MEETING REPORT

Regional Review Meeting Health Equity and Human Rights: What role for Health Rights in EQUINET work?

Regional Network for Equity in Health in Southern Africa (EQUINET)
With University of Cape Town School of Public Health and Primary Health Care

Birchwood Conference Centre, Johannesburg, South Africa
November 25th 2003

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with support from IDRC (Canada)

Background

Although intuitively attractive, there are potential contradictions between public health approaches that prioritise equity, and views of human rights as individual entitlements or values associated with Western libertarian traditions. For these reasons, the Network on Equity in Health in Southern Africa (EQUINET) has identified the importance of developing a strategic approach to human rights, that offers a deeper and more nuanced approach to the relationship between equity and human rights than is presently evident in public debates.

As a result, EQUINET, in conjunction with the Health and Human Rights Division in the School of Public Health and Family Medicine at the University of Cape Town convened a workshop examining the role of human rights in promoting health equity at the Birchwood Conference Centre, Boksburg, South Africa on November 25th 2003.

The aim of the workshop was to develop a clearer conceptual framework on which to link human rights and health equity, and to explore the practical actions in terms of research, advocacy and policy interventions that would strengthen an equity agenda in health in the region.

The workshop was part of theme work initiated by EQUINET on health rights, the first phase of which commissioned research in 2002/2003 to explore the conceptual and practical links between human rights approaches and health equity. The research took the form of a literature review and framework development, linked to three case studies from Southern Africa. These case studies include the question of treatment access for HIV (Treatment Access Campaign, TAC, South Africa), Patient Rights Charters (Malawi, Zimbabwe and South Africa), and Civic Mobilisation around health (the Community Working Group on Health, CWGH, Zimbabwe). Lessons drawn from these cases studies formed part of a discussion document presented at the workshop, which was attended by 14 participants from civil society groups and researchers across the region (see Annexure 1).

The workshop provided an opportunity for civil society participants to collectively reflect on the proposed models, analyse its implications, and point directions for community agency in harnessing rights approaches to an equity agenda. The discussions therefore served as a review meeting for the research, as well as helping identify opportunities for advancing health equity in the region.

Workshop Format and Process

The workshop was structured around group and plenary discussions on presentation of material on human rights and the findings of the research (Annexure 2 contains the programme). Discussion was active and generated many useful ideas summarized below. Expectation expressed by participants

(Table 1 below) appeared to have been mostly well-met by the end of the workshop. Underlying all the comments was an expectation that the workshop would feed useful ideas into other Equinet processes taking place subsequent to the meeting.

Table 1. Participant Expectations

- Stronger argument for equity using human rights
- More practical sense of interface human rights-equity
- Greater collaboration human rights & equity activists
- Ideas for mass campaigns around health
- Understanding equity
- Deeper understanding of human rights
- Incorporate human rights into Patients' Charters
- Strengthen solidarity in region
- Networking - common goal

What are human rights?

Nomafrench Mbombo clarified the nature of human rights as being internationally agreed norms that embrace the range of civil and political, through to social and economic rights. These were codified in various international conventions in the period after the Second World War, when there was global consensus on the need for a human rights framework to prevent a recurrence of the atrocities committed during that war.

Although distinctions have been made which seek to distinguish rights on the basis of their implementability, such distinctions are incorrect and rather reflect ideological positions inherited from the Cold War. Once a country has signed and ratified an international human rights convention, it is legally bound to develop and test its legislation against the standards of the international convention. However, unlike international trade law, enforcement of international human rights law is relatively weak, relying mainly on international opprobrium ('name and shame'). Some conventions have provisions that allow individuals to lodge complaints with the UN Secretariat responsible for that convention. Shadow reporting by NGOs (where NGO's comment on the official report submitted by their national government to the responsible UN committee monitoring the convention) is an important tool for civil society to monitor the performance of governments in meeting their international human rights obligations.

Health itself is increasingly being recognized as a socio-economic right and the right to the highest attainable standard of health is contained in the International Covenant on Social, Economic and Cultural Rights (ICSECR). This right has

been more recently clarified by the Committee on Social, Economic and Cultural Rights, in its General Comment 14, where the committee explain what constitutes the mimimum core obligation of a state in meeting the right to health.

Participants in the workshop were asked to suggest how human rights can support health equity. Responses are listed below in Table 2.

