. Of all Arab students abroad, only 4,5% return home.
- About 80% of Ghana?s doctors leave the country within five years of graduation; and about 25% of all doctors trained in Africa work abroad.

51 U.S. Department of Health and Human Services. ?Projected Supply, Demand, and Shortages of Registered Nurses: 2000?2020.? Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, 2002, cited in: U.S. Based International Nurse Recruiters: Structure and Practices of a Burgeoning Industry, Report on Year I of the Project, International Recruitment of Nurses to the United States: Toward a Consensus on Ethical Standards of Practice, Produced by Academy Health with Support from the MacArthur Foundation, August 2007, available at www.

52 Gorik Ooms points out that there is some unanimity on the $ rate of per capita health spending at between $40 and $80. See G Ooms, Do We Need a World Health Insurance to Realise the Right to Health, Plos Medicine, xxxxx. He also points out that international health assistance was 0.03% of the combined GDP of OECD countries in 2006.

53 See for example UNAIDS/OHCHR, *Revised Guideline 6, the International Guidelines on HIV/AIDS and Human Rights*, 2002, which sets out state duties in relation to access to prevention and treatment technologies for HIV/AIDS.

54 For the application of human rights standards to non-state actors see: ?Human Rights and Intellectual Property?, Statement by the Committee on Economic, Social and Cultural Rights, 2001 available at: www. . Also, Commission on Human Rights, ?Economic, Social and Cultural Rights: Norms on the Responsibilities of Transnational Corporations and Other Business Enterprises with Regard to Human Rights?, 26 August 2003:

> ?Transnational corporations and other business enterprises shall respect economic, social and cultural rights as well as civil and political rights *and contribute to their realization*, in particular the rights to development, adequate food and drinking water, the highest attainable standard of physical and mental health, adequate housing, privacy, education, freedom of thought, conscience, and religion and freedom of opinion and expression, and shall *refrain from actions which obstruct or impede the realization* of those rights.? (my emphasis)

55www.who.int/tobbacco/framework/faq Frequently asked questions on the WHO FCTC and the Context in which it was negotiated

---