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Competing Interests: None declared.

The Framework Convention on Global Health: A tool for empowering the HIV/AIDS movements in Senegal and South Africa

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Abstract

Despite the Alma Ata-inspired slogan "health for all by 2000," the world remains afflicted with poor health in the second decade of the 21st century.[1] This situation has generated much debate, and as a result, national and global responses have arguably entered a new era, building on the past success and failures of health movements, most notably on the back of the global HIV/AIDS movement.[2]

This article aims to contribute to the existing knowledge around a Framework Convention on Global Health (FCGH) from the perspective that any international legal framework conceptualisation on the right to health must involve those whose health is at stake. In order to achieve this analyses of the role played by civil society, who aim to give a voice to those unheard in the halls of state power, are vital for any discussion around the international right to health framework.

The two case studies, Senegal and South Africa, were used to look at the current status of the international right to health framework, specifically in the context of the civil society's role in combating the HIV/AIDS epidemic. Through this, the article explores the possible role of an FCGH in empowering the HIV/AIDS movements in the protection and promotion of the right to health in Africa.

The findings discerned that African states face different challenges regarding the realization of the right to health in the context of HIV/AIDS. However, the important role played by civil society in this realization is highlighted in both cases. They emphasize the diverse roles that an FCGH could play in empowering civil society, through the formulation of a global standard and framework on the right to health, in the form of an FCGH, particularly if it is as a result of a movement of rights education and advocacy from below.[3]

Introduction

Despite the Alma Ata-inspired slogan "health for all by 2000," the world remains afflicted with poor health in the second decade of the 21st century.[4] The state of health has generated much debate among activists worldwide.[5] As a result, national and global efforts on the realization of the right to health have entered a new era. These efforts build on the past successes and failures of health movements, most notably the global HIV/AIDS movement. Within this context, the need for innovative solutions to the challenges facing public health has seen the rise of a new vision for the right to health within the international legal framework. The concept of a Framework Convention on Global Health (FCGH) has emerged out of these debates.

This article aims to contribute to the existing knowledge around a FCGH. It examines the role of civil society in the realization of the right to health, and explores the possible role of an FCGH in empowering the HIV/AIDS movements and those working in the health sector in the protection and promotion of the right to health in Africa.

The article examines two case studies, Senegal and South Africa, and examines lessons learned from HIV/AIDS movements in realizing the right to health in the context of the HIV/AIDS epidemic. It goes on to illustrate how an FCGH could be effective in this context. Importantly, the case studies show that in situations where the social and political contexts are widely divergent, an FCGH could have great impact by outlining a comprehensive set of standards around which civil society can unite. Much of the power of the FCGH would be in its potential to extend those standards around which HIV/AIDS activists have mobilized for years. The response to HIV/AIDS has resulted in real strategic planning for HIV treatment and prevention, but the FCGH could expand standards, planning, and responses to other areas of health systems that have received less attention. The HIV/AIDS response and its relationship to the FCGH will be explored below, following a brief introduction to the concept of an FCGH.

Brief introduction to the Framework Convention on Global Health

A FCGH builds on a large body of international and domestic legal frameworks. The current international framework on the right to health is characterized by vague rights in various conventions. Some of the most obvious examples of right to health articles include: Article 12.1 of the International Covenant on Economic Social and Cultural Rights recognises 'the right of everyone to enjoyment of the highest attainable standard of physical and mental health'; Article 55 of the UN Charter states to 'promote… solutions of international economic, social, health, and related problems', Article 25 of the Universal Declaration of Human Rights recognizes 'standard of living adequate for… health.' Other references to the right to health in African human rights instruments include: Article 16 of African Charter of Human and Peoples Rights. When outlining more material public health needs and guidelines, such measures are non-binding. The UN Committee on the Economic Social and Cultural Rights (Committee on the ESCR) has written one of the most recognised and expansive documents on the right to health entitled General Comment No 14. This raises the question of where an international right to health framework should go from here. The discussions around an FCGH are not based on replacing the current existing framework but rather aim to explore how an FCGH could support and develop the existing system. It could cement the popular shift away from vague human right norms guaranteed in the various binding treaties toward the concretization of the substantive content of the right to health, as defined by UN General Comments and other non-binding documents.