Table 2. Participant views on how human rights can support health equity

- Global instruments (eg CRC) and national instruments (eg constitutions' Bill of Rights) can be used to press sorts and international bodies to meet their HR obligations. There are 2 prerequisites, however:
    - Mass mobilization/popular pressure/advocacy to raise awareness
    - Link explicitly to equity
- In a sense equity itself is a term wedded to Human rights principles. Human rights principles can be used to justify calls for equity.
- Rights can act as a pressure point and goal for social action to redistribute resources for health BUT can also be a way for middle class and higher income people to secure move resources for themselves.
- Human rights do not discriminate but treat everyone as equals. The promotion of human rights would therefore ensure equity in health. Inequity in health is a violation of human rights.
- Human rights can serve as a tool for promoting equity because:
    - All human beings are entitled to guaranteed basic rights
    - The guaranteed basic rights are of equal value irrespective of age, gender, race, social status and religion.
- Human rights [means we] must have coordinators at the hospital to check doctors from Casualties and the dispensary [to make sure] they are serving well.
- I understand human rights to mean that people should be treated equally and benefit equally from the resources of a country. Thus, if human rights are well understood and adopted as fundamental to life, it will ensure that all people have equal access to health.
- Human rights can serve to promote health equity by all people accessing national, regional and global resources equally.
- It can inspire us to strive for and demand health care for all as a right rather than a favour or accident of history.
- If human rights are observed, there will be equity in health because access to health will be achieved for all people especially the marginalized.
- Resource allocations to the health sector should be based on need (pro-poor) so that there is a balance between the have and the have-nots.
- I think we can do workshops so that we can have more information, patients must (save) [know their rights] well.

Many of the concerns expressed in Table 2 emerged in subsequent discussion on the case studies.

Human Rights and Health Equity – Case Studies

Leslie London then outlined the research conducted for Equinet, which explored some of the key tensions between public health and human rights approaches.

Public health approaches are undergoing increasing contestation around what constitutes the core of public health, particularly in the relationship between equity, effectiveness and efficiency. “Newer” conceptions of public health are increasingly calling for greater agency on the part of communities most affected by public health policy and practice, within a social justice framework, rather than relying on traditional technological responses to public health problems, often implemented through paternalistic state interventions.

Human rights approaches recognise power, social justice and anti-discrimination as key dimension of rights work, as well as the indivisibility of rights, and the place of health itself as a socio-economic right. Because human rights analyses have human dignity and anti-discrimination as their central focus, considerations of social justice and social patterning are core to what constitutes a human rights approach. Moreover, because provisions in international human rights law introduce the concept of progressive realisation as a mechanism to operationalise socio-economic rights, this establishes a key an arena for contestation of State policy by rights activists.

Human rights approaches therefore include four not entirely distinct usages, of which the first three may be considered to be more strictly ‘legalist’ approaches.

i. The use of human rights standards and norms to develop policy and programmes
ii. The use of human rights standards and norms to analyse and critique government performance, sometimes combined with a monitoring function
iii. The use of human rights standards and norms to facilitate redress for those who suffer violations of their rights
iv. The use of human rights standards and norms to support advocacy and civil society mobilization

Human rights have traditionally been framed as protecting the individual from an oppressive state. The tension between the best interests of the individual, and the public good, lie at the heart of public health practice particularly related to equity. However, careful analysis shows that international human rights law does actually address many elements of group rights, such as in provisions that recogonise peoples rights, autonomy and self-determination. As with the dispute over the indivisibility of rights, it is largely in the selective way that nations choose to focus on particular aspects of rights that human rights are seen to acquire a particular character as individualistic. Particularly in Africa, international human rights law, embodied in the African Charter on human and peoples’ rights, gives a high profile to the rights of peoples as a distinctive feature of its intention to “… reflect the African conception of human rights…”. Activists have increasingly

begun to grapple with conceptualising the ways in which rights frameworks can be extended to those groups deserving of the same protections afforded to individuals under international human rights law, as well as expanding the purview of human rights to bring accountability to supranational players and the private sector in a globalised environment.

Three case studies were outlined: treatment access for HIV (TAC, South Africa), use of Patient Rights Charters (Malawi, also briefly South Africa, Zimbabwe), and Civic Organising for Health (CWGH, Zimbabwe).

