Abstract

Through a description of the four major challenges faced by Latin American human rights groups and the strategies that they have adopted to overcome these challenges, this article seeks to incorporate the perspective of human rights activists into the discussion of how to make health a universally recognized human right. The ill-defined normative content of the right to health, the lack of precedents and procedures for enforceability, and the lack of consciousness of health as a right have presented major obstacles to the implementation of the right in the region. Also, Latin American human rights groups must move beyond traditional legal methods and expertise to work in an interdisciplinary fashion with health professionals and grassroots health groups. Despite the obvious obstacles, Latin American human rights groups cannot afford not to become involved in advocacy on the right to health.

Par une description des quatre principaux défis majeurs auxquels sont confrontés les groupes de défense des droits de la personne en Amérique Latine et les stratégies qu'ils ont adoptées pour surmonter ces défis, cet article cherche à incorporer la perspective des activistes des droits de la personne dans la discussion sur la manière de faire de la santé un droit universellement reconnu. Le contenu normatif mal défini du droit à la santé, le manque de précédents et de procédures en matière d'applicabilité et l'absence de conscience de la santé en tant que droit, ont eu pour effet de présenter des obstacles majeurs à la mise en œuvre du droit dans la région. De même, les groupes de défense des droits de la personne en Amérique Latine doivent aller au-delà des méthodes légales traditionnelles et se former au travail pluridisciplinaire avec les professionnels de la santé et les groupes de santé à la base. En dépit des obstacles évidents, les groupes de défense des droits de la personne d'Amérique Latine ne peuvent pas se permettre de ne pas s'engager dans la défense du droit à la santé pour tous.

A través de una descripción de los cuatro retos mayores enfrentados por grupos de derechos humanos latinoamericanos y las estrategias que han adoptado para vencerlos, este artículo busca inyectar algo de las perspectiva de los activistas de derechos humanos en el debate de cómo hacer que la salud sea reconocida como un derecho humano universal. El contenido mal definido de la norma del derecho a la salud, como la falta de precedentes y procedimientos para su cumplimiento, y la falta de conciencia sobre la salud como derecho han presentado grandes obstáculos para la implementación del derecho en la región. Además los grupos de derechos humanos latinoamericanos tendrán que ir más allá de los métodos legales y las estrategias tradicionales de trabajo en una forma inter-disciplinaria con profesionales de salud y grupos de organizaciones de base de salud. A pesar de los obstáculos tan obvios, los grupos de derechos humanos latinoamericanos no pueden darse el lujo de no estar involucrados en la abogacía sobre el derecho a la salud.

PROTECTING AND PROMOTING THE RIGHT TO HEALTH IN LATIN AMERICA: Selected Experiences from the Field

Alicia Ely Yamin

In recent years a rich discussion has emerged within the academic health and human rights community on how to bring the disciplines of public health, medicine, and human rights together in order to effectively make health a universally recognized human right. However, the voices of human rights activists, who have been fighting the battles on the ground, have largely been absent. This piece seeks to incorporate their perspective into that discussion. Specifically, some groups within the Latin American human rights movement are now developing innovative new ways of approaching an evolving political and economic context in the region that include advocacy on the right to health.

Forged in the era of military dictatorships, the Latin American human rights movement has proven itself to be one of the strongest and most successful in the world. Human rights nongovernmental organizations (NGOs) in the region have secured relief for victims; achieved significant legal, judicial, and electoral reforms; provided evidence in truth and reconciliation processes; and devised a panoply of strategies through which to hold their governments accountable for abusive policies and practices. Despite widely varying contexts among countries, human rights groups throughout the region have attained a hard-won authority in the political arena.[1]

Today human rights NGOs in Latin America find themselves confronting new assaults on human dignity, includ-

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ing the degradation of entrenched poverty and the growing inequality that threatens the fragile democracies of the region. In recent years, political and economic programs have marginalized large sectors of the population. The obvious attendant consequences of that social exclusion on people's health and well-being have led some Latin American NGOs to focus a portion of their advocacy on the right to health.[2]

Latin America is of course a very diverse region, in which different stages of development, indigenous and Ibero-American cultures, urban and rural settings, and a related panoply of health issues are all represented. Yet regional commonalities can be seen in the challenges facing human rights groups that are now seeking to implement the right to health, as well as in the approaches that these groups have assumed in their work.