According to Gostin, an FCGH would be an innovative solution that would set targets, dismantle barriers to constructive engagement with the private sector, and actively engage with civil society.[6] The exact content of an FCGH is subject to much debate, and it is not the aim of this article to anticipate that debate. However, in broad strokes, it is possible to observe that an international agreement would at least set global norms and standards in the most common areas of health delivery, and perhaps a timeframe for the achievement of these standards.[7] For the purposes of this paper, it is important to highlight the following areas which the FCGH may include:

> 1) Recommended levels of domestic public sector expenditure on health services;
> 2) a definition of the essential health services that should be available to all;
> 3) priority setting with appropriate targets and benchmarks for progress; and
> 4) recognition of elements of non-discrimination and protection of vulnerable groups.[8]

Discussions around an FCGH call for the inclusion of concrete public health concepts that focus on the poor, rather than merely a normative ideology constituted by vague concepts of rights.[9] The FCGH is based on the argument that human beings fundamentally need secure access to an essential package of basic goods for the personal value of human life.[10] These may include adequate supplies of food and drink, clothing, shelter, and basic health care.[11] Therefore, despite the differences of culture, social position, or circumstance, all human beings must receive the minimum necessary means to meet their

needs and realize their full capacity.[12] An FCGH would aim to outline and concretize health care as a basic good, moving away from the vague concept of rights.

Activists and academics alike assert that an FCGH could also play an empowerment role, particularly in the context of civil society movements across the world.[13] The proliferation of networks of NGOs, linking local and international levels, is one of the most striking developments of human rights regimes since 1948.[14] The HIV/AIDS epidemic has helped to catalyze the modern health and human rights movement, which extends far beyond the disease.[15] The movement's ethos expresses the idea that promoting and protecting health and promoting and protecting human rights are inextricably connected.[16] Gostin and others state that "the most transformative changes in global health have come from the 'bottom up' through social movements, such as campaigns to fight HIV/AIDS."[17] Heyns and Viljoen argue that civil societies in countries like South Africa have used the international rights framework to demand that the right to health is fulfilled; and to translate law into language that resonates with local communities as they demand their rights.[18] These developments have created space for the emergence of strong civil society movements around health. The movements consist of a wide variety of actors, depending on the context, but they generally include NGOs, as well as women's groups, faith-based organizations, youth groups, government agencies, the private sector, and the media. These groups are able to counter the growing influence of vested state and private interests, which challenges the realization of the right to health.

There is an expanse of literature critiquing the concept of an FCGH, especially its ability to assist in the tangible realization of rights for those most in need. Critics have questioned the value of yet another international agreement, when the real obstacles to health care lie at a national level and should be actively negotiated at that level.[19] In a study, Palmer et al. showed that ratification of human rights treaties was not significantly related to a positive change in national health.[20] This is especially pertinent in arguments for context-specific health solutions. It is argued that an interntional convention that was too detailed would become outdated and therefore defunct. [21] This article will examine this criticism within the context of case studies to highlight the usefulness of an FCGH in practical terms; this includes the possibilities for innovation using the FCGH to support and enhance the work of civil society in the realization of the right to health.

The HIV/AIDS movement in South Africa and the Framework Convention on Global Health

In the South African context, discussions about the international right to health framework and the potential role for an FCGH ought to be grounded in South Africa's status as a young democracy (with its first democratic elections taking place in 1994).[22] It is also necessary to take into consideration the new constitutional architecture based on the conception of human rights and responsibilities that emerged in the mid-1990s.[23] The history of unequal opportunities and disadvantaged conditions presents one of the greatest challenges to the realization of rights in South Africa, impacting all spheres of society. The economic disparities have fundamentally affected the delivery of all economic and social goods to the poorest and most vulnerable. The advent of the AIDS epidemic only compounded these inequalities.

In 2010, it was estimated that 10.9% of the South African population was infected with HIV.[24] An estimated 5.5 million people were living with HIV in 2009, which is only marginally lower than the 5.8 million estimated in the early 2000s.[25] The high number of people infected with HIV in South Africa can be attributed to various factors, but is linked strongly to President Thabo Mbeki's denial of the causal link between HIV and AIDS.[26] Moreover, funding problems and health systems weaknesses facing the current health system have presented additional challenges to the realization of the right to health and those living with HIV. Civil society has had to find new and innovative ways to engage and challenge government to ensure the delivery of basic health services to people living with HIV/AIDS.