The main findings to emerge from the case studies are that when,

a) rights approaches are predicated upon casting rights in a group context, specifically vulnerable groups, and
b) the operationalisation of rights is conceived of in terms of agency on the part of those most affected, and
c) rights are conceived of as the complete spectrum of civil and political, through to socio-economic rights,

then human rights approaches appear to offer powerful tools to support social justice and institutional transformation. Public health concerns for equity then become entirely consonant with human rights-based strategies and tactics. The synergy between public health and human rights in relation to equity lie less in the setting and mechanisms for pursuing individual rights but rather in social processes and consciousness, and the interface with the state that secures collective rights.

However, the relationship between health equity and human rights is complex, and the role of community agency is particularly important for better understanding the equity-rights interface.

Seven key themes illustrating this interface emerge from the case studies:

- Rights alone are not enough, but need to be coupled with community engagement
- Rights, appropriately applied, can strengthen community engagement
- Rights, conceived in terms of agency, are the strongest guarantors of effective equity-promoting impacts
- Rights should strengthen the collective agency of the most vulnerable groups
- Rights approaches should aim to address the public-private divide in relation to Human Rights
- Information and Transparency are key to human rights approaches that build equity
- Human rights approaches provide additional opportunities for mobilising resources outside the health sector

Feedback on the Paper

Discussion on the paper started with comments relating to the case studies:

Zimbabwe (CWGH): Advocacy work in Zimbabwe started on Patient Rights, and health promotion (e.g. the slogan "if we can pay for guns and war, why can't we pay for health.") However, the CWGH and other health activists are increasingly being pushed to address abuse of civil and political rights, such as victims of violence being denied medical treatment. This has propelled the CWGH to work closely with other NGO's and human rights lawyers. Of course, this runs the risk of CWGH being labeled as partisan, especially in an environment where it is difficult to speak openly in rights terms. Moreover, where there is a systematic attempt to infiltrate progressive organizations, as in Zimbabwe, it is difficult to build strong alliances because of a lack of trust and openness.

Malawi: The MHEN experience was different in that it did not seek to identify alliances, or act upon recognizing the importance of developing partners in civil society. Instead, its focus was on working with parliamentarians. Yet, in retrospect, it is not clear how relevant it is to work with parliament and the executive? A sense was expressed that health activists may over-invest in parliamentary processes, or may fail to recognize that what may have been appropriate at that particular time may not always be the case. One should recognize the relationship to parliamentarians as a fluid, everchanging, dynamic interaction.

The success of the TAC case study illustrated the importance of how 'vulnerable groups' have to achieve alliances across the spectrum of society (i.e. with non-vulnerable, e.g. organized labour, researchers, parliamentarians, health professionals, etc). In the same way that the TAC has brought HIV positive and HIV negative into alliances, campaigns for basic services have to, for example, bring those who have access to water into alliance with those who do not. Secondly, one cannot take individual campaigns out of context, since they resonates with structures in communities. The diagrammatic framework outlining rights approaches and equity needs to incorporate the role of alliances and the linking of local and global issues.

Other points emerged in the discussion:

The dominance of donor agendas is evident in the region but we should not ignore the interest of local elites. For example, local politicians can use cultural rights to protect themselves, ostensibly claiming to respect Muslim traditions. An example was given of a commission set up to review Tanzanian law on marriage, which has failed to make any progress in advancing the position of women, seemingly because of a multiplicity of submissions from religious and cultural

groups. The question is whose voice is given precedence and why? The argument was made that human rights strategies should be used to create space for civil society to challenge policies locally by shifting governments' focus from their international allies (lending agencies) to local partners.

It was also suggested that rights approaches can be steered through regional structures (e.g. SADC) to bring pressure on member countries. The East African Parliamentary Alliance is unusual in that its policy positions are binding on member states, so engagement on Socio-economic rights would have significant implementability. A regional position (or even a South – South position) on Brain Drain, drawing on human rights obligations, could also help to promote a health equity agenda.

There are strong monitoring traditions (for example, in Zimbabwe) on civil and political rights, which could useful be extended to Socio-Economic Rights. Shadow reporting at national level could be linked to advocacy.

Some key challenges emerged in reflection on the material. Firstly, why is there such a focus on Human Rights at this present time? Civil Society groups are increasingly using rights discourses to increase accountability of government staff, yet it is possible that rights language is seen as less threatening to the powerful in society because it can be deployed in ways that legitimizes power. This is both a question for further research as well as a challenge for how we situate rights work.

Secondly, what is the underlying vision in human rights approaches of what it takes to produce health? Tensions may arise due to different understandings in the human rights movement. For example, curative emphases foster the biomedical model and move away from PHC. This remains a challenge for how we implement human rights approaches.