This article focuses on four principal challenges to the Latin American human rights movement in taking up advocacy on the right to health: clarifying normative content; promoting enforceability; raising consciousness of health as a fundamental right; and moving beyond the traditional skills and methods of the legal profession to engage in interdisciplinary collaboration with health professionals.[3] The article examines what strategies have proven successful in facing these challenges, as well as what work remains to be done. It concludes that some elements of the Latin American human rights movement are making exciting strides towards the institutionalization of the right to health, despite the dismal economic and social conditions that prevail throughout the region today. In fact, it is that bleak reality that speaks most forcefully to the need for NGOs to expand their view of traditional human rights work or risk becoming increasingly irrelevant to the concerns of the vast majority of citizens in the region.

Clarifying Normative Content

To a greater extent than most economic and social rights, the right to health, as it is enshrined in international instruments, has suffered from vague normative definition. Among the general public, there continues to be confusion

over whether there is an ostensible right to health care or to some broader notion of preconditions for health.[4] The central provision regarding the right to health under international law, which is found in the International Covenant on Economic, Social and Cultural Rights (ICESCR), speaks of the right to "the highest attainable standard of physical and mental health" and sets out four steps toward achieving that standard that encompass far more than health care.[5] Yet for many years the broad language in the ICESCR did little to define the concrete requirements that States parties must fulfill.[6]

Recently, however, the normative definition of the right to health has been elucidated significantly by the Committee on Economic, Social and Cultural Rights (CESCR), which issued a General Comment on the right to health in May 2000.[7] In 1999, the Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW), which monitors the Convention on the Elimination of All Forms of Discrimination Against Women, issued its General Recommendation on Women and Health.[8] Both of these documents provide authoritative interpretations regarding the right to health and ensuing state party obligations. They have provided advocates with critical tools to hold governments accountable for their commitments in a way that simply was not possible before.

In addition, specific aspects of the right to health have been further clarified through international and regional conferences and the declarations and programs of action emerging from such meetings. At the international level, the International Conference on Population and Development (ICPD), held in Cairo in 1994, and the Fourth World Conference on Women (FWCW), held in Beijing in 1995, together advanced the connection between reproductive rights and health and helped to clarify the components of women's rights to reproductive health.[9]

Latin American NGOs have played an active role in the processes that led to these normative developments. For example, certain Latin American NGOs provided critical input and observations to the drafters of the CESCR's General Comment and CEDAW's General Recommendation mentioned

above.[10] Moreover, women's rights groups across Latin America organized themselves into networks and played a major role in drafting and proposing language and pressuring their governments before and during the international conferences at Cairo and Beijing, as well as in the five-year follow-up processes to these conferences, which have recently been concluded.[11]

At a regional level, NGOs have taken the lead in drafting instruments and declarations to clarify the content of the right to health and reproductive rights, as well as state obligations flowing from these rights. For example, in July 1998, a meeting that included 50 organizations and five networks of NGOs from 16 Latin American countries, together with activists and representatives from elsewhere, was held in Quito, Ecuador. The Declaration of Quito Relating to the Enforceability and Realization of Economic, Social and Cultural Rights in Latin America and the Caribbean, which emerged from that meeting, sets out a legal framework for NGOs to make demands upon governments in the region regarding health and other economic, social, and cultural rights.[12] The Declaration of Quito is not a legally binding document, but it is important in providing interpretive guidance as to governments' obligations. Among other things, it sets out the tripartite scheme of state obligations—respect, protect, and fulfill—that has now been accepted as applying to economic and social rights and also relevant to civil and political rights, thus foreshadowing the authoritative interpretations by the CESCR and CEDAW of the right to health and women and health, respectively.[13]

The Latin American and Caribbean Committee for the Defense of Women's Rights (Comité Latinoamericano para la Defensa de los Derechos de la Mujer, or CLADEM), a regional network of women's rights groups, is in the process of producing an Inter-American Convention on Sexual and Reproductive Rights, which includes provisions on the right to health. The idea behind the convention is to fill the vacuum regarding sexual and reproductive rights within the Inter-American system, in which virtually none of the new "gendered" understandings of human rights brought forth through the international conference processes have been

incorporated. The CLADEM project also seeks to strengthen regional mechanisms and set out or clarify regional standards because national legislation relating to reproductive rights in Latin America tends to be weak and subject to the vicissitudes of political whim.[14]

