Human Rights and Global Health Funding: What Contribution Can the Right to Health Make to Sustaining and Extending International Assistance for Health?

Lisa Forman, Donald C. Cole, Gorik Ooms, and Merrick Zwarenstein

Global health funding has experienced dramatic growth over the past decades, rising to unprecedented levels through the 2000s. Since the onset of the 2008 global recession, funding growth has significantly slowed down and in some cases regressed. In this paper we argue that the right to health and a rights-based approach to health may offer important norms, strategies and tools to sustain, supplement, and advance global health funding and to thereby mitigate persisting inter- and intra-country health inequities. This paper interrogates this thesis through the legal framework of the right to health, the theoretical perspective of social constructivism, and practical strategies where human rights have contributed towards progressive health outcomes within countries and in global fora. While many new institutional global health funders are non-state actors and therefore weakly bound under international human rights law, the predominant source of funding still comes from states, which are the primary human rights duty-bearers under international law. Accordingly, we argue that states hold international responsibilities to cooperate and assist in realizing the right to health in low and middle income countries (LMICs) and that this duty extends to providing international assistance for health. We set out five paths by which use of the human right to health might directly and indirectly advance funding for health and health services at the domestic and global levels: including rights-based litigation, rights-based social advocacy, development of the ethical content of the right to health, use of rights-based approaches to monitor and promote the right to health, and developing a new legal paradigm of funding essential health services globally. We conclude that human rights and the right to health can offer important tools to health policy-makers and civil society actors alike to address inadequate resource allocations to health at various levels.

INTRODUCTION

The last decades have seen a sea change in political and institutional responses to global health, specifically focused on the "crisis" diseases of HIV/AIDS, tuberculosis (TB) and malaria predominantly affecting low and middle-income countries (LMIC). What is increasingly viewed as a 'revolution' in global health has been marked by greatly increased international health funding, new funding institutions and powerful new state and non-state actors focused on advancing health services in relation to priority diseases in LMICs. Even as recession-related cutbacks have seen slowing state contributions to global health, international assistance for health (IAH) remains at historically high levels. These changes in funding and institutional support have resulted in significant progress in the availability of infectious disease treatments in LMIC, particularly for HIV/AIDS, TB and malaria. Moreover, the focus of this funding is increasingly (albeit often still inadequately) shifting to other health issues such as maternal and child health, neglected and non-communicable diseases, health systems strengthening and universal health coverage.

Concurrently there have been important evolutions in human rights related to health, marked by the emergence of scholarship, research and practice seeking innovative approaches to realizing the human right to the enjoyment of the highest attainable standard of physical and mental health ("the right to health") given inadequate health and health care within countries and growing recognition of deleterious impacts of globalization. From the vantage point of both developments, we argue that the right to health and rights-based approaches to health offer important norms, strategies and tools for sustaining and advancing global health funding and mitigating persistent health inequities. The necessity and contribution of such norms, strategies and tools are underscored in the face of recession-related funding cuts that illustrate the evanescent nature of charity-based state commitments to global health funding. While we do not suggest that non-state actors such as the Global Fund against HIV/AIDS, Tuberculosis and Malaria (Global Fund) or Gates Foundation lack human rights responsibilities,[1] in this paper we focus exclusively on the obligations of states as both the primary providers of IAH and as primary duty bearers under international human rights law. In doing so we argue that high-income countries in a position to assist are obligated under the right to health to cooperate and assist in realizing the right to health in low and middle income countries (LMICs) and that this duty extends to providing IAH.

While states' international right to health responsibilities are weakly specified in international law, we suggest that this functional limitation can be remedied through human rights norms, strategies and tools. These latter include litigation, advocacy and rights-based approaches to health policy and programming (including rights-based indicators), as well as applying the right to health in defining international responsibilities to fund essential health services globally, for example through the prospective development of a Framework Convention on Global Health. Moreover we argue that while these strategies may achieve directly beneficial outcomes, they may also assist in advancing public recognition, adoption and internalization of the ethical imperatives underlying the right to health (including those applying internationally), which social constructivist theory asserts is key to ensuring long term compliance with human rights. Our focus on the duties of high-income countries is not intended to absolve low and middle-income countries of their primary responsibilities to realize the right to health domestically, nor to absolve the human rights responsibilities of key non-state actors such as the World Bank, Gates Foundation and Global Fund. Moreover, we do not ignore that global health funding can have deleterious impacts, including by enabling "cunning states" to bypass their domestic duties,[2] fostering a precarious dependency on aid for the provision of key population health interventions, and allowing providers of IAH to impose aid conditionalities such as social austerity, privatization and user fees, that have potentially damaging health impacts. Instead we suggest that for better or worse, IAH constitutes a key component of the capacity of low and middle income countries to realize the right to health, and, as such, attention to its focus, sustainability and impact continues to pose pressing human rights and global health dilemmas. This point is underscored in a 2010 World Health Organization (WHO) Report noting that only eight of forty nine low-income countries have "any chance of generating from domestic sources alone the funds required to meet the (Millennium Development Goals) by 2015."[3]

Our central thesis is grounded not simply in law and theory, but in the convictions borne of many of our professional experiences of effectively using rights to combat health inequities, particularly in relation to HIV/AIDS. This paper explores this thesis and associated strategies through the legal framework of the right to health, the theoretical perspective of social constructivism, and cogent practical examples where human rights have contributed towards progressive outcomes. As we acknowledge and respond to below, these views and experiences contrast somewhat with critiques of the right to health as weak, unenforceable, and

structurally limited in its failures to define a fair and just distribution of resources at global and domestic levels, and to elucidate clear and enforceable duties on the part of domestic and foreign governments and non-state actors regarding these allocations.

In investigating this proposition, the paper explores the genesis, progression and regression of the transformation in global health funding. We move on to explore the intertwined evolutions of global health and human rights scholarship and advances in the right to health, including through interpretation, enforcement and innovative rights-based methods. We locate these developments in relation to broader political, social and economic changes, and recent advances in relation to AIDS treatment. We also explore persistent challenges in inequities in both health status and funding; clarifying what a just distribution of global and domestic resources might look like. Finally, we assess the potential contribution of the right to health to addressing disparities in resource allocations. In doing so, we adopt the analytical framework of social constructivism to understand both the potential impact of these mechanisms and the strengths and limitations of right to health based approaches to global health.