Thirdly, our conception of what constitutes a human rights approach needs to recognize that the "use of human rights standards and norms to support advocacy and civil society mobilization" should be the overarching element to our human rights work, rather than a 4th option in a spread of legal approaches. The example of the failure of the Grootboom decision to lead to any material benefits to affected community in terms of access to housing illustrates that the lack of an advocacy base for legal rights challenges is a huge weakness for pro-equity approaches.

Lastly, civil society movements are often small and fragmented and are themselves not immune to factionalism. The challenge is how to link 'single-issue campaigns' in a way that is mutually strengthening and which can serve a health equity objective.

Group Discussion:

Small group discussions focused on what kind of Rights work should be promoted.

Areas for activism identified by the groups included: Treatment Access; Food security activism (which would be specific to local context – for example, the South African situation is very different to that in Zimbabwe); Brain Drain and Human Resources (where there was a strong potential for alliances with health worker organizations; local, national and global dimensions; and opportunity to engage strategically with government); Global trade policy / GATS; Resource allocation (which strongly emphasizes Civil Society involvement in the formulation, implementation and monitoring of policies; Quality of care at facility level.

The kinds of rights that should be focused upon include rights to Health Services, rights of access to goods and services that promote Health (Public goods), and the politicization of health promoting services.

Human rights could facilitate mobilization by bringing out "real issues" that the current discourse is failing to put on the agenda. By stressing basic needs, identifying obstacles to fulfilling these needs and raising awareness and analysis on what is really happening, human rights approaches can help to fill a vacuum in the struggle for equity. Rights approaches need to focus in ways appropriate to local context (e.g. general rights in Zimbabwe and Zambia, socio-economic rights in South Africa, constitutional rights in Zambia) as well as building alliances for equity at local, national and global levels. Ultimately, rights are about harmonizing power relations between the state and citizens in ways that create the "space" for governments to take up their SER obligation to citizens, and balance Democratization and Liberalization as advocated by powerful lending agencies and developed economies.

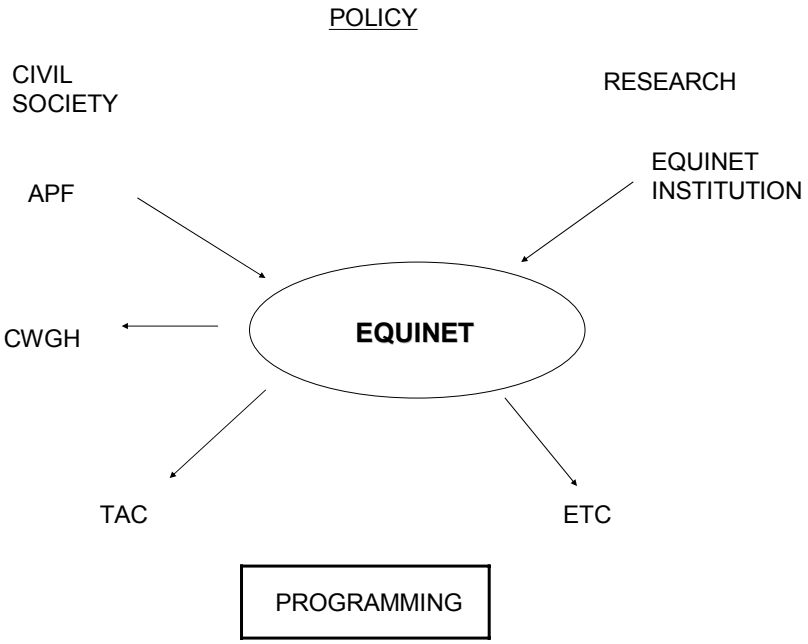
A process was needed to prioritise or focus, and Equinet should take its cue from the coming civil society meeting. Alliances should also draw in (not only civics) but also professionals, researchers and human rights activists.

In terms of research, areas identified include:

- Mapping commitments (e.g. Human Rights Conventions that have been signed / ratified) and their impact on the realisation of health as a right.
- Interaction HIV/AIDS and food security (Regional)

In summary, human rights have to be seen as rooted in struggle, and should be centred around SER

What is the relationship between research, civil society advocacy and policy? It was proposed that EQUINET act as a kind of node.



Way forward

The Overall Objective of work in this theme should be to facilitate increased awareness, advocacy & action towards realization of human rights in health.