Certain human rights NGOs have begun independent efforts to clarify the normative content of the right to health in particular. For example, the Venezuelan Program for Education and Action (Programa Venezolano de Educación y Acción en Derechos Humanos, or PROVEA) has made the right to health a priority since 1992 and has developed a conceptual framework for the minimum core content of health as a human right. Many elements of this framework, such as nondiscrimination, physical and economic accessibility of medical care, protection against health hazards, emergency care, special attention to vulnerable groups, respect for the dignity and integrity of the person, community participation, legal remedies/justiciability, and accessibility of information about prevailing health conditions and means of prevention, appear in the General Comment issued by the CESCR.[15] PROVEA has argued in both legal and political fora that state failure to meet the minimum obligations laid out in its framework constitutes a violation of the right to health.[16] PROVEA actively engages in advocacy with the government as well as educational campaigns aimed at the public in order to reframe the public debate surrounding health and to make it easier to file actionable claims of violations of the right to health.[17]

Thus, in addition to lobbying for the adoption and ratification of international treaties and conference declarations that enshrine the right to health, human rights NGOs in the region are also actively engaged in advancing interpretations of the meaning of the norms set out in those instruments and agreements.[18] Far from a neutral process, this "clarification" of norms is itself an exercise in advocacy, whether by explicitly adding a gender perspective to narrow legal language and principles or by articulating the minimum core content of the right to define a state's minimum legal obligations. Although much remains to be done, with the active participation of these groups, significant strides

have recently been made toward defining the content of international norms and state obligations with respect to health.

Promoting Enforceability

The lack of precedent for enforcing the right to health through judicial or quasi-judicial mechanisms, a problem closely related to the vague normative content of the right to health, has also posed obstacles to implementation of the right throughout the region.[19] Ill-defined norms are difficult to implement in legislation or to apply in specific cases of violation. Moreover, historically, conventional thinking in the region was that the right to health involved programmatic obligations, which courts were unsuited to arbitrate and for which governments could not be held legally accountable as they might be for the direct actions of a government agent, for example.[20] This conception prevailed at the international level as well, where few judicial procedures have traditionally existed to bring cases relating to the right to health.[21]

Several human rights NGOs in the region, however, have recently begun to make progress in establishing possibilities for national judicial enforcement of specific aspects of the right to health in cases of extreme gravity. Moreover, at the international level, these NGOs have not only creatively taken advantage of existing mechanisms and procedures but have also engaged in efforts to expand those mechanisms, successfully lobbying for the adoption and ratification of protocols that will permit greater enforceability of the right to health in the future.

At the international level, unlike the International Covenant on Civil and Political Rights (ICCPR), none of the major international treaties that enshrine the right to health historically has provided for individual complaints. This situation will soon change, as an Optional Protocol to the Women's Convention that could permit individual complaints regarding discrimination against women in health care was adopted by the UN General Assembly in 1999. Women's rights groups throughout Latin America are engaged in advocacy for the ratification of this important

Optional Protocol, which will soon enter into force.[22] Until now, States parties' compliance with the right to health at the UN level essentially has been limited to monitoring by the treaty bodies, which review reports submitted by States parties as well as independent "shadow reports" submitted by NGOs and other information provided by specialized UN agencies.

Increasingly, Latin American NGOs—in Mexico, Venezuela, Argentina, Chile, Perú, and elsewhere—have been submitting such shadow, or parallel, reports, containing alternative information on state compliance with the right to health, as well as other economic and social rights, to UN treaty bodies.[23] The more specific the information gathered and submitted by these NGOs, the more targeted and quasi-judicial in nature the recommendations and observations by the treaty bodies tend to be.[24]

At the regional level, the American Declaration on the Rights and Duties of Man (American Declaration), an OAS Charter–based document, contains specific provisions regarding the right to health.[25] The American Convention on Human Rights (American Convention), the governing treaty in the region, does not contain such a provision. However, the recent entry into force of an Optional Protocol to the American Convention in the area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador, mentions the right to health and represents a milestone toward debunking the historic idea of the non-justiciability of these rights.[26] Although the Protocol of San Salvador does not explicitly provide for individual petition procedures except in the areas of unionization and education, it is only a matter of time before NGOs in the region present complex cases of interdependent violations that will force the Inter-American Commission and the Inter-American Court to examine aspects of the right to health.[27]

The American Convention itself mentions economic and social rights in only the broadest language; it does not specifically address health. Human rights NGOs in the region, however, have creatively incorporated right-to-health claims through a variety of legal approaches. For example, the regional office of CLADEM in Perú has suc-

cessfully brought cases relating to the right to health in the Inter-American system by making indirect procedural and equal protection arguments and by integrating the right to health into other actionable civil and political rights, such as life and bodily integrity.