TRANSFORMATIONS IN GLOBAL HEALTH FUNDING

Over the past 10-15 years, health status and health care in low and middle-income countries have received a tremendous increase in political attention from powerful states, international organisations and other global actors.[4] This shift has seen the creation of new institutional actors and new governance mechanisms, and involved a transformation in the priority of health in political and economic decision-making.[5] Global health concerns increasingly feature on the summit and agenda plans of leading political-economic fora, such as the Group of 8 (G8).[6] New global health actors have proliferated, including rising powers like China, influential inter-governmental organizations (IGOs) (e.g., World Trade Organization (WTO)), non-governmental organizations (NGOs) (e.g., Médecins Sans Frontières), and individual policy entrepreneurs (e.g., Stephen Lewis).[7] Unprecedented governance regimes of varying levels of enforceability have been established, including the 2003 WHO Framework Convention on Tobacco Control, the 2005 WHO International Health Regulations, and the 2001 Millennium Development Goals.[8] Global health governance has become a significant focus of academic scholarship,[9] including among policy and academic communities (such as foreign policy and trade) not previously interested in global health matters.[10]

These developments have been concomitant with significant conceptual shifts regarding the relevance of health to non-health related statecraft and concerns such as security and economic development.[11] The HIV and AIDS pandemic in high prevalence regions provoked concerns that entire societies and countries would be destabilized, facilitating civil unrest and war, decimating armed forces in Sub-Saharan Africa and potentially creating safe havens for terrorism.[12] In 2000 a UN Security Council resolution framed HIV/AIDS as a threat to global security, the first time health was considered in this way at the UN Security Council.[13] The failure of early structural adjustment approaches which mandated the slashing of health budgets to deliver better economies gave way to an understanding that health services are a social protection mechanism capable of preventing catastrophic financial losses that drive families in LMICs into poverty.[14] The idea that health services should appropriately be viewed as an economic investment developed from an early articulation in the 1993 World Development Report, to a broader elaboration in the 2001 report of the Commission on Macro-Economics and Health,[15] on to active debates in both high and middle income legislatures about health as a component of foreign aid.[16]

Broader recognition of the interconnections between health and other state interests began to be reflected in the emergence of health-related policy declarations from foreign policy and trade ministries, including the 2001 *Doha Declaration on Public Health* issued at a WTO Ministerial meeting,[17] and the 2007 *Oslo Ministerial Declaration on Global Health and Foreign Policy* issued by foreign ministers in Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.[18] Increasingly global health has come to be viewed as a core part of "smart power driven foreign policy," that considers improved healthcare key not simply to pandemic control, but to advancing the interconnected realms of development, diplomacy and defence.[19]

Perhaps the greatest transformation in attention to global health is evident in funding. While estimates vary widely, all suggest dramatic increases in IAH since 1990, which is estimated to have doubled, tripled and even quadrupled over this period.[20] Moreover these increases picked up considerable speed since 2001, with IAH doubling between 1990 and 2001, and doubling again between 2001 and 2007.[21] State funders, acting primarily through bilateral agencies, have been the primary drivers of these increases, and despite recession-related slow-downs and regressions in the past year, continue to be the principal contributors towards IAH growth.[22] The US led this trend through a major expansion in its IAH from 2002,

cumulatively contributing $51.94 billion between 1990 and 2008,[23] albeit this growth has slowed down significantly in the face of rising domestic unemployment, home foreclosures and national debt.[24] From 1990-2010, continental European countries contributed the second largest share of IAH, followed by the UK, Japan and Canada.[25]

This period also saw the creation of major new funding institutions including the Global Fund in 2002, and the US Government's *Presidential Emergency Plan for AIDS Relief* program (PEPFAR) in 2003; both of which assumed key roles in funding global health. By 2009, the Global Fund had approved around US$19.3 billion in 144 countries to support HIV/AIDS, TB and malaria prevention, treatment and care programs. PEPFAR has made the US Government the leading state provider of IAH, capturing both the perceived emergency nature of the devastation posed by HIV/AIDS and the need for relief, in both the classic post-war and Christian evangelical sense of charitable giving to those less fortunate.[26] With PEPFAR, the US Government committed an unprecedented US$15 billion over five years to AIDS treatment and prevention, subsequently increasing this amount to US$32 billion.[27] By 2009, PEPFAR reported that it had supported antiretroviral treatment for over 2.4 million people; prevention of mother-to-child transmission (PMTCT) programs allowing nearly 340,000 babies to be born HIV-free; and HIV counselling and testing for nearly 29 million people.[28] With calls to extend the generosity of PEPFAR and achieve even greater impact (Denny and Emanuel 2008),[29] the US Government's focus on HIV/AIDS has broadened beyond infectious disease funding, to more general global health funding: In 2009 the US Government announced the initiation of a Global Health Initiative (GHI) through which the United States proposed investing US$63 billion over six years to help partner countries improve health outcomes through strengthened health systems - with a particular focus on improving the health of women, newborns and children through programs including infectious disease, nutrition, maternal and child health, and safe water.[30]

Multiple additional institutions related to global health have been established, including the Stop TB Partnership in 2000, the Global Drug Facility in 2001, and the International Finance Facility for Immunization in 2006. New private institutional and non-governmental actors now account for an increasing share of global health funding, accounting in 2010 for almost one third of all IAH.[31] The *Bill and Melinda Gates Foundation* is the largest private funder, providing nearly sixty five percent of all private aid worldwide and almost four percent of all IAH in 2010.[32] Since its creation

in 1999, the Gates Foundation has disbursed more than US$13 billion,[33] with US$1.8 billion disbursed in 2008 alone.[34]

As the Global Fund and PEPFAR attest, global responses to HIV/AIDS account for a substantial portion of the global health funding boom.[35] HIV/AIDS funding has experienced explosive growth, increasing 25-fold from US$0.2 billion (3.4 percent of IAH) in 1990 to US$5.1 billion in 2007 (23.3 percent of IAH).[36] HIV/AIDS together with other infectious diseases received almost half of all global health funding, growing from 12.7 percent of IAH in 1993 to 49.1 percent in 2005.[37] TB and malaria funding have also increased, albeit nowhere near as dramatically as HIV/AIDS: tuberculosis funding grew from US$1 billion in 2002 to US$3.3 billion (3.2 percent of IAH) in 2008, and malaria funding grew from US$0.06 billion in 1998 to US$0.6 billion in 2008 (3.5 percent of IAH).[38] Malaria funding increased by almost 49 percent between 2008 and 2009; it reached nearly $2 billion in 2009.[39] Funding for maternal, newborn and child health has increased in light of MDG 4 and 5 to reduce child and maternal mortality rates by two thirds and three quarters by 2015, albeit that it fluctuated significantly between 2007 and 2009.[40]