Conceptual areas that could be usefully developed further include:

- Exploring more experiences of the rights / equity interface in other settings drawing on the EQUINET Network
- Ensuring that our networking emphasizes the full range/scope of rights
- Fleshing out the place of culture in SER analysis
- Exploring different forms of social and economic systems and their implications for the rights / equity interface.

Action and Research:

- Human rights analyses linked to equity offer opportunities for policy analysis and critique to engage policy makers. For example, EQUINET should bring to the attention of parliamentarians what the implications are of signing and ratifying International Conventions and Protocols (e.g. for realising SERs)

- What does this mean at regional level? Equinet should explore how, through networking, one could develop a regional position (on HR and health) that encourages space on the ground for civil society action.
- Research undertaken by Equinet should be participative with civil society to build civil society. Research could help in training and skills development for activists in civil society. For example, using modules from MPH to develop short courses which can involve activists in research in the field, and review. Oral testimonies (stories) are powerful tools, particularly for advocacy. Research should demonstrate successes combined with "hard" research.
- One example suggested would be to map the impact of trade agreements and contracts (e.g. IMF conditionalities) that prevent nation-states from fulfilling SER's such the right of access to health care. We could usefully explore the legal contradictions [Invite participation through Equinet newsletter]
- Within EQUINET we must look at ways of mentoring to build capacity. Networking opportunities and collaborative research activities are important opportunities for such capacity building.
- Research results should be disseminated through popularising the findings, making them accessible through appropriate materials for dissemination/education. Appropriateness is not just about language but about identifying with civil society what is useful to know and act upon (strategic information) and preparing materials in that way. For example, listing which countries have signed / ratified different conventions and what this implies for activists (how rights can facilitate demands for health equity).
- Ongoing networking and convening of forums is key to continuing this work. For example, EQUINET should host a workshop on Human Rights and Equity at its June 2004 meeting, and ensure a presentation at the International Society for Equity in Health (ISEqH) meeting, held back to back. Note also the PHASA and IHPA conference with the theme Challenging inequalities in health
- Human rights are powerful tools for mobilisation for health equity through awareness raising and mobilising a constituency. Therefore, rights approaches are attractive to strong advocacy groups (e.g. TAC) and could encourage them to engage in a shared agenda with EQUINET. ('bring the TACs to the table')
- Monitoring is a key element of action related to rights, and a strategy for monitoring SERs is particularly needed. Monitoring is also essential to enable a whistleblowing role. Links should be established with organisations doing SER monitoring (e.g. in Zimbabwe)
- Rights approaches also enable solidarity actions

APF raised the crisis at Chris Hani Baragwanath, and problems of patients being turned away from emergency services in the private sector. Equinet will facilitate links between PHM and APF to see if there are opportunities for support.

APPENDIX 1:

EQUINET - University of Cape Town

Network for Equity in Health in Southern Africa

Health Equity and Human Rights: What role for Health Rights in Equinet work?

Regional Review meeting: Birchwood Conference Centre, East Rand
Johannesburg, SA - Tuesday 25th November 2003

Programme

08h30 – 08h50	Welcome and introductions
08h50 – 09h10	Expectations and Exercise
09h10 – 09h30	What do we understand by human rights
09h30 - 10h15	Presentation: Case Studies and framework (LL) Questions of clarity (e.g. methodological issues)
10h15 – 10h35	TEA
10h35 – 11h15	Plenary discussion on the case studies and framework Discussants: TAC, CWGH, MHEN 1. How applicable is the framework? 2. What other lessons or themes are evident? 3. How do the examples match your experience? What in your experience is relevant?
11h15 – 12h00	Group work: Revisit the core question based on case material: How can Human Rights serve as a tool for equity? [What kind of rights work should we be pursuing?]
12h00 – 12h45	Report back and discussion
13h00 – 14h00	LUNCH
14h00 – 14h45	Group work: What follow up work needs to be done 1. What rights activism for equity (in what areas and with what targets? 2. What research and organizing of knowledge? (how and for what purpose? Both groups to address: ➢ What is already being done and by whom? ➢ What needs to be done? ➢ How does EQUINET add value to this work – through what tools, resources, inputs, co-ordination?
14h45 – 15h30	Report back and discussion
15h30 – 15h45	TEA
15h45 – 16h30	Plenary discussion on crosscutting issues: ➢ Strategic goals ➢ Regional support ➢ Co-ordinated and guided how? ➢ Linked how to other theme areas? ➢ Funded how? Way forward and closure

APPENDIX 2: Participants' List

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