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THE CATALYTIC SYNERGY OF HEALTH AND HUMAN RIGHTS: THE PEOPLE'S HEALTH MOVEMENT AND THE RIGHT TO HEALTH AND HEALTH CARE CAMPAIGN

Laura Turiano and Lanny Smith

The move from *many* to *everyone* is a small semantic shift, but one with extraordinarily radical consequences.

– Hardt and Negri, *Multitude: War and Democracy in the Age of Empire*[1]

ABSTRACT

The People's Health Movement (PHM) is a global network at the intersection of many health and human rights organizations that has articulated and attempted to put into practice a human rights-based approach to improving health, organizing particularly in the area of economic, social, and cultural rights. PHM's approach to human rights and its Right to Health and Health Care Campaign (RTHHCC), the focus of this article, are responses influenced by several concerns: the failure to implement the primary health care strategy defined in the Alma Ata declaration, the discipline of social medicine, and the application of human rights methods to local health problems and to organizational practice. Through PHM, a global network of activists is renewing the concept of citizenship and creating new forms of direct democratic social organization.

INTRODUCTION

Since the founding of *Health and Human Rights* over a decade ago, organizations and institutions within almost every sector have adopted human rights-based approaches, with particular growth in the area of economic, social and cultural rights (ESCR).[2] Those in the health sector have been among the most supportive of these efforts, due in large part to the work of Jonathan Mann, the founding editor of this journal, and because of the centrality of health to all human rights. The People's Health Movement (PHM), a global network at the intersection of many health and human rights organizations, has articulated and attempted to put into practice a critique of mainstream human rights approaches.[3] The PHM perspective on human rights has been shaped by lessons learned in the struggle for health. The failure to implement the primary health care strategy defined in the Alma Ata declaration, the discipline of social medicine, and the application of human rights methods to local health problems and to organizational practice are among the influences that inform PHM's approach to human rights and its Right to Health and Health Care Campaign.

PHM was founded during the first People's Health Assembly (PHA) at *Gonoshathaya Kendra* (People's Health Center) in Savaar, Bangladesh, in December 2000. The year-long preparatory process for the Assembly included distribution of papers on the Internet and meetings worldwide organized by eight large activist organizations and NGO networks, from

which delegates were elected and selected.[4] About 1,500 persons from 76 countries attended, including health workers, scientists, activists, academics, and NGO workers. Central themes included "Health for ALL," "to hear the unheard," and "the right to health." Testimonies by community health workers and community members introduced all of the scientific sessions. The World Bank was put on trial with invited representative Richard Skolnik in the hot seat to defend the Bank's policies of structural adjustment, spending caps for health care professionals, dam building, and their impacts on health. Official representation from the World Health Organization (WHO) was conspicuously absent, despite an invitation. At the close of the PHA, delegates voted to form the People's Health Movement, and unanimously endorsed the People's Charter for Health ("the Charter"), a previously drafted document that was finalized during the Assembly.[5] The Charter has since become the most widely endorsed consensus document on health since the Alma Ata Declaration.[6]

PHM is not an organization in the traditional sense, but a network within the growing global movement of groups that are working on health-related issues, for health systems that work, and to redress inequities in access and power that affect health. The PHA was an expression of this movement, and the shared vision of the People's Charter for Health forms the basis of the supportive relationships and coordinated action of the PHM. Most groups join PHM by endorsing the Charter. The organizational structures of PHM serve as a hub for communication, coordination, movement building, and advocacy activities to support the global movement, but PHM does not control the actions of any of the affiliated organizations.[7]

By their individual and collective actions, the organizations connected to PHM have succeeded in putting primary health care back on the agenda of development organizations and multilateral institutions. It has done this, in part, through "PHM Circles" in which member organizations have led research and advocacy-based efforts to revitalize primary health care.[8] They have developed and used tools to monitor the state of health and the right to health on multiple levels. In global debates about health systems, access to medicines, the crisis in the health care workforce, and health equity, PHM has consistently advocated for human rights standards, for meaningful community participation in their health services, and for the favoring of people's health over corporate profits.[9] The core of the PHM vision — equity, sustainable development, and peace — has put PHM at the forefront of issues that have recently become more urgent: that is, the increasing inequity in the distribution of the benefits of global economic growth and the ecological crises that are the consequence of that growth.