Funding to strengthen health systems remains low despite all supportive rhetoric.[41] One funding study found that while virtually all global health actors claim to support health systems, they focus instead on disease-specific interventions or on system functions essential to implement their own programs, potentially undermining progress towards achieving effective and inclusive health systems.[42] While health systems funding has increased since the Paris Declaration on Aid Effectiveness in 2005, at 5 percent of total IAH in 2009 it is far smaller than funding for HIV/AIDS (25 percent) and maternal, infant and child health (16 percent).[43] Moreover, while non-communicable diseases represent 45 percent of the disease burden in low and middle-income countries, they received only 1 percent of total IAH in 2009.[44]

Since the global recession that began in 2008, global health funding growth has slowed significantly, from a growth rate of 17 percent between 2007 and 2008 to an annual rate of 4 percent growth each year from 2009 to 2011.[45] While this rate of growth appears consistent with research showing that global health funding has not reduced in previous recessions,[46] the aggregate slow-down masks regressions from almost every funding source in response to the European financial crises, looming US budget cuts and devastating cuts to funding channels like the Global Fund.[47] It is notable that a significant proportion of the 4 percent increase in IAH over the last two years is attributable to loans (rather than grants)

from the World Bank's International Bank for Reconstruction and Development (IBRD), which are primarily targeted towards economic stimulus in middle-income, rather than health improvement in low-income countries.[48] In contrast, loans to low-income countries from the World Bank's International Development Association have reduced since 2006.[49] The rate of slow-down is therefore even greater than these statistics attest, and as Ruckert and Labonte point out, raises significant equity concerns given the explicit reallocation of health funding by IBRD from low to middle income countries.[50]

Since 2008, several European countries have cut IAH including the Netherlands, Spain, Italy, Iceland, and Portugal,[51] while IAH has plateaued or slowed from governments like Canada, Sweden and Norway.[52] These cuts are in stark contrast to the UK's decision to increase IAH by 14 percent between 2010 and 2011.[53] The US decreased its funding to the Global Fund, PEPFAR (a 10 percent reduction between 2009 and 2010)[54] and the Global Health Initiative (a 3.4 percent reduction in a prospective US budget for 2013).[55] Since the Global Fund and PEPFAR are responsible for almost 70 percent of current antiretroviral access in LMIC (over 6 million people at present),[56] funding cut-backs to these channels may have particularly harmful health impacts.[57] Private channels of assistance have regressed more than any others, with IAH flowing through NGOs declined by 15 percent and 22 percent in 2009 and 2010 (albeit that it rebounded by 8 percent in 2010-11), while funding through the Gates Foundation declined by 16 percent ($529.33 million).[58]

The most serious funding regression has been in relation to the Global Fund, which in late 2011 cancelled its 2012 funding round after several Northern providers of IAH cut or dropped funding. In its place the Global Fund introduced limited transitional funding to prevent disruptions of essential prevention, treatment and/or care services in countries that cannot secure alternative sources of funding.[59] However, this funding can only be used to continue core interventions at the current scale, rather than to support scale up.[60] Moreover the Global Fund is uncertain about the extent of resources that will be available through this mechanism,[61] suggesting that funding interruptions or discontinuation are a real threat for many countries, with potentially devastating consequences for millions reliant on global funding for sustained access to antiretroviral, tuberculosis and malaria treatments.

The era of exceptional growth in IAH that began in 2002 appears to have ended, with growth patterns returning to historic levels (for example, the annual growth rate for IAH was 7 percent between 1990 and 1995, 6

percent between 1995 and 2000).[62] This peripatetic trajectory suggests the evanescent nature of state motivation to provide IAH, as well as the imperative to promote funding sustainability.

HEALTH AND HUMAN RIGHTS DEVELOPMENTS

Over a longer period, the right to health and related human rights have experienced their own coming of age through two transformative developments: First, the emergence of scholarship, research and practice exploring the relationship between health and human rights; second, the development of a considerably strengthened right to health in international law. Health and human rights scholars increasingly argue that these interconnected phenomena could aid the achievement of global health equity at national and global levels.[63] The following section overviews these developments, as well as tactical and theoretical ways of assessing the contribution of human rights to global health efforts.

Emergence of the Health and Human Rights Movement

The past two decades have seen the emergence of a global health and human rights movement, motivated in large part by the seminal scholarship of Jonathan Mann, an American public health expert who worked with the WHO Global AIDS Program in the 1980s. Mann argued that health and human rights are inextricably interconnected with substantial practical consequences, so that health policies, programs and practices impact on human rights, while human rights violations have health impacts.[64] Mann asserted that these relationships suggest that the promotion and protection of human rights and health are fundamentally linked. Mann's insights were driven by his work on HIV/AIDS which excavated consistent patterns showing that discrimination, marginalization, stigmatization, and a lack of respect for the human rights and dignity of individuals and groups heightened vulnerability to HIV exposure.[65] Drawing from these insights, Mann surmised that HIV/AIDS "may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity".[66]

Mann's hypothesis has generated a broader scholarly field exploring the synergies between health and human rights.[67] This scholarship is rooted in the recognition that public health is deeply affected by governmental successes or failures in realizing human rights, where the worst health

status often correlates with "dictatorship, civil conflict, corruption, malfeasance, and human rights violations".[68] The inherently political nature of public and global health points to its intrinsic relationship with human rights, which as Amartya Sen argues, are powerful determinants of action on these fronts.[69]

The linkages between global health and human rights are increasingly recognized outside this scholarly domain. For example, the 2008 WHO Commission on the Social Determinants of Health Report views the reparation of health inequities as a matter of social justice, seen not just as an ethical but human rights imperative rooted in legal protection of the right to health in international law.[70] The Commission argues that poor health and health inequities within and between countries are not "natural" phenomena, but rather the result of the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.[71]

On the one hand, human rights may offer the opportunity to hold state and other actors accountable for the inequitable social relations that produce health inequities.[72] On the other, people's abilities to access health care, education, work and adequate housing (and ergo to flourish) are directly addressed within the social rights protections in international law.