In two closely related investigations in 1996–1997, CLADEM uncovered gross abuses in the Peruvian public health system. The first investigation covered a broad spectrum of abuses from lack of adequate facilities to intentional assault, such as rape, by doctors employed by the state. The second focused more specifically on government policies involving surgical contraception, including cases of involuntary sterilization and other practices contrary to informed consent and the right to health. It also documented gender discrimination in health rights associated with race or ethnicity, socioeconomic status, and rural versus urban status.[28] CLADEM submitted information regarding these cases to the Inter-American Commission during a site visit in November 1998. In 1998 and 1999 CLADEM, together with other NGOs, submitted petitions to the Inter-American Commission in two cases, one of a women raped by a doctor in a public hospital, the other of a woman involuntarily sterilized. The first case went to an amicable resolution procedure, one of the first such procedures in Peruvian history.[29]

At the national level, review of the right to health takes place in virtually every Latin American country, based on either provisions of the national constitution or transformation of the international right into a domestic right through implementing legislation.[30] Historically, however, there has been a misconception that the right to health is merely "an admonition to the legislature, a promise of future action [and as such] is not legally enforceable in the traditional legal sense, but is a strong statement of policy."[31]

The key to NGO success in combating this outdated view and reframing the judicial understanding of the right to health at the national level is a mechanism called the *acción de amparo* (protection suit), the chief means of protecting an individual's constitutional rights in many if not most Latin American countries. When granted, the *amparo*

itself is a form of writ that includes but greatly expands upon the Anglo-Saxon writ of habeas corpus.[32] Although the scope of protections afforded, the taxonomy of different causes of action, and the procedures for obtaining an *amparo* vary substantially among different countries, it is now also proving to be an important tool for NGOs in the vindication of health rights in a number of different countries in Latin America.[33]

In 1998, for example, the Argentine Center for Legal and Social Studies (Centro de Estudios Legales y Sociales, or CELS) successfully brought an *amparo* suit on behalf of 3.5 million affected people to force the Argentine government to manufacture and distribute a vaccine against Argentine Hemorrhagic Fever, a disease that exists only in Argentina and is often fatal.[34] CELS argued that, given that rapid diagnosis of the disease is difficult and it affects a population that does not have easy access to medical services, the most effective means of combating the disease is the administration of a vaccine.[35] In a historic ruling, the Court found that the state had an obligation to manufacture the vaccine and, as requested by the plaintiffs, prescribed that this obligation had to be met by the end of 1999.[36] It must be noted that the Argentine government has not yet complied with the ruling as of this writing; however, CELS recently submitted another motion to force compliance.[37]

When and if compliance is secured, this case will be important in having established these obligations as legal and enforceable, rather than merely policy goals. Indeed, even though the sentence has not yet been executed, this case has already set a valuable precedent for various broader social and political reasons. First, the suit established that the legal process could be used to open a dialogue among common citizens and a variety of state institutions regarding different environmental and health policies aimed at resolving the public health threat posed by this horrific disease. Second, the Court's having directly applied international treaty norms regarding the right to health strengthens the utility of domestic procedures for future international human rights cases. Third, and more broadly, because of the importance of this judicial precedent and the critical impor-

tance of this case for the affected population, the ruling awakened great interest in the mass media, sparking a broader discussion about the right to health among many sectors of Argentine society. If, as expected, the enforcement of the judgment is obtained within a reasonable period, this awakening of public awareness may prove to be the most important success of the case in the long run.[38]

At the other end of South America, the Venezuelan group PROVEA is at the forefront of developing strategies for the justiciability of economic, social, and cultural rights, including the *amparo* recourse. PROVEA filed an *amparo* action in August 1997 with respect to the rights to health and social security on behalf of 10 patients who were affiliates of the Venezuelan Institute of Social Security.[39] Due to drastically reduced public spending on public hospitals, the patients had been hospitalized in the neurosurgery unit of a large hospital in Caracas for over a year, waiting for brain surgery to be performed.[40] The trial court ruled in favor of the plaintiffs on the basis of an imminent threat of violation of the right to life, as well as violations of the rights to health and social security. As in the Argentine case, the Court's judgment confirms the responsibility of the Venezuelan state as guarantor of health care, here conceived as part of social security. Other NGOs in Venezuela and elsewhere in the region have also used the *amparo* to defend the right to health in the context of securing care and medication for HIV-positive individuals, with encouraging results.[41]

It must be noted that there is a significant limitation in Venezuela, as well as in a number of other Latin American countries, to using the *amparo* remedy to make the right to health justiciable: such suits are limited to establishing or remedying the situation of individual plaintiffs. Only a few countries follow the common-law approach of invalidating a law *erga omnes*, or granting general, positive relief.[42] Although in practice *amparos* can serve at least as *dicta*, or guidance, in other cases, until the jurisprudence in Venezuela and most other countries in the region recognizes the possibility of representative actions, the benefits of these cases will be limited to the particular plaintiffs before the court.