The global health movement's "shared sense of direction and collective consciousness" has emerged as people's organizations everywhere confront the same global economic regime that undermines the sovereignty of existing nation states and produces similar patterns of increasing socio-economic inequality that have a negative impact on health.[10] This inequality and social insecurity is promoted by increasing corporate control over areas of life that had been previously managed outside of corporate, profit-maximizing structures either by traditional community systems (such as seed saving and sharing) or by the state (such as national health and education systems).[11]

THE RIGHT TO HEALTH AND HEALTH CARE CAMPAIGN

PHM's Right to Health and Health Care Campaign (RTHHCC), launched in 2005, attempts to build on and link these diverse efforts. It does this by uniting activists as they make demands at local, national, and international levels, and as they seek to implement innovative strategies for making the right to health real. Groups that apply human rights-based approaches (HRBA) to health contribute their different projects and skills to the process framework provided by PHM's RTHHCC, so that participation does not require drastically changing what a group is already doing. The framework does, however, require the inclusion of individuals and groups affected by human rights violations; collaboration to develop new and effective ways of using the right to health to improve lives (such as new methods of accountability); and finally, contributing these experiences to the development of international strategies that reinforce national movements' demands. Ultimately the RTHHCC seeks to demonstrate how quality health services can be made available to everyone equitably.

BUILDING ON THE RIGHT TO HEALTH CARE CAMPAIGN IN INDIA

The RTHHCC is an outgrowth of the national Right to Health Care Campaign of PHM-India (*Jan*

Swasthya Abhiyan or JSA) that was launched in 2003 and is ongoing.[12] JSA pioneered the strategic use of a right to health and health care framework to fight deterioration of the Indian public health system.[13] The Campaign developed procedures to record "individual denial of health services" and to demonstrate "structural denial" of health care. Ordinary people and local activists — with some orientation and simple tools — have documented the denial of services, audited health facilities, and monitored implementation of health system reforms. Standard checklist forms were developed to facilitate inspections of the infrastructure and services of primary and community health centers.[14] The documented cases of denial of health care were presented to panels of "pro-people" experts at People's Health Tribunals held before public audiences of up to 1,000 people. Organizers connected public events to ongoing grassroots activities in a unified, well-planned campaign that empowered the "witnesses" and strategically engaged public health structures.

The documentation from the People's Health Tribunals was presented to the Indian National Human Rights Commission (NHRC). The NHRC then collaborated with JSA on a series of regional hearings, leading to a National Public Hearing on Right to Health Care on December 16–17, 2004.[15] Officials present at the public hearing included the Central Health Minister, Health Secretaries or senior health officials from 22 states, the NHRC chairperson and officials, as well as more than 100 JSA delegates selected from over 20 states. JSA representatives made presentations on the scale, depth and range of health rights violations. These included five regional overviews, specific reports on groups facing a high incidence of health rights violations, and a national analysis highlighting the structural and systemic nature of these violations. The hearing concluded with the declaration of a National Action Plan to Operationalise the Right to Health — jointly drafted by the NHRC and JSA. It recommended enacting a National Public Health Services Act that recognizes the health rights of all citizens, a Clinical Establishments Regulation Act related to the private medical sector, and a Health Services Regulatory Authority. It also recommended increasing the health budget to three percent of the GDP and establishing Health Services Monitoring Committees with civil society participation. This Action Plan represents a significant step forward in the recognition of the right to health care at the national level.

More recently, civil society organizations, mostly from JSA, are involved in community planning and monitoring of health services as part of the official National Rural Health Mission (NRHM). Here, a range of health care-related issues are expected to come up directly from communities in more than 1,500 villages, across 35 districts in nine states of the country.[16]

The Indian Right to Health Care Campaign has taken advantage of opportunities existing at a particular political moment, such as support from the National Human Rights Commission, in order to impact policy. The Campaign engaged multiple points in the policy process — problem identification, policy creation, and implementation — applying standards of the right to health at all stages. National activists also stayed engaged with local community partners whose on-the-ground documentation, paired with statistics from a variety of sources, produced a compelling body of evidence for claims of systemic human rights violations. These strategies have been promoted by the RTHHCC and are shared by other successful national campaigns. It is worth noting that similar strategies have emerged independently in other countries. In the examples that follow, these national campaigns were already underway before linking to the global RTHHCC.