The Evolution of the Right to Health in International Law

Like other social rights, the right to health has been protected in international law since the inception of the UN. For example, the 1946 *Constitution of the World Health Organization* recognizes the enjoyment of the highest attainable standard of health as a fundamental right of every human being without distinction, and recognizes that governments are responsible "for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."[73] Similarly, the 1948 *Universal Declaration on Human Rights* recognizes every person's right to a standard of living adequate for their health and well-being, which includes medical care.[74] The most authoritative codification of this right is found in the 1966 *International Covenant on Economic, Social and Cultural Rights* (Social Rights Covenant), where state parties recognize everyone's right to the enjoyment of the highest attainable standard of health and agree to take a number of steps to achieve this.[75] Subsequently,

numerous other international instruments have protected rights to health for specific populations, including racial minorities, women, children, migrant workers, and people with disabilities.[76] In addition, each of the regional human rights systems contains treaties with health rights.[77]

Despite these legal protections, the right to health had little political or social impact until fairly recently. A major development came in 2000 when the UN Committee on Economic, Social and Cultural Rights issued General Comment 14, an extensive interpretation of this right. General Comment 14 significantly advanced clarity regarding the scope and content of the right to health, as well as the entitlements it confers on rights-holders and corresponding duties it places on states and the international community. The Comment gives workable content to the right to the highest attainable standard of health, defining this to not only include people's ability to access adequate, acceptable and good quality health care, but to also access the underlying determinants of health such as food, housing, access to water and adequate sanitation, safe working conditions and a healthy environment.[78]

Long-standing critiques of the concept of progressive realization argue that it allowed countries to violate health without limit, and created considerable confusion regarding when governments were violating rather than progressively realizing the right.[79] In contrast, in General Comment 14 the Committee interprets progressive realization as requiring states to take immediate action towards realizing this right, including by guaranteeing the non-discriminatory exercise of rights, and taking steps towards full realization, which are deliberate, concrete and targeted as clearly as possible towards meeting treaty obligations.[80] This means that while states can justify some health care deficiencies, they cannot justify the failure to work towards rectifying them.[81] Further guidance on state obligations is provided by the tripartite framework of duties to respect, protect and fulfil rights which impose a range of positive and negative duties on states to realize rights in various contexts.[82]

General Comment 14's most important conceptual contribution lies in its elaboration of the essential elements of the right to health and the corresponding core obligations they place on states. While the Committee recognized that the highest attainable standard of health and the system of health protection will vary from country to country according to resources, they held that these must contain certain essential elements irrespective of a country's developmental levels.[83] The committee defined the essential elements of the right to health to require health care facilities, goods and services and the underlying determinants of health which are available,

(physically and economically) accessible, acceptable and of good quality.[84] Allied to this idea, states are held to have core obligations which must be complied with irrespective of resources. The Committee defined these core duties to include ensuring non-discriminatory access to health facilities, goods and services; access to food, basic shelter, housing, sanitation and water; providing essential drugs as defined by WHO; ensuring equitable distribution of all health facilities, goods and services and adopting a national public health strategy and plan of action addressing the concerns of all.[85]

The prominence of the right to health within the UN was further boosted with the establishment in 2002 of a UN Special Rapporteur on everyone's right to the highest attainable standard of physical and mental health, since confirmed as a permanent post. The Special Rapporteur has sought to clarify and expand the interpretation of this right and to identify good practices at the community, national and international levels for operationalizing this right, including through country missions and other visits and communications with states and non-state actors regarding alleged violations.

At the same time, ratification of treaties containing health rights has grown to the extent that a majority of states have now ratified the Social Rights Covenant and other treaties containing health rights.[86] Allied to this development, a majority of domestic constitutions now entrench general health-related rights.[87] While ratification of treaties alone has necessarily limited outcomes,[88] the act nonetheless renders treaties domestically enforceable with important downstream legal consequences. Thus while states may wilfully or negligently ignore their duties under these treaties, civil society actors have become adept at approaching courts under the legal imprimatur of increasingly enforceable rights to health within international and domestic law. This outcome is evident in the exponential rise in right to health litigation globally over the last decade, where social actors have claimed access to health care (particularly medicines) on the basis of health rights within ratified international human rights treaties and domestic laws.[89] Notably, a hallmark of successful legal action is that the countries in question have both ratified the Social Rights Covenant and entrenched the right to health in its domestic constitution.[90]

In this context it is notable that state duties to realize the right to health in other countries are increasingly recognized within international law and scholarship. Duties of international cooperation and assistance are an integral part of international human rights law, first articulated in the UN Charter,[91] Universal Declaration of Human Rights,[92] and subsequent

international instruments.[93] These duties are entrenched in article 2 of the Social Rights Covenant, where state parties undertake to take steps individually and through "international assistance and cooperation, especially economic and technical" to realize Covenant rights.[94] This article seems to suggest both poorer states' obligations to take steps to realize rights through international assistance, as well as richer states' obligations to cooperate and assist. In General Comment 14, the Committee emphasizes that given international law on this topic, and the common concern to all countries of remedying gross health inequalities, that States parties to the Covenant should comply with their commitments to take joint and separate action to fully realize the right to health.[95] Accordingly, the Committee interprets what duties to respect, protect and fulfill mean in relation to international obligations. Thus, states must respect the right to health in other countries, and protect it by preventing third parties from violating it elsewhere if they can influence them by legal or political means.[96] In particular "depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, where possible and provide the necessary aid when required."[97] The Committee emphasizes that the international community has a collective responsibility to address disease, since some diseases are easily transmissible beyond state frontiers.[98] In this regard developed States have a special responsibility and interest in assisting poorer developing States.[99] The Committee emphasizes that "it is particularly incumbent on States parties and other actors in a position to assist to provide international assistance and cooperation to enable developing countries to fulfill their core and priority obligations identified in general comment 14.[100]