Civil society's struggle in this arena was largely led by the Treatment Action Campaign (TAC). Launched in 1998, TAC was a response to South Africa's increasingly apparent HIV/AIDS epidemic. TAC campaigned for greater access to testing and treatment for all South Africans by raising awareness and understanding about the availability, affordability, and use of HIV treatments.[27] This community engagement was particularly important where late or absent HIV diagnosis, aggravated by denial, was associated with

high morbidity and mortality.[28] TAC became a vocal and visible justice and non-discrimination lobby in the developing world for the rights of people living with HIV/ AIDS.[29] However, TAC had not planned on the need to campaign against the government.[30] Initially, their targets were multinational pharmaceutical companies, which were expected to obstruct attempts to secure affordable treatment for people living with the virus.[31]

The mobilization throughout the era of denial focused mainly on the South African Constitution and the meaning of the rights and responsibilities outlined in Section 27.[32] Using that domestic legal framework proved highly effective, both in terms of the mobilization of TAC members, the majority of whom were community members, and in terms of litigation strategy. TAC's politics-centered approach to right-to-health advocacy included aspects of grassroots empowerment and international collaborations.[33] Its grassroots treatment literacy campaign aimed to empower poor and physically and emotionally debilitated South Africans with HIV to participate in and make demands for their own treatment and care.[34] The campaign also intended to make people living with HIV/AIDS rights-bearing members of local communities, activist organizations, and schools.[35] International collaborations included partnerships with international organizations like Medecins Sans Frontieres (MSF), who provided important science and medical support. But coalescing local and international action seemed insufficient.

Instead of shunning national political action and large-scale national institutions, TAC's critical engagement with government, proved imperative to the struggle.[36] It included strategic litigation strategies that forced the government to change state policies, open up policy-making processes, and fashion and implement democratic programs of social provision for people living with HIV.[37] For example, in one of the most famous social and economic rights cases in South Africa, *Treatment Action Campaign v Minister of Health*, the court ordered the government to implement a more reasonable policy regarding PMTCT essential in the prevention of mother-to-child transmission of HIV.[38] This was a success for activists advocating around the right to health as the court upheld the rights of people living with HIV over denialist-based government policy.

However, the outcome of the case disappointed many South African human rights advocates who had hoped for broad judicial declarations of the core substance and programmatic contours of social rights, including the right to health, in Section 27 of the Constitution.[39] Critics argued:

> The disposed and impoverished citizenry are entitled to have the minimum content of their [economic and social rights] articulated, so they and their political and legal advocates may be more ready to hold the government to account.[40]

TAC continued to face challenges from government even after universal access to antiretroviral treatment was finally adopted in 2004, as there was minimal investment made in monitoring systems.[41] As a result, civil society groups including TAC established their own monitoring network to track equity and coverage of antiretroviral treatment (ARV) access across South Africa during the rollout. This illustrated the essential role of civil society monitoring in holding the state accountable for providing basic goods and services for all.

With gross inequalities of resources between the private and public sectors, challenges faced by the health sector served to compound challenges for the HIV/ AIDS movement.[42] Major inequities remain in South Africa, with huge variation in health status and health service access across the nine provinces, and even between neighboring communities.[43] For example, only 14% of citizens are able to access the private health care sector, yet they benefit from up to 60% of national health expenditures.[44] Therefore, there is a new strategic challenge for the realization of the right to health: immediately implementing the government's operational plan while strengthening the broader health care system over the longer term.

Considering this South African context, an FCGH could fulfill a number of functions. It could provide a comprehensive blueprint, including setting out a basic level of domestic public sector expenditures on health services and a definition of essential health services. This blueprint could be used for various purposes: to galvanize communities around certain demands, to encourage international support

around specific issues, and to engage directly with government. A recent example is the government's response to projected over-expenditures in the Free State Provincial budget 2008-2009. In November 2008, the Provincial Department of Health in South Africa's Free State province enacted a moratorium on starting new patients on ARV treatment. The moratorium, which was part of a series of cost curtailment measures that affected the purchasing and delivery of HIV/AIDS treatment and other medicines, lasted for four months and had detrimental consequences for people living with HIV. The situation highlighted the larger human resource and funding challenges facing health care provision. These funding challenges resulted in a national commitment to introduce a system of National Health Insurance (NHI) within the next five years. It will be funded by a single health insurance system and aims to guarantee an essential package of health care services to all people.[45] In an initiative like this, an FCGH may prove instrumental in its ability to provide a comprehensive blueprint for government.