NATIONAL CAMPAIGNS IN URUGUAY AND PARAGUAY

In Uruguay, over the past two years a coalition of groups that include health service users, women's organizations, health professionals, and the Latin American Association of Social Medicine (ALAMES) held a series of public events around the country introducing the concepts of the right to health. Discussion topics included: the RTHHCC, environment and health, sexual and reproductive health, and the new government's health system reform. At the end of this process in 2007, a consensus statement emerged that detailed key challenges for the government on health system reform and declared the need for civil society to participate in the construction of a healthier nation based on the right to health. Participants emphasized the importance of an open government, an active citizenry, and attention to the social determinants of health by the health care system and other government sectors. The principles emerging from these meetings will be the basis for a strategy to influence the nation's health system reform.[17]

The National Movement for the Defense of the Right to Health (NMDRH) in Paraguay, a nationwide coalition of more than 50 organizations that have been working together for several years, has also launched a right to health campaign. One element of the campaign is *Carpas de la Vida* or "Tents of Life." NMDRH activists set up tents in front of health care facilities with information about the right to health and an "open microphone" for people to speak about their experiences. The Tents of Life take place in the context of NMDRH's involvement with *Paraguay Sin Excusas Contra la Pobreza* (Paraguay – Against Poverty Without Excuses), a multi-organizational platform that demands implementation of all economic, social, and cultural rights.

Inside the tents, health facility users are presented with information on the services that should be available by law. Paraguay's constitution guarantees the right to health and health care, but facilities often lack equipment, fail to provide key services, and are not clean. Furthermore, basic services are supposed to be free, but charges are frequently levied that prevent access. In order to document compliance — or non-compliance — with government policy, service users provide information about their experience in the facility. The public attention garnered by the campaign has forced facility administrators to address some of the identified problems.

THE THREE PHASES OF THE RTHHCC

The global RTHHCC consists of three phases, the first of which involves grassroots organizations carrying out rights-based assessments of national health policies. To support these efforts — and in order to allow comparability and to begin to unify activities undertaken in each country — the RTHHCC has developed an Assessment Guide to apply the human rights framework to information gathered by campaign participants. This RTHHCC Assessment Guide leads users through a five-step process to determine if violations of the right to health are occurring systemically. The five steps provide a legal framework, with the goal of documenting legitimate evidence for the claims the RTHHCC can make about the state of the right to health.[18] Presented in the form of questions, the steps are: 1) What are your government's commitments? 2) Are your government's policies appropriate to fulfil these obligations? 3) Is the health system of your country adequately implementing interventions to realize the right to health and health care for all? 4) Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care? 5) What does the denial or fulfilment of the right to health in your country mean in practice?

The Assessment Guide process makes it possible for users to construct comparable descriptions of health system issues and to identify human rights violations with supporting evidence. This enables local and national committees to develop focused strategies to address violations through policy advocacy or other forms of activism. After completing the assessments, results are presented at national strategy sessions where campaign participants make plans to tackle the most important violations.

Using the Assessment Guide enables participants in the RTHHCC to develop an understanding of what the right to health actually means. Human rights-based analyses of problems cannot remain exercises carried out by intellectuals for academic publication, but must become a strategic tool to be used by grassroots activists and people affected by problems in the health system. Only when such vulnerable groups know and claim their rights will the right to health be realized. For example, in the US it was the efforts of Black and Latino rights groups — most notably the Black Panthers and the Young Lords in the 1960s — that finally led to the social changes necessary to get lead out of paint and (most) other products long after its health effects were well known.[19] The activism of people living with HIV/AIDS — through groups like ACT UP, Treatment Action Campaign, and others— was the lever that made increased HIV medication access a reality in the US and in South Africa and helped increase awareness of global inequity in HIV treatment and prevention, despite other diseases killing more people, even more children.[20]