These duties hold particular relevance in the present context, albeit that their legal content and enforceability remains both controversial and unclear. In recognition of the need for interpretive clarity, a group of international law and human rights experts adopted a set of principles in 2011 recognizing the extraterritorial obligations of states towards economic, social and cultural rights.[101] The Maastricht Principles recognize that the realization of human rights is increasingly dependent on extraterritorial acts by states, particularly in the context of globalization. Accordingly, the principles hold that states have obligations to respect, protect and fulfil economic, social and cultural rights extraterritorially, including through creating an international enabling environment conducive to the fulfillment of such rights, and in which core obligations to realize minimum essential levels of such rights are prioritized.[102] The principles recognize in particular

that states in a position to do so, "must provide international assistance to contribute to the fulfillment of economic, social and cultural rights in other States," in a manner that prioritizes the rights of disadvantaged, marginalized and vulnerable populations and that prioritizes core obligations.[103] In this light we argue that government contributions to IAH and to institutions such as the Global Fund should be viewed as obligatory under the right to health. While we recognize that the realization of such duties remains subject to progressive realization within resources, and that accordingly, an economic recession can justify reduced assistance (particularly for countries experiencing serious economic recessions), given how short existing assistance falls of older international commitments to provide 0.7 percent of gross domestic product to international assistance, or 0.1 percent to health specifically, it is unlikely that many primary global funders can justify the extent of current cuts. Indeed, as Tobin suggests, the value of this otherwise weakly binding legal duty may lie in its ability to "require states to remain actively focused on, and accountable for, the measures by which they intend to give effect to their obligation to assist other states in light of their own resource constraints."[104]

POLITICS, AIDS AND NORMS CASCADES

The legal and political shifts described above are best understood in relation to broader historical trends and changes, particularly the end of the Cold War, the intensification of economic globalization, the communications revolution, and the growing influence of non-governmental organizations and social movements. [105] These broader changes have had significant implications for both global health and human rights: on the one hand they have created new health threats, including new infectious disease outbreaks, massive health personnel shortages from increased global migration, and reduced domestic policy autonomy on social spending from the ascendancy of neoliberal economics. On the other hand these transformations have greatly enhanced the capacity of non-state actors to bring social issues such as health into the global political arena, allowing global health issues to gain "political footholds within countries and in relations between them".[106]

In this regard it is worth noting the detrimental impacts of the Cold War on the international human rights system and the rhetorical use of human rights more generally. The ideological and geopolitical conflict of the Cold War effectively ensured that the 1948 Universal Declaration of Human Rights was not turned into a single human rights treaty as

originally planned, but split into the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights.[107] It took almost 30 years for these two treaties to become operational (in 1976), with the Committee on Economic, Social and Cultural Rights only created in 1985. The basic cornerstones of the international human rights law system were therefore not in place until shortly before the end of the Cold War, and the significant political, technological and social changes of the ensuing period. Certainly the Cold War shaped the UN system itself, which became a battleground for the competing superpowers, with human rights rhetoric used as a "subterfuge for advancing the realpolitik interests of East and West".[108] The relatively recent (and arguably ongoing) detangling of human rights from this geopolitical conflict and the consequently delayed development of the human rights system ensured that human rights only became a more broadly accepted rhetoric relatively recently. Yet equally apparent is that since that time, and despite obvious legal weaknesses and political abuses of human rights rhetoric, human rights have assumed an undeniably powerful legal and rhetorical significance: seen to have become the "dominant moral vocabulary of our time",[109] and the only political-moral idea that has received universal acceptance.[110] We suggest that the development of the right to health and indeed of the global health funding revolution is best understood alongside these broader legal, political and social shifts.

This linkage is particularly important given the political nature of the global health revolution and the growing force of human rights, exemplified in the global focus on HIV/AIDS and treatment access.[111] Why and how did HIV/AIDS, a traditionally stigmatized and marginalized disease, transform into "high politics" to become a central driver of the global health revolution? Grave as the global AIDS pandemic is, the global focus on HIV/AIDS was at least in part motivated by effective human rights-based advocacy by NGOs and social movements (see for example Table 1 below).[112] Treatment advocates successfully reframed the issue of inaccessible AIDS treatment from irremediable poverty to a gross human rights violation causally sustained by the unethical and unjust practices of leading state and private actors.[113] The impact of this advocacy was to create "a 'norm cascade' leading to immediate and structural changes not only in the market accessibility of life-saving drugs, but in the global understanding of questions of intellectual property and the application of appropriate norms for global health equity".[114] Indeed it is arguable that the drive towards AIDS treatment succeeded in concretizing notions of

international human rights responsibility as evidenced in the 2011 Maastricht Principles discussed above.

Why HIV/AIDS advocacy achieved this outcome may be best understood through the lens of social constructivist theories which understand interests and power to be less constituted by material facts than by ideas.[115] Social constructivists argue that ideational variables in conjunction with social movements are key factors in achieving political change, pointing to historical successes like the abolition of slavery and achievement of women's suffrage.[116] They argue that these experiences suggest processes whereby norms are advanced by norm entrepreneurs and transnational networks, leading to the emergence of new rules and their internalization as they are adopted as collective understandings.[117] From the perspective of social constructivist theory, the key activity of a global health policy community is ideational, through efforts to secure attention on particular issue areas by advancing truth claims about the issue in question.[118] This ideational component is increasingly well-recognized in relation to health: for example, the 2008 WHO Commission on the Social Determinants of Health recognizes that social norms are key structural drivers of global health inequity, in that that they may "tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources".[119] To the extent that norms sustain global health inequities, so too do they drive efforts to remedy these inequities. This ideational contribution alerts to a role that human rights and the right to health, in particular, could play in consolidating gains and remediating regressions in global health funding.

Box 1: US-Brazil World Trade Organization (WTO) Dispute

IMPACTS ON INEQUITIES BUT PERSISTING CHALLENGES

Against the backdrop of these changes, increased global health funding has produced variable improvements in global health inequities. Perhaps understandably, given the predominant focus of global health funding on HIV/AIDS, the greatest progress achieved has been in relation to HIV/AIDS treatment, which has increased from a few thousand people in 2000 in LMIC (well under one percent) to 6.65 million in 2011.[120] The increases have been tremendously rapid and have picked up increasing speed: a 10-fold increase over five years and a 36 percent increase in one year.[121] International funding has been responsible for progress in relation to other infectious diseases: by 2008, combined bilateral, GFATM and

United Nations efforts had decreased malaria-related deaths by fifty percent in key African and Asian countries (largely due to the dispersal of pesticide-treated mosquito nets and insecticide spraying campaigns).[122] Smear case detection for new tuberculosis cases had increased to more than sixty percent in 2006, and treatment success rates have improved to just below eighty five percent.[123]