Moreover, the HIV/AIDS movement could use an FCGH to challenge the state's organization around the right to health. Movements such as TAC and the AIDS and Rights Alliance of Southern Africa (ARASA) have advanced democracy by demanding accountability from governments that have not been accustomed to such pressure. In drafting an FCGH, civil society, government, and communities could build a common vision of the priorities and basic needs of those they are representing. HIV/AIDS activists have mobilized for years around basic standards for health care, creating a strong foundation for those activists to work proactively in other areas within the health system, for example the monitoring of health systems. Within this context, the HIV/AIDS movement could use an FCGH to hold government to account within a broader environment.

The South African case study highlights various areas where an FCGH could assist civil society in the realization of the right to health for people living with HIV/AIDS. In this case, an FCGH could provide an important legal and advocacy tool to re-engage the government and NGOs like TAC, who have been mobilizing around basic health standards for years. It could also be used as an instrument of pressure against a government, holding it accountable to its citizenry. In the current environment, though the political space has become more conducive, there are challenges of monitoring, limited funding, and a lack of human resources. In this context, an FCGH would contain a concrete blueprint for civil society with comprehensive standards to which the government could be held accountable.

The HIV/AIDS movement in Senegal and the Framework Convention on Global Health

The next case study will look at the role of an FCGH within the context of the HIV/AIDS movement in Senegal. In contrast with the sub-Saharan African countries, Senegal's successful attempts to prevent the spread of HIV/AIDS have transformed the country into a best-practice model over the last two decades.[46] The epidemiology of HIV/AIDS in Senegal is different from that of South Africa and the rest of Sub-Saharan Africa because the profile of the disease is concentrated, with a country HIV prevalence low of about 0.7%, but a higher prevalence among vulnerable groups such as sex workers (about 20%) and men who have sex with men (MSM) with a prevalence of about 21.5%.[47]

Senegal's relatively low infection rate is due in part to a speedily mounted public education strategy that mobilized the population soon after the epidemic broke out in 1984.[48] Senegalese society has a tradition of active community involvement in health and development issues; thus, when it became clear that HIV/AIDS was a potential threat to national well-being, community groups were well-placed to respond.[49] The effort involved women's groups, faith-based organizations, youth groups, government agencies, the private sector, and the media.[50] Therefore the epidemiology of the disease, the political environment, and the nature of civil society differed greatly from that of South Africa.

The HIV/AIDS movement involved religious communities and leaders, an integral component to its success.[51] It was clear that religious leaders wanted to be involved when as early as 1989, a conserva-

tive Islamic organization, Jamra, approached the National AIDS Council to discuss HIV prevention strategies.[52] Although initially hostile to condom promotion and some other aspects of AIDS prevention, the group became an important partner in a dialogue between public health officials and religious leaders.[53] Furthermore, Christian organizations are important providers of health services in Senegal.[54] Early in the epidemic, churches developed a more supportive outlook towards prevention, led by a Catholic NGO, SIDA Service, which provided counselling and psychosocial support.[55]

Currently, there are more than 3,000 civil society organizations involved in the Senegalese HIV/AIDS response, from community-based groups to national NGOs.[56] Some of the most prominent organizations are *l'Agence pour la Promotion des Activités de Population* (APAPS), ENDA-Sante, Society for Women and AIDS in Africa (SWAA Sénégal), *Association Sénégalaise pour le Bien Etre Familiale* (ASBEF) and SIDA Service (as mentioned above). Moreover, these NGOs and other partners have encouraged the establishment of organizations aiming to strengthen the social networks of vulnerable groups like MSM and sex workers. There are a handful of MSM associations (which provide social spaces and are centrally involved in HIV/AIDS outreach) in Senegal, mostly in the urban areas.[57]