The RTHHCC Assessment Guide gets participants beyond the use of the "right to health" or "health care" as a slogan. Currently, groups commonly claim human rights violations without documenting them properly. For example, just because a person says s/he wasn't well-served by a health care facility does not mean that a human rights violation has occurred. Furthermore, discrimination against a group cannot be proven from the charges of just a few members of that group. These are the risks of collecting individual testimonies without further documentation of actual impacts on health status or the compilation of

incidents to demonstrate a pattern. The point is to show that there are systemic problems, not just mistakes or a few "bad apples."

The RTHHCC Assessment Guide specifically deals with critical, globally prevalent health system issues — privatization, inequity, and lack of access — using the rights-based framework. Within PHM's broad perspective and range of activities, the RTHHCC focuses on (but is not limited to) strengthening the right to health care. PHM and campaign activists at all levels have spent many hours debating how to conduct a campaign on a theme as all-encompassing as the right to health; indeed the power of the "right to health" comes from its universality and connection to multiple struggles. However, political campaigns require targets and goals. This tension has been partially addressed by leaving key decisions on campaign tactics in the hands of country committees. Committees may choose to focus primarily on the right to health care or they may decide to tackle other key determinants of health using the same five-step evaluation process.

The PHM vision of primary care also aims to at least partially resolve the question of "health vs. health care." Like the Alma Ata Declaration, it encompasses preventive, curative, and rehabilitative health services; health promotion and protection services (e.g., nutrition, quality drinking water and sanitation, and health education); and community participation in the health system. While PHM strives to promote the entire range of determinants of health through various activities, it is not feasible — or necessary — to launch a single global campaign on all health determinants. Global and national efforts on the rights to water, education, housing, food, and against racism are already under way, led by other organizations. PHM, as a whole, supports all these parallel and complementary efforts and actively engages with them at various levels.

In the second of the three phases of the RTHHCC campaign, participants in the national assessments will be linked in a global mobilization around the right to health, with the aim of producing a "nutcracker effect" of bottom up and top down action.[21] In a series of regional assemblies, the participating country PHM Circles, and regional and global strategic allies, will meet to: a) share results of assessments and action plans; b) facilitate a dialogue between PHM and partners with national health policy makers on the implementation of health rights-based changes in the health system; and c) make recommendations for how PHM as a global movement should support national demands for compliance with right to health and health care commitments. It can be expected that national level groups will have developed new and creative ideas and strategies. PHM has promoted regional collaboration in all its activities; these assemblies will build upon existing solidarity relationships. The outcomes of these meetings could include action to intercede with WHO and/or other multilateral institutions, to hold accountable multinational corporations whose activities have a negative effect on health, or other forms of international grassroots solidarity activism.

The third phase of the campaign will be to mobilise for the implementation of these plans, for universal recognition of the right to health, and the legitimization of actions to respect, protect, and fulfill it.

At present, approximately twenty national committees are in formation or already working on country level evaluations and other campaign activities. Countries in which these committees work include Guatemala, Brazil, Uruguay, Paraguay, Ecuador, South Africa, Benin, Togo, Congo, Democratic Republic of the Congo, Cameroon, Gabon, Egypt, Morocco, Burkina Faso, Bangladesh, the United States, and India. Any organization or person that supports the right to health is invited to participate.

A GLOBAL RIGHT TO HEALTH MOVEMENT IS A STRATEGIC KEY TO THE REALIZATION OF ALL HUMAN RIGHTS

The promotion of the right to health in a global campaign is critical at this time. Health has certain advantages as a path toward understanding human rights' full implications. The right to health is central to the enjoyment of all other rights because their fulfilment is necessary for the attainment of the highest possible standard of health, a clear example of the indivisibility of rights. The right to health is a bridge that can unite social movements because most social justice struggles sooner or later turn to health arguments in order to justify their claims. Health arguments possess a universal appeal in that everyone has been or could become sick, but these arguments also come with a well-developed scientific base of evidence through which the impacts of policies can be evaluated and influenced. Placing health at the center of policy considerations intrinsically counters

the philosophical underpinnings of neoliberal ideas on government and social relations. PHM in general, and the RTHHCC in particular, seek to capitalize on these advantages and the strategic opportunities they present.