Nonetheless, other key global health inequities demonstrate uneven and sometimes regressive outcomes.[124] While under five child mortality decreased from 13.5 million in 1980 to 9.7 million in 2005,[125] and life expectancy at birth increased by nine years globally (to 64.5 years in 2004), reversals were seen in some countries of the former Soviet Union, likely due to alcohol consumption, and in Africa, due to HIV/AIDS.[126] Most troubling has been limited reductions in maternal mortality, which decreased globally at less than one percent between 1990 and 2005,[127] a rate far below the 5.5 percent required to achieve Millennium Development Goal Five.[128] Since that time however there have been notable declines, with a 2011 study showing a reduction from 409 100 deaths in 1990 to 273 500 in 2011.[129] While recent gains are notable, the overall data nonetheless show a disturbing lack of progress for the second leading cause of death in adult women globally.[130] In many of the countries with the highest burden of maternal mortality, progress has reversed.[131] Furthermore, the impact of maternal mortality is highly differential between regions: While women in LMICs face a 1 in 16 lifetime risk of dying from pregnancy-related causes, this risk is only 1 in 4800 for women in high-income countries.[132] These disparities suggest both the remediable nature of the problem and the inequitable nature of its persistence.

While funding for child health and maternal mortality more than doubled in developing countries from 2003-2008, these increases only kept pace with increases in IAH.[133] Furthermore, these increases have not been equitably targeted, with IAH often not given to countries with the highest rates of maternal and child mortality.[134] Obstetric care, a major determinant of maternal mortality,[135] was simply not a priority of global health funders until very recently when Northern governments made grand announcements of forthcoming funding at a G8 meeting in June 2010.[136] Similarly, while a 2011 UN summit generated unprecedented political attention to non-communicable diseases, there is little parity between their health impacts in developing countries (at 45 percent overall disease burden) and their funding (1 percent of IAH in 2009).[137] Moreover, while health systems strengthening has become a significant component of international assistance rhetoric, IAH for health systems remains a small

component of all IAH, at 5 percent in 2009, compared to 25 percent for HIV/AIDS.[138] Certainly there are indications that growing HIV programs have assisted in strengthening national health systems: for example, a recent WHO, UNAIDS and UNICEF report indicates that integrating ARV therapy into existing public sector maternal and child health clinics in Lusaka, Zambia has doubled the proportion of eligible women receiving treatment.[139] Yet this impact may not fill the gap in funding health systems given the extent to which earlier aid conditionalities requiring reduced social expenditure in favour of the private sector have weakened health institutions in low and middle income countries.

Moreover, even where health conditions receive adequate funding, the nature and form of such interventions can also have unintended deleterious impacts. For example, a WHO lead team has teased out the uneven impacts of global health initiatives, including "steepening inequalities in health services, reduced quality of services because of pressures to meet targets … distraction of government officials from their overall responsibilities for health … and the increased burdens on already fragile health workforces".[140] Moreover, institutions such as the World Bank and International Monetary Fund (IMF) have historically imposed conditionalities for the receipt of health aid with potentially deleterious health impacts, including requirements of social austerity, privatization and health sector user fees. The distributive justice of aid is also somewhat misaligned with national health needs, since while overall aid distribution corresponds with disease burden, 11 of the 30 countries with the highest disease burdens do not appear among the 30 countries that receive the most IAH.[141] Moreover, while poor countries received more IAH than middle-income countries with the majority of funding going to Sub-Saharan African countries, some African countries received less aid than South American countries with lower disease burdens.[142]

At the same time, evidence suggests that IAH is 'crowding out' domestic health expenditure, with estimates that for every US$1 of IAH, government health expenditures from domestic resources were reduced by a range of between US$0.43 to US$1.14.[143] These figures underscore both the 'fungibility' of increased IAH and that overall aggregate increases in resources available for health have not been completely erased by domestic reductions.[144] There is also evidence to suggest that increases in IAH have been matched by increased domestic health spending, which varying estimates suggesting growth rates of between 88 percent and 120 percent between 1995 and 2006.[145] Domestic health spending has far exceeded IAH, especially amongst the poorest countries (with spending among all low-

income countries increasing 100 percent from US$9.03 billion in 1995 to US$18.07 billion in 2006).[146] In this light, the impact of movements in IAH to other sectors remains unclear: if these resources are being reallocated to other social sectors that determine health (such as housing, sanitation or agriculture), population health may still benefit. However there is not yet clear evidence to suggest that this is the case, nor that governments are not displacing health funding to finance sectors such as the military or industrial development.[147]

USING RIGHT TO HEALTH TO SUSTAIN AND ADVANCE GLOBAL HEALTH FUNDING

What contribution can the right to health and associated strategies make to motivating global health funding? While litigation clearly plays an important role in advancing health equity, its limited scope and intermittent incidence cannot provide a structural solution to the inadequate allocation of resources which often underlies health inequities at the national level, nor to the inadequate provision of health care services within these resources. Nor does it resolve the legal weakness of state duties to realize the right to health in foreign populations (arguably a key duty necessary to sustain and promote global health support). Indeed, it is precisely in these areas that human rights and the right to health are viewed as particularly weak.[148] General Comment 14 has little explicit guidance for states regarding resource allocations to health, specifying only that where a state is unwilling (rather than simply unable) to use the maximum of available resources to realize the right to health, it is in violation of this right.[149] Similarly the Committee suggests that insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health is a violation of this right.[150]

Yet while General Comment 14 has little explicit guidance on the macro-level extent of health allocations, its delineation of duties (both minimum core and otherwise), including the creation of a national health care plan sufficient to meet the needs of all, arguably demand allocations sufficient to meet these purposes. Moreover General Comment 14's definition of criteria to assess health systems and determine priorities may also guide such allocations as well as assist in exploring the impact of international health funding. General Comment 14 also attempts to consolidate the legality of international duties to realize the right to health, specifying a range of duties, including (depending on resource availability)

facilitating access to essential health facilities, goods and services in other countries where possible and providing the necessary aid when required.[151]