In short, there is a regional consensus among NGOs that work to establish legal remedies for violations of the right to health is critical to advocacy for the right. This consensus no doubt emerges in part out of the particular regional history of the Latin American human rights movement.[43] Despite the Kafkaesque nature of some of the national judicial systems in the region, from their inception Latin American human rights NGOs have emphasized the importance of using all available legal recourses in order to establish the legitimacy of human rights causes. In various countries, these NGOs have confronted military dictatorships under which the *amparos* presented on behalf of the disappeared were routinely denied by the hundreds; faceless judges sentenced people with no due process; and judiciaries became virtual extensions of the executive. Yet Latin American NGOs achieved some significant victories and, equally critically, they demonstrated the flaws in the system, exposed the futility of exhausting domestic remedies, and proved—by its very absence—the fundamental importance of the rule of law to any society.

As recognized in the recent CESCR General Comment, the rule of law is as important in securing the right to health as it was in the struggle for civil and political rights. Today, a number of Latin American NGOs in the vanguard of this work have been using the important but imperfect *amparo* mechanism, as well as other judicial and quasi-judicial remedies at the regional and international level, to seek injunctive relief and establish the justiciability of even the most programmatic obligations ensuing from the right. Although this is only the very beginning of a long process, NGOs have already gained leverage in key cases, established important precedents as to the "realness" of the right to health, and conducted publicity and consciousness-raising campaigns around violations of the right to health.

Raising Consciousness of Health as A Right

Problems with respect to the lack of enforceability of the right to health, as well as many other economic and social rights, cannot be isolated as a juridical issue. Rather, they must be viewed within the larger social context of the

recognition of the right to health.[44] Legal victories relating to the right to health attain a greater significance when they are accompanied by other actions aimed at raising public awareness, and when civil society assimilates those victories into their understanding of their own entitlements.[45] In many ways, legal enforceability is dialectically related to consciousness of health as a right. The more people receive remedies for violations, the more they perceive the right as real; the more people perceive the right as real, the more they clamor for remedies.

In Latin America there is a distinct lack of public outcry regarding violations of the right to health; by and large, people do not perceive health as a fundamental right. Thus another serious challenge to the promotion of the right to health—as well as other economic and social rights—is the need to reshape and mobilize public opinion. In a report published by the Andean Commission on Jurists, Alejandro Teitelbaum argues that there is

> . . . a need to begin to awaken social alarm with respect to this class of calamity [g]iven that public opinion is conditioned in such a way that it reacts against someone who steals a handbag on the street or commits murder, but considers the systematic robbing of entire nations and the condemning to hunger or sickness or death of millions of human beings to be part of the normal order of things or that it follows the law of the market.[46]

Most people in Latin America still do not connect patterns of ill-health—and other indices of social exclusion that are closely associated with poverty—with patterns of social spending and systematic policy decisions on the part of governments. Therefore, they tend not to hold the state responsible for promoting and, conversely, violating the right to health.

The statistics on inequality and health spending, or even social spending, in Latin America are indeed disheartening.[47] Most countries in Latin America are burdened with immense foreign debts, a fact that points to the need to view violations of the right to health and other economic and social rights in a broader international context. For example, in Nicaragua, the total external debt is fully 306% of the

gross national product (GNP).[48] At the same time, inequality within countries is increasing dramatically. The United Nations Development Programme reports that, in Brazil, "the poorest 50% of the population received 18% of national income in 1960, falling to 11.6% in 1995. The richest 10% received 54% of the national income in 1960, rising to 63% in 1995."[49] In addition, countries in the region have failed to direct the aid they receive to basic health care and other social services that might improve living standards and therefore the health of the population. In 1996, for example, the governments of Bolivia and Perú spent 8% and 5%, respectively, of their total foreign aid on basic social services, and only a fraction of those small amounts on health and health care.[50]

Ideas about health and health care in Latin America are intimately related to the prevailing sociopolitical discourses of poverty and the role of the state. For example, it is no accident that, as Victor Correa-Lugo writes, health care models in Latin America continue to be "based on a notion of assistance and ignore socio-environmental factors in illness."[51] The few moves away from a charity-based approach toward a rights-based one in the past have all but evaporated in the current context of structural adjustment and health sector reform.