Health indicators are the same for every person and population, whereas other human rights may be more particular to local contexts. What constitutes adequate and dignified housing in the Arctic is not the same as in the tropics. Health also is a key indicator of comparative development: not "development" as defined by the current global regime — i.e. development as economic growth — but development as the creation of systems of human organization that foster the well-being, dignity, and potential of every person. Health is a measurable and universal outcome of many social factors, making it key to any improvement in the definition of the poverty line. The current $1-a-day standard is, for both ethical and technical reasons, completely inaccurate and inadequate, and thus unacceptable.[22] In the battle of ideas over government roles and forms of governance that underlie most major policy debates on health, the right to health implies that a fundamental purpose of government is to promote the highest attainable well-being for all.[23]

In 2000, the Office of the High Commission on Human Rights explicitly stated, in General Comment 14 of the International Covenant on Economic Social and Cultural Rights, that, "the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extends to the underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment."[24] Eight years later, the work of the World Health Organization's Commission on the Social Determinants of Health (CSDH) has left little doubt that every government and all government agencies must consider the health impacts of their policies in order to improve health disparities.[25] In the report of its Measurement and Evidence Knowledge Network, the CSDH also points out that "while the general relationship between social factors and health is well established, the relationship is not precisely understood in causal terms…although the precise causal pathways are not yet fully understood, enough is known in many areas, and the evidence is good enough, for us to take effective action."[26]

There is underutilized potential in the human rights framework for managing conflict between claim holders and duty bearers, such as between an industry and the community in which it is located. Placing health at the center of development means balancing economic and environmental factors to maximize well-being and provides a standard for decision-making when the rights of different groups conflict. Rather than focus on punishment of wrongdoing, the focus is on increasing the capacity of the parties to fulfill their duties to claim holders. Human rights are not anti-business or anti-economic vitality. People need a sustainable livelihood and a clean environment to achieve good health. As environmental crises caused by over-growth and over-consumption worsen, using these kinds of human rights-based processes will lead to alternative solutions.[27]

BEYOND SLOGANS AND TOWARD HEALTH FOR ALL

Organizations using an HRBA in their internal operations and program must adopt transparent planning and monitoring so that others can benefit from their experiences. One excellent example is the international anti-poverty non-governmental organization, ActionAid, that has produced accessibly written materials about their internal evaluation processes. The papers included in their *Critical Webs Resource Pack* frankly assess the organization's successes and failures and lay out the lessons they have learned in applying an HRBA.[28] Principal among the challenges they identify is the tendency, as human rights-based approaches have become popular, to emphasize policy and advocacy work over people's direct participation in the improvement of their lives and in changing power dynamics. Such approaches leave people in the status of "beneficiaries."

Oxfam America and CARE USA are other organizations implementing similar sophisticated learning and evaluation processes as they shift to human rights-based work. The two groups recently co-published *Rights-Based Approaches: Learning Project,* reporting on the comparison of human rights-based approach (HRBA) projects with non-RBA projects, identifying best practices and lessons that can be used to

improve the application of rights-based approaches in programming.[29] Although HRBAs are being used by more organizations, this report points out the complexity of this shift and that the practical aspects of rights-based organizational practice and programming strategies are not entirely clear.