As an authoritative interpretation of the right to health, General Comment 14 may over time contribute to transforming the "soft" legal force of these duties into binding "hard" law. However, we argue that the transformative potential of the right to health lies in a set of distinct but mutually reinforcing paths that can contribute to increasing funding at the global level: namely, through supporting rights-based litigation and rights-based social advocacy, placing emphasis on the ethical as well as legal content of the right to health, using rights-based approaches to monitor and realize the right to health, and providing clarity on a new paradigm of funding for essential health services globally. We briefly outline each of these with examples, recognizing that fuller evaluation of each could benefit from more extensive human rights and public health law research.[152]

Rights-based Litigation

The significant increase in rights-based litigation for health care described above has often advanced equitable access to health care services as well as allocations to health. This impact is exemplified in South Africa where a social group successfully claimed access to drugs to prevent perinatal transmission of HIV/AIDS on the basis of international and domestic human rights protections, with the court order ultimately assuring the establishment of a national perinatal program.[153] Similarly successful litigation in India and Latin America illustrates how respect for and promotion of human rights can lead to improved access to health care as well as increased budgetary allocations to health.[154] Certainly litigation can be a double-edged sword in terms of achieving positive health outcomes, particularly if courts favour individual claims over collective interests.[155] Nonetheless, as the South African case described in Table 2 below indicates, a successful rights-claim need not pit individual interests against population health, and may in fact assist in reducing systematic disparities in health care access. While we do not suggest that national litigation can increase global health funding directly, social advocacy surrounding such cases can indirectly influence global funding by drawing public and political attention to particular health issues and ergo funding flows, as is discussed in relation to HIV and AIDS below.

Box 2: South African Minister of Health v. Treatment Action Campaign

Right to Health Based Social Advocacy

As the outcomes of the AIDS experience illustrate, rights-based social advocacy can achieve outcomes compliant with the right to health even where international law is most vague and unenforceable. Despite the legal weakness of international duties of assistance, major state actors have increasingly behaved in rights-compliant ways by significantly increasing their contributions to support HIV/AIDS treatment and other health services in foreign populations. These changes have been achieved through rights-based advocacy rather than litigation, underscoring the possible contribution of such strategies to advancing global health equity. Moreover these contributions appear to hold the capability to initiate a 'norm' or 'justice cascade':[156] the focus on HIV/AIDS appears to be extending to global health issues more generally, if the US government's transformation of PEPFAR into the Global Health Initiative is to be taken as a harbinger of broader changes to come. The power of social mobilization to actualize the right to health is evident when national authorities in countries usually less comfortable with arguing for human rights such as China encourage their populations to act upon their rights to health care through widespread publicity campaigns,[157] similar to those undertaken in Latin American countries on social accountability grounds.[158] This effect is illustrated in a 2011 study by London and Schneider showing that while parliamentary personnel in Sub-Saharan Africa have limited knowledge of General Comment 14, civil society submissions to parliament which used rights arguments have been very influential in subsequent decisions.[159] In this light, London and Schneider argue that rights "commitments can increase leverage for resources for the health sector within parliamentary processes and within cabinet negotiations."[160]

Box 3: Rights-based Citizen Monitoring of Health Services in Peru

Building the Ethical Content of the Right to Health

The AIDS treatment experience alerts to the utility of viewing human rights and the right to health as encompassing not just legal but also ethical claims. This distinction is made by leading health and social justice scholars who argue that the right to health holds both legal and ethical components which may work in conjunction to advance its realization.[161] Thus Amartya Sen argues that human rights like the right to health are more

appropriately seen as ethical claims which can motivate various outcomes including the formulation and implementation of legislation, enabling help from others, and motivating public agitation against rights violations.[162] Similarly, Jennifer Prah Ruger argues that the right to health involves an ethical demand for equity in health, which not only involves legal instruments for enforcement, but more importantly will require individuals, states, and non-state actors to internalize public ethical norms to implement and achieve compliance with a right to health in international human rights policy and law.[163]

Similar arguments have been made for the core social values associated with the advancement of public health.[164] The process of normative internalization is a key component of the social constructivist explanation of social change, which argues that significant political changes can be achieved through normative advocacy whereby norms are advanced by norm entrepreneurs and transnational networks, leading to the emergence of new rules and their internalization when they are adopted as collective understandings.[165] Once normative internalization occurs, compliance with the rights in question becomes a matter of course, rather than a topic of debate. In this view, achieving broad normative internalization of the right to health, including through rights-based approaches, would be necessary to ensure continued compliance beyond the immediate benefits of litigation or advocacy. We posit this social process as a key background condition for advancing the right to health and global funding generally, since growing public acceptance of an ethical commitment to fund health in other countries may strongly influence political action accordingly.

Rights-based Approaches to Health Policy and Programming

Scholars have argued for innovative methods of advancing the right to health, including rights-based approaches, tools and indicators which use human rights concepts and standards to guide policy and programs seeking health equity. Thus, rights-based approaches mandate the incorporation of core human rights principles like non-discrimination, participation and accountability, demand a focus on poor and marginalized, and require explicit reference to international human rights instruments. They have been adopted by a variety of UN institutions. An important study in 2008 proposed 72 rights-based indicators to guide both researchers and policy makers in achieving health equity, strengthening health systems and realizing the right to health.[166] Its authors suggest that in the same way that

the right to a fair trial has advanced a well-functioning court system, the right to health "can help to establish health systems that are reasonably equitable". [167] Significantly, eight of these indicators address national financing and international assistance and cooperation, including whether per capita government expenditure on health is greater than the minimum required for a basic effective public-health system, and indicators calling for comparisons between expenditures on health, military and debt servicing as percentages of gross domestic product.[168] Viewed from the perspective of international human rights law, the adoption of right to health based indicators offers to advance health equity within national health systems by integrating key concepts and standards of the right to health. Viewed from a social constructivist perspective, adopting these indicators offers to advance the process of normative internalization within domestic policy-makers of right to health language, concepts and standards, which may, in turn, lead to greater compliance with this right over time. Such tools also provide important support to social groups seeking to assure realization of the right to health and greater accountability by state actors including in relation to the restrictive impacts of globalization (see for example Tables 3 and 4). For example, Schrecker et al argue that using a human rights approach would enable policy-makers and social groups to assess policies by international agencies like World Bank and the IMF in light of the international assistance obligations specified in Article 2(1) of the Social Rights Covenant. [169] They argue that this section implies "an obligation on the part of shareholder governments, notably the G7 governments that hold close to an absolute majority of votes at both the World Bank and the IMF), to oppose Bank and IMF policies that might interfere with that realization." [170]