Stigma and discrimination are some of the biggest challenges for the HIV/AIDS epidemic in Senegal . The perception of HIV/AIDS as a "gay disease" has stigmatized those who operate in the MSM community and placed them at increased risk of discrimination and violence.[58] The belief that MSM are to blame for the epidemic or that they are the only at-risk group is still common.[59] As affirmed at the 15th International Conference on AIDS and STIs in Africa (ICASA) in 2008, criminalization of homosexual conduct is a significant hurdle in providing education, testing, and treatment to MSM populations in Africa.[60] But even if the epidemic could be fought effectively from a clinical and epidemiological perspective, it is not enough to encourage voluntary testing and monitoring of people who agree to declare their HIV status. The social context of stigma and discrimination against people living with HIV/AIDS naturally leads them to hide their status.[61]

It is within this social context that a criticism of the FCGH could arise; an international treaty would not help civil society combat context-specific health challenges, especially in the realm of cultural and social issues. In fact, the use of rights language in the Senegalese context may prove challenging, as the wider society does not see those infected with HIV/AIDS as deserving of special rights.[62] People living with HIV/AIDS are viewed as asking for special rights and the community questions why that group has claim to more rights.[63] As an international framework, an FCGH cannot respond to the social and cultural specificities in every country. However, it can provide a concrete blueprint for civil society organizations to build on the effective collaborative efforts made by the HIV/AIDS movement and to conceptualize a comprehensive right to health for all.

An FCGH could be instrumental in conversations about what in Senegal is termed 'Code de la santé' or 'Health Code.' The philosophy behind this project is to understand the relationship between health and the law, while considering emerging ethical and health challenges. The development of the Health Code would take into account the global context and universally agreed standards.[64] Such a process would require concrete concepts that frame and define the various components of the basic right to health. The FCGH would also advocate for inclusive processes, thereby accommodating marginalized and vulnerable populations.[65] Examples of this inclusivity can be found in the strength of government leadership and intersectoral collaboration between different civil society members, including churches, mosques, and women's groups in Senegal.

Finally, the development of an FCGH could mobilize Southern and Northern civil society and communities for advocacy on health issues that require global cooperation.[66] HIV/AIDS movements in both South Africa and Senegal are facing global challenges that impact health, including trade and intellectual property, health financing, health worker migration, and the environmental change.

The case study of Senegal provides an important contrast to the South African experience. It recognizes that an FCGH as an international framework

will not contain silver bullets for obstacles to the realization of the right to health, especially in country-specific social and cultural contexts, as well as different constitutional domestic frameworks. However, its role in galvanizing civil society groups around health issues could be valuable, and a tool for outlining the contents of health as a basic good upon which to build a national consensus.

Conclusion

The two case studies, Senegal and South Africa, look at the role that civil society played in realizing the right to health in the context of combating the HIV/AIDS epidemic. Through this lens, an FCGH could empower these movements to extend their gains further in protecting and promoting the right to health in Africa; this is despite very different social and political contexts.

The contemporary nature of the subject means that there is scant literature available on an FCGH, and where it does exist, it is unpublished or difficult to access. Therefore, some of the research in this paper is based on internal working papers of research groups. Furthermore, the article has focused on the FCGH in the context of HIV/AIDS in Senegal and South Africa as an example, and the conclusions cannot necessarily be said to apply to broader health care systems or other communicable diseases. However, this research is useful in explaining some of the broad concepts coming out of new discussions surrounding an FCGH. Also, it has expanded on the existing literature on the important work and accomplishments of the HIV/AIDS movements in South Africa and Senegal.

The two case studies emphasize the importance of taking into account the political, social, and economic context of the places in which the FCGH would be implemented. In the case of HIV/AIDS movements, it was necessary to consider the context-specific formations of the epidemic, the different nature and history of civil society, and government responses to the epidemic. It is possible to see that different states on the African continent face diverse challenges regarding the realization of the right to health in the context of HIV/AIDS and more widely. The HIV/AIDS response in Senegal highlighted these challenges, especially the social and cultural obstacles to the realization of the right to health.

However, both cases demonstrated that an FCGH would assist health activists by setting a standard against which citizens are able to measure their governments.[67] The two examples highlight specific gains by the HIV/AIDS movements in South Africa and Senegal over the past 15-20 years. These gains would enable civil society organizations to mobilize outside of the relatively narrow focus of HIV/AIDS movements and more towards health systems delivery - and social determinants of health - more broadly, for which the FCGH could also galvanize support. Even in two contexts where the disease epidemiology, political environments, and nature of civil society are completely different, it is possible to conclude that an FCGH could be advantageous. It is only a failure of imagination that will limit discussions about the next step for the international right to health framework.

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