Generally speaking, groups and scholars that have engaged in these kinds of evaluations have reached similar conclusions on what a fully realized human rights-based approach means:

- undertaking complex analyses of poverty, power, politics, human relationships and social change;
- looking at an organisation's work in the context of broader social change processes, which then promotes links across programs, between organizations, and from the local to the international level, as well as strategies to foster short and long-term change;
- engaging strategically with government and other duty bearers to build capacity and political will to uphold commitments — while avoiding co-option by official structures;
- supporting marginalised sectors of society in ways that engage them as innovators, protagonists and colleagues in a common struggle for a better world;
- focusing on transforming power relations and structures, including their own relationships with partners and their positions of privilege;
- working on building active constituencies for change in the Global South as well as solidarity in the North;
- supporting local groups and communities in their efforts to achieve immediate changes in their lives while strengthening their organizations and social movements so they can better contest and advance their rights in the longer term; and
- paying attention to sustainability.[30]

While recognizing the growing popularity of human rights approaches, it is clear that all actors do not share the same goals or the same understanding of human rights in theory or practice. As opposed to the in-depth application of human rights standards described in the previous paragraphs, there is a way in which human rights, simply and elegantly laid out in a document like the Universal Declaration Human Rights, are easy to understand superficially, like a slogan, but are challenging when their full implications are contemplated.[31] This apparent simplicity makes it easy — and tempting — for the language of rights to be appropriated for aims that are squarely opposed to their actual fulfillment. As ActionAid states in *Critical Webs of Power and Change*,

> With the growing demands and complexities of advocacy and donor needs for accountability, (advocacy and rights) work has become more professionalized and, in some cases, taken on the language of business and government. As this has happened, important concepts have been toned down or co-opted, making them less challenging of the status quo and current relations of power. At times, terms can become so loosely defined that people can easily use the same language while actually talking about fundamentally different notions.[32]

Without an explicit link between human rights, participation, and empowerment for social change — and without the concepts of claim holders and duty bearers as a key focus for analysis — the potential benefits of human rights approaches are minimal. An empowering participation is the most difficult requirement of the human rights-based approach to implement meaningfully, but its emotional and political appeal makes it very vulnerable for use in "rights-washing" projects or organizations. Like "greenwashing," when corporations with major negative impacts on the environment publicize pro-environment projects or charitable contributions, "rights-washing" gives political cover to groups whose overall impact on human rights is negative.[33] Certain jargon and technical terms become useful for rights-washing when they have vague meanings or meanings that vary in different disciplinary contexts, or when they represent complex concepts that can be reduced and co-opted for the wrong purpose.

For example, the concept of "creation of demand for services" has recently been used to undermine the human rights context in which it is placed. This phrase often appears in association with US Agency

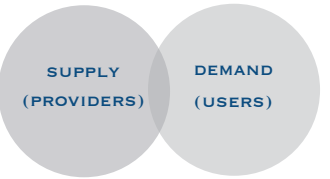
for International Development (USAID) projects, maternal child health services, and the Millennium Development Goals.[34] There was some informal discussion at the 2007 Clinton Global Initiative meeting about whether or not this phrase is another way of talking about human rights without talking about rights.[35] The ambiguity of the word "demand" comes from it having both a technical meaning in economic theory (the relationship between the price that is charged and the amount that will be bought at that price) and a common meaning (how much of something that people want). Unfamiliarity and unease with using the concepts of claims and duties allows the idea of creation of demand to be slipped into this weak spot in the understanding of human rights. The United Nations Population Fund (UNFPA) web page on *Improving Reproductive Health: Building Demand for Health Services* (http://www.unfpa.org/rh/demand.htm) demonstrates one example of how this phrase has been used:

> [G]ood reproductive health requires partnership. While governments are obliged to make quality reproductive services and information widely accessible, users should be encouraged to articulate what they need and expect in terms of services. Users can also provide valuable input into monitoring and evaluation efforts that can improve quality of care. In this way, users can provide a feedback mechanism to support services appropriate to their needs.
>
> The health care system can be seen as an interaction between supply (trained personnel, equipment and services) and demand (active participation from individuals, groups and communities for quality services). Interaction between these two parts of the system can improve the reproductive health needs of users.

In the next paragraph of the same document, introducing a section titled "Empowering Individuals and Mobilizing Communities," the phrase is used as an equation with concepts of human rights:

> The idea of human rights underpins this whole model. The rights of individuals to exert control over their own lives and their reproductive and sexual health needs have been acknowledged by the international community. But people need information, as well as affirmation and support, in articulating and exercising their rights and in creating demand for the services they need.

