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"Rights from below"?

Rights-based approaches in international health

Von Hilary Standing

Rights-based approaches are currently receiving a lot of emphasis in international health. There are several discourses of health and rights. Human rights and health is grounded in fundamental rights that inhere in the person as a human being and citizen, such as freedom from torture, slavery, gender discrimination, etc. These are a prerequisite to a healthy life, they are independent of governments and they cannot be abrogated by governments legitimately. 'Rights to health' are rights that entail claims to specific forms of care or treatment. As such, they are arguably context dependent and subject to the capacity of states to underwrite them.

Debates and approaches to health and rights at the macro level are generally cast in terms of rights formally given by constitutions or international law. From a demand side point of view, there is an equally important discourse of rights as situated in experience and gained and maintained through empowerment and struggle: that is, rights from below. In terms of health, examples of this kind of empowerment from below are to be found in the women's health movement (often focused on reproductive health and rights such as abortion), and in HIV/AIDS and disability rights advocacy. Such struggles are usually aimed at both access issues (interpreting access in its widest sense) and at broader citizenship claims, such as anti-discrimination. For these reasons, rights-based approaches are important. They frame health as a social justice/aspirational issue and provide a way of situating health in the context of the claims and entitlements of citizens to equal consideration and treatment on the basis of need.

Other demand side elements of a rights-based approach include:

- an empowering strategy for health that includes vulnerable and marginalised groups engaged as meaningful and active participants;
- a powerful authoritative basis for advocacy and cooperation with governments, international organisations, international financial institutions, and in building partnerships with relevant actors of civil society;

- a recognition that universal conceptions of needs, met through uniform social policies, fail to recognise the diversity of the poor. New approaches to social citizenship seek to link concepts of universal rights with recognition of diversity of needs in the delivery of social services.

In terms of actualising rights-based approaches in the health sector, there is practical convergence with agendas on accountability and participation, particularly those concerned with the voice and empowerment of users and advocacy groups.

Key challenges and implications

Some discussions of rights and health distinguish strongly between citizen-based rights and consumer-focused discourses. The basis for this distinction lies in a view of health as an entitlement rather than a set of market-based services and commodities. While citizenship entitlements unify, markets differentiate users according to their purchasing power. The implication of this is that consumer rights are a less supportable form of right as they do not have relevance to poor populations. The reality in many low and middleincome countries is of rampant marketisation that greatly affects poor people.

This suggests the need to revise this purist view of rights and see consumer-based movements as potential allies in the struggle for rights.

It is important to be aware of other discourses in health that have a bearing on rights but use different entry points. Equity is a key one, as in health it poses an interesting challenge to some formulations of rights. Given high levels of health inequalities and their well-attested link to poverty and social exclusion, health equity requires unequal treatment on the basis of need. An equity discourse is not averse to rights, but it does require rights to be specified in a way that does not elevate demand-based rights above needs. And needs require some objectively or collectively agreed standard by which they are to be judged. They cannot depend solely on pressure from below. A useful illustration of this is a study of priority setting in Ghana which found that strong pressure from middle class women (initiated by the President's wife) had resulted in the introduction of a breast cancer screening programme in urban areas. However, clinically, the far greater need was for screening and treatment services for cervical cancer, which was a disease primarily of poor rural women. But these women lacked advocates for their needs.

Rights-based approaches can be very contentious and external agencies have to consider how to position themselves. In some contexts, rights language is not necessarily the best entry point. Concepts such as 'participation', 'accountability' and 'responsiveness' can be less contentious ways of talking about the key elements of a rights-based approach.

Finally, working with rights does not mean actions only on the demand side. There are legitimate concerns about raising expectations that then cannot be met because of real resource constraints. Responsiveness requires equal attention to the supply side.

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Further reading on health equity and human rights: Paula Braveman and Sofia Gruskin, Health Equity and Human Rights: What's the Connection? in: Human Rights, Equity and Health. Proceedings from a Meeting of the Health Equity Network held at the London School of Economics. March 28th 2003. The Nuffield Trust 2004 (download available at: www.nuffieldtrust.org.uk/policy_themes/docs/hrehnov2004.pdf).

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