Box 4: The People's Health Movement's (PHM) Right to Health and Health Care Campaign (RTHHC)

Defining International Responsibilities to Fund Essential Health Services Globally

Novel approaches to global health financing have increased acceptance of the international obligation to (help) fulfil the right to health beyond borders.[171] The 2008 High Level Taskforce on Innovative International Financing for Health Systems recognized that universal coverage for health is a worthy goal and that the rights-based approach to

health is generally welcome Discussions within the Taskforce have shown, however, that this goal needs an internationally agreed-upon language and common mechanisms to measure progress agreed within countries.[172]

Development of internationally agreed upon language and common mechanisms have advanced by leaps and bounds through the institutional innovations associated with the global health funding revolution. Recession-related cutbacks underscore the importance and indeed necessity of formalizing the underlying shift from traditional emergency, relief and aid paradigms to one founded more firmly on the right to health. Building on General Comment 14 and existing scholarship pushing for a Framework Convention on Global Health, we envisage agreements where maximum available national resources are joined with appropriate international assistance on an ongoing basis to provide essential health services.[173] As we have described elsewhere, various models could be developed for countries of different means in order to maintain a floor below which all would agree that the right to health has not been realized.[174] Sharing the load for such a scheme among rich countries and responsible national authorities in low and middle income countries would be in keeping with their commitments to the Social Rights Covenant in ways that would be clearer for both groups of countries.

CONCLUSION

The now historic increases in global health funding demonstrate the tremendous potential for a myriad of forces to coalesce in making seismic shifts in resource allocations for health services in LMIC. Action on HIV/AIDS treatment demonstrated that human rights can punch well above their weight in the global arena, and offer potentially powerful tools to challenge those persisting health service inequities rooted in current political, economic, and health governance. We set out five paths by which use of the human right to health might advance funding for health services: rights-based litigation, continued rights-based social advocacy, emphasis on the ethical as well as legal content of the right to health, use of rights-based approaches to monitor and promote realization of the right to health, and clarity on a new paradigm of funding for essential health services globally. We suggest that further research on these approaches may offer important strategies for actors working towards the achievement of global health equity.

Lisa Forman is a human rights lawyer; Lupina assistant professor at the Dalla Lana School of Public Health at the University of Toronto in Toronto, Canada; and director of the Comparative Program on Health and Society at the Munk School of Global Affairs, University of Toronto.

Donald C. Cole is a public health and preventive medicine specialist engaged in research on agriculture, environments and health; he is an Associate Professor and Head, Global Health Division, Dalla Lana School of Public Health, University of Toronto.

Gorik Ooms is a human rights lawyer and doctor in medical sciences; researcher at the Institute of Tropical Medicine in Antwerp, Belgium; Hélène De Beir research fellow at the International Center for Reproductive Health of Ghent University, Belgium; and adjunct professor of law at Georgetown University in Washington D.C., U.S.A.

Merrick Zwarenstein is a health services researcher; senior scientist at the Sunnybrook Research Institute; an associate professor at the department of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario; and Professor, Dept of Family Medicine, Schulich School of Medicine and Dentistry, Western University, London, Ontario, Canada.

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Box 1: US-Brazil World Trade Organization (WTO) Dispute[175]

In 2001, the US lodged a complaint at the WTO against Brazil's intellectual property law for a provision that enabled compulsory licenses to be issued even without local working of the patent in Brazil. Human rights activists organized global demonstrations against the US WTO complaint against Brazil given their implications for the human rights and health of poor people in a developing country. This created a significant public backlash, turning the dispute into a public relations disaster for the US. The US withdrew its complaint, and reached a settlement with Brazil agreeing that the Brazilian clause in question could remain, as long as Brazil met certain pre-condition if it used the law.

Box 2: Minister of Health v. Treatment Action Campaign

In 2001 the Treatment Action Campaign (TAC), a South Africa treatment advocacy group, together with doctors working in the public sector and a children's rights NGO instituted legal action against the government for its delays and refusal to make Nevirapine, a drug to prevent mother to child transmission of HIV/AIDS (MTCT), available in the public sector. They argued that government's action breached the South African Constitution's right to access health care services as well as children's right to basic health services. The case came in the context of broader political controversy over President Mbeki's support for 'AIDS denialism' which disputes that HIV causes AIDS and views antiretroviral drugs as toxic agents that are themselves the real cause of AIDS related death. In July 2002 the South Africa Constitutional Court delivered a unanimous judgment in support of the TAC, finding that state policy violated the South Africa Constitution's rights to access health care services. The Court declared the government's responsibility to

devise and implement a comprehensive MTCT program.[176] As a result of this litigation, a national MTCT program was implemented which is today available in 95 percent of public facilities, and which is believed to have contributed to declines in child mortality (which had increased from 50 per 1000 live births in 1994 to 60 in 2005).[177]

Box 3: Rights-based citizen monitoring of health services in Peru[178]

In 2004 Care-Peru implemented a rights-based approach programme to improve the health of the poor, including particularly through improving the relationship between citizens and the state, and by assuring greater accountability on the part of health care workers. The program resulted in the creation of a variety of strategies to achieve these outcomes, including in particular the strengthening of citizen monitoring of health services in the Piura and Puno regions. A national NGO (Forasalud), the Regional Ombudsman's Office, and networks of community Quechua and Aymara women created a strategic alliance, whereby 47 women were selected in order to monitor local health authorities and ensure that the health rights of local populations, including women and Quechua people, are realized. The monitoring is reported to have resulted in a "distinct improvement in the quality of health service provision.

Box 4: The People's Health Movement's (PHM) Right to Health and Health Care Campaign (RTHHC)

PHM is a multi-regional mobilization effort which brings together activists, professionals, civil society representatives and citizen representatives to advance the health especially of the poor and the marginalized who are negatively affected by the current global economic and geographical order. The PHM has embarked upon a global Right to Health and Healthcare campaign (RTHHC) aiming to produce a 'Global Action Plan on the Right to Health Care' to show how quality essential health care services could be made available universally. PHM will use a consultative process in 40 countries to produce rights-based evaluations of national health policies in countries with PHM circles. These evaluations will be produced according to the "Assessment of the Right to Health at the Country Level: A People's Health Movement Guide" to ensure that activists produce consistent reports using international human rights law. This process will generate lobbying/activist strategies for use on the national and international level.

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