The text is illustrated with the following image:



Despite the mention of human rights and government obligations, claims and duties are replaced in this UNFPA program by supply and demand. The concept of participation is not framed by the role of a claim holder who is entitled to certain conditions, but by the role of a consumer of services whose participation is through their ability to "articulate what they need and expect" and provide "input" and "feedback." In this model, a program would empower service users by telling them what they should demand, as if people are too dumb to know that they need quality health care and have not been demanding it all along. But human rights are political, not commercial. The concepts of claim holders and duty bearers were developed in human rights theory specifically to remove people from the subordinate position of asking for things to be granted by more powerful others. Here, exercising rights is equated with asking for quality services. Claims and duties also implicitly acknowledge that the market is not always effective in ensuring the best outcomes for the most people, health care being one well-documented example.[36] Supply and demand make no sense in a human rights-based approach to health except to evade its most powerful elements.

In the case of reproductive health in developing countries, it also makes no sense economically to use a demand side model if the goal is to improve the health of the poor. Current consumer demand for health care services — the amount of health care that people who have money want to buy — is already unmet in sub-Saharan Africa and other developing regions.[37] There can be no real demand in economic terms if an individual does not have the money to

purchase necessary or desired goods or services. Although the poorest may want health services, all their wanting does not create much actual demand unless they give up some other necessity, or the government steps in with public funds to buy services for them. This economistic reframing of real community empowerment and engagement only makes sense if your goal is to open the door for the privatization of health services.

When participants in the RTHHCC (and other movements and projects fully committed to health and human rights) actively engage with human rights concepts in relation to their own experiences, their understanding is resistant to this kind of manipulation. These activists are renewing the concept of citizenship and creating new forms of direct democratic social organization. Only by getting human rights standards off the pages of UN covenants and into the hands of those affected by human rights violations will progress be made in the construction of a human rights system that can impact human lives. Health and human rights have emerged as a focus of the global opposition to the dominant order because they are the most powerful unifying concepts available at this time in the face of widespread social upheaval. Demanding a world that prioritizes health for ALL over wealth for a few is the only option, society by society, until there is social justice everywhere.

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2. An Internet search easily turns up work on human rights approaches to an array of topics, including natural disaster response, budget analysis, prison management, climate change, essential medicines, health information systems, and water.

3. Others, such as Paul Hunt, have critiqued both the focus and strategies of well-intentioned progressive mainstream human rights organizations. See P. Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health at the United Nations Human Rights Council, 4th Session, and, P. Hunt, Report on progress and obstacles to the health and human rights movement, in addition to cases on the right to health and other health-related rights (UN Doc. No. A/HRC/4/28), January 17, 2007. Available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/council.pdf. There is also increasing opportunistic use of human rights language by various establishment development organizations and multilateral institutions whose actions and impact do not demonstrate a real commitment to human rights. See the end of this essay.

4. For example, at the Indian Health Association meeting held the week before in Calcutta, 2,500 delegates elected their representatives for the PHA.

5. *The People's Charter for Health* (December 2000). Available at http://www.phmovement.org/cms/en/resources/charters/peopleshealth.

6. Further information on specific PHM history is available on the organization's website, especially in the *PHM Newsbrief*. Available at http://www.phmovement.org/cms/en/resources/newsbriefs. For other perspectives on PHM and its role in the growing political movement for health for all, see M. Fort, M. Meredith, M. A. Mercer, and O. Gish (eds), *Sickness and Wealth: The Corporate Assault on Global Health* (Cambridge, MA: South End Press, 2004); I. Kawachi and S. Wamala, *Globalization and Health* (Oxford, UK: Oxford University Press, 2006); K. Lee, *Gender, Globalisation and Health in Global Change and Health* (Maidenhead, UK: Open University Press, McGraw Hill Education, 2005); H. Rosling (ed), *Global Health: an Introductory Text Book* (Sweden: Studentlitteratur, 2006); M. Rowson, "Health and an Emerging Global Civil Society," *Global Change and Health* (Maidenhead, UK: Open University Press, McGraw Hill Education, 2005); and T. H. MacDonald, *Health, Trade and Human Rights* (Cambridge, MA: Radcliffe Publishing, 2006).

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