In the 19th century, religious or quasi-religious clinics and hospitals began to be established, reflections of an understanding of health care as a form of charity that still persists today. Government hospitals in what are almost all overwhelmingly Catholic countries also subscribed to this view of health care.[52] Further, illness was often perceived as a form of punishment for sin.[53] An alternative paradigm emerged as the labor movements in many Latin American countries were consolidated during the first half of the 20th century and institutions of social security were created to provide health care, among other services. Governments that counted on populist support, including that of labor movements, created a series of legal reforms including the establishment of hospitals and systems of health care affiliation based on employment status.[54] These health care regimes were based on notions of entitlements, or rights.

However, they were and still are open only to full-time employees in the formal economy, which has radically limited the possibilities for affiliation.[55]

The current World Bank–sponsored health sector reforms have introduced into the region a new paradigm of health care that views health largely in terms of productivity. Of course, development banks' policies on sector reform cannot be divorced from their wider policies of structural adjustment and economic deregulation, which also affect preconditions that determine health and illness.[56] In simplified terms, the World Bank–sponsored model of social policy, including health services, consists of a standard menu of three strategies: privatization, targeting, and decentralization.

In Latin America, the first step was the privatization of social security hospitals and health centers, followed by the installation of for-profit clinics and the imposition of users' fees in public institutions.[57] Given the reduction in the amount of public resources devoted to social services, including health, targeting of remaining health subsidies is intended to ensure that programs reach the poorest of the poor. In practice, however, targeting often has been used in the region for political patronage purposes.[58] Moreover, the premise of targeting the neediest might be reconsidered in societies in which 50 to 80% of the population lives below the poverty line.[59] In theory, decentralization means bringing administrative and financial procedures to the state and local level. In practice, however, decentralization has often meant transferring tasks to the local level while maintaining all policy and budgetary control at the central level, thereby defeating any possibility of greater community participation or true efficiency. Indeed, in many cases, income generated at local facilities must be turned over to central or regional health districts and is not reinvested in services.[60]

It should be noted, however, that some results of the reforms have been positive. For example, the distorted emphasis placed on building tertiary care facilities in urban areas that had been common throughout most of the region has been replaced by an emphasis on placing primary care facilities in previously underserved areas.[61] Unfortunately,

in practice, human rights groups have found many rural health posts to be little more than concrete structures with no trained personnel, few or no supplies, and little capacity for doing more than dispensing contraception.[62]

At the same time, as noted above, spending on health and other social services has dramatically decreased across the region. Subsidies for public hospitals have been cut back, and the costs of care have become prohibitive in many cases.[63] For example, in Venezuela, austerity programs reduced public spending on health from 2.6% of gross domestic product (GDP) in 1992 to 0.86% in 1997.[64] In Perú, a recent study by the Colegio Médico del Perú, the national medical association, found that "self-generating resources policies" had in effect left at least 20% of the population with no access to health care whatsoever.[65] In general, the efficiency, cost-cutting, and improved managerial skills emphasized in the World Bank and Inter-American Development Bank sector programs ignore the realities in most of Central and South America, where few resources are devoted to health in the first place, and low salaries and poor working conditions undermine retention of personnel, let alone allow for improved management.[66]

This stark context requires NGOs to go beyond legal and policy initiatives to transform the public understanding and discourse around issues of health and health care. Privatization implies a definitive abandonment by the state of the idea that access to health care is a right, replacing it with a model of for-profit business. Meanwhile, targeting, through which palliative measures are intended to alleviate the worst suffering of those marginalized in the neo-liberal economic model, has revived the charity view of health.[67] NGOs engaged in advocacy around the right to health have also been forced to analyze sources of violations beyond the state, such as the development banks and the multinational corporations whose interests often drive reforms aimed at attracting foreign investment. Consciousness-raising and education have therefore become central pillars of NGO campaigns for the right to health.

Human rights NGOs, together with an array of other social actors, have been active in challenging the dominant

political-economic model posited by international financial institutions and most governments in the region. In reports on different aspects of the right to health and on economic and social rights generally, NGOs regularly set forth analyses of the effects of globalization and neo-liberal economic programs on their countries.[68] Networks of NGOs, such as the Inter-American Platform for Human Rights, Democracy, and Development (Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo) have developed concerted lobbying and educational campaigns addressing the effects of this economic model on a core group of economic and social rights, including health. Yet much more remains to be done—first, to understand clearly how structural adjustment and sector reform affect the right to health and, second, to popularize these campaigns and put questions about the neo-liberal economic program, health sector reform, and the right to health on the public agenda in countries across Latin America.

In fact, indigenous movements, rather than human rights NGOs, may have had the most success in raising public awareness about the connections between neo-liberal economic programs, foreign investment, and economic and social rights, including health.[69] Of course, human rights NGOs and indigenous movements often work together in the promotion of the right to health. For example, in a case relating to a campaign to protect the health of the largely indigenous inhabitants of the Ecuadorian Amazon from the effects of exploitative oil development, the Center for Economic and Social Rights (CESR), along with a number of other NGOs, filed a groundbreaking suit against Texaco on behalf of Ecuadorian plaintiffs in the United States in 1996.[70] CESR and its allies used the lawsuit to raise awareness about the right to health and to build capacity and long-term oversight and activism around these issues. Christopher Jochnick, the director of the Ecuador office of CESR, has argued:

> The U.S.-based lawsuit against Texaco has probably done more than anything else to raise the profile of the oil problem and to change the terms of the debate from one of government needs and environmental problems

> to one of rights and violations. . . . Despite the lack of progress on the case, . . . the suit has reinforced the idea among the Ecuadorian public that "rights" are at stake and that the industry has been acting with irresponsible double standards.[71]

CESR and its partners held workshops that in turn sparked the formation of the "Amazonian Defense Front," a coalition to support the Texaco suit and to combat irresponsible dumping by oil companies.

The Ecuadorian campaign attests to the importance of going beyond exclusive state accountability for violations of the right to health. It has also achieved some measure of success in raising consciousness and levels of social alarm at violations of the right to health in that country. Both the local Amazonian population and the general public in Ecuador are more aware of the negative impact of oil development on a number of human rights, and these rights issues are regularly raised in the mainstream media in Ecuador.[72] In turn, the Ecuadorian Congress is now more actively engaged in regulating oil development. For the first time in the history of Ecuador—a country that depends on oil revenues from foreign companies for the largest share of its GNP—mass protests have convinced the government to support the Ecuadorian plaintiffs against Texaco on certain issues.[73]

Despite some success stories, however, lack of consciousness of health as a right remains a fundamental challenge—if not *the* challenge—for human rights NGOs engaged in promoting the right to health. Although the experiences recounted here demonstrate that advocacy aimed at clarifying norms or promoting enforceability must be combined with consciousness-raising, this is a difficult process, and much more work is required to transform legal victories into social and cultural change.

In sum, in order for the right to health to be meaningful, it must become part of the understanding that people at the community level have of themselves, their well-being, and their relationship to the state. Violations of the right to health—whether caused by poverty-related conditions or by lack of access to health care—continue to be invisible, accepted as part of the natural order of things. Models of

health care based on paternalistic charity and productivity prevail in the region. Human rights NGOs must be able to articulate for the public the connections between political-economic models sponsored by international financial institutions, government policies and spending, and violations of the right to health, as evidenced by patterns of unnecessary morbidity and premature mortality. At the same time, as shown by the example of CLADEM discussed earlier, it is also necessary for health care providers to be retrained to see themselves as satisfying the rights of patients rather than performing paternalistic charity. Finally, decision-makers in governments, international financial institutions, and even multinational corporations must come to view health and health care as non-negotiable entitlements, not as matters of governmental largesse or productivity.

Exploring Interdisciplinary Collaboration with Health Professionals and Health Promotion Organizations

As is typical around the world, the Latin American human rights movement developed as a fundamentally legal movement. NGOs developed expertise in defending people arbitrarily detained and tried without due process, championing new legislation, and bringing suit in the international arena. Yet promoting the right to health—perhaps more than is the case for any other economic or social right—implies using skills beyond those of the legal human rights community. While the discourse of human rights often provides the basis for seeing an issue of health in terms of injustice, it alone cannot provide the framework for monitoring progress or designing interventions that can improve health.[74] Moreover, although documenting abuses and securing remedies for violations remains essential, the promotion of the right to health clearly requires a different paradigm from the "expose and denounce" model traditionally used to address most civil and political rights violations. The realization of the right to health will require just as much long-term grassroots promotion activity as documentation of abuses.

In general, violations of the right to health cannot be effectively monitored in the same manner as classic civil

rights violations, such as torture or other atrocities. For example, simply counting children under the age of five who have died reveals little of the true magnitude, distribution, or causes of child mortality. As compelling as individual narratives can be in human rights advocacy, in most cases they will have to be coupled with information that demonstrates their representativeness of systematic patterns or policies, which in turn may reveal the state's failure to respect, protect, or fulfill the right to health.[75] Yet gathering and interpreting information on health lies beyond the traditional expertise of most human rights NGOs in the region. The tools of epidemiology and toxicology, together with clinical expertise, have already proven critical in providing NGOs with the evidence necessary to monitor progress or detect violations of the right to health.[76]

For example, in the Ecuadorian CESR case discussed above, a team of toxicologists, physicians, and public health specialists was assembled long before any legal actions were undertaken. Toxicologists collected and analyzed water samples from the affected area, while physicians examined local residents to diagnose any adverse health effects stemming from the oil dumping. Without this multidisciplinary team, it would have been impossible to gather the necessary evidence or to mount an effective advocacy campaign.[77]

However, epidemiology is not only critical to documenting violations of the right to health. It also provides standards and indicators that can be used to infuse meaning into the international legal obligations with respect to the right to health. Despite significant steps toward normative clarification, public health professionals must play a role in selecting the benchmarks and criteria for assessing state compliance with the right to health.[78] Human rights professionals can assess whether health indicators should measure governmental obligations of conduct (process indicators) or obligations of result (impact indicators). But epidemiological expertise is required to establish concrete, objectively verifiable, cross-nationally comparable indicators that will permit human rights professionals to know what to look for when analyzing governmental statistics or examining health facilities.[79]

As part of its work on indicators to monitor governmental compliance and assess the effects of public policies on the right to health, as well as other economic and social rights, PROVEA has actively collaborated with medical and public health experts. PROVEA is also engaged in advocacy efforts to convince the Venezuelan government to adopt health indicators that reflect a human rights perspective—for example, equality of access and nondiscrimination in treatment.[80]

A second challenge to human rights NGOs in this area lies in expanding the notion of advocacy. Unlike many of the traditional areas of work for human rights NGOs, health promotion cannot be understood exclusively from a human rights perspective. Historically, health advocacy groups have not by and large incorporated a rights perspective in their work. Increasingly, however, some of these organizations have become interested in doing so.[81] Interdisciplinary collaboration with these field-level groups will be critical if providers are to be retrained with a human rights perspective and institutional management and community oversight mechanisms are to be implemented.

Increasingly, new hybrid human rights and health assistance organizations are being formed. For example, in the southern Mexican state of Chiapas, a variety of NGOs have been formed by physicians and other health professionals not only to address the health needs of displaced and other affected populations but also to do human rights education and documentation work. The group Advocacy and Social Education in Health (Gestión y Educación en Salud, or GESS), founded by Drs. Abraham Castañeda and Arturo Sanabria, and the NGO Health Defense Office (Defensoría de la Salud), for example, include explicit human rights outreach and education, as well as documentation, in their health promotion activities.

The work of these Chiapas groups, however, has been difficult. Although the political conflict in Chiapas has made their situation extreme, their experience nevertheless serves to illustrate more broadly the difficulties in combining human rights advocacy with even a small amount of service delivery.[82] Health NGOs engaged in the provision of services

have traditionally collaborated closely with government health ministries, often using government facilities, relying on access to government data, and training government personnel. Moreover, health NGOs are frequently financially dependent on a combination of funds from their government and other governments, such as the U.S. Agency for International Development (USAID). They must also rely on governments for visas for foreign personnel and for timely customs approvals of imported supplies and medicines.

Given this dependence on governments, it can prove difficult to incorporate human rights into service delivery work. After all, if a human rights approach to health is to move beyond rhetoric, it must be accompanied by efforts to make critical reforms, secure remedies for victims, and alter the governmental discourse on health. This requires a simultaneous engagement with and independence from governments that can be difficult to maintain. On the one hand, there must be negotiation and collaboration with governments, in addition to exposure of abuses, if such reforms are to be initiated and sustained. On the other hand, a human rights approach implies questioning entrenched socioeconomic power structures that produce patterns of health and ill-health. Such an approach calls for a certain degree of critical independence, which in turn renders activities undertaken inherently "political."

In Latin America, as elsewhere, in practice some health NGOs are more independent than others, and so much depends on the particular local and national political context that it is not terribly useful to attempt universal prescriptions about how to approach these dilemmas. It *is* clearly true, however, that not all groups need to do everything. With regard to women's health and rights, for example, certain health-focused NGOs in some Latin American countries have taken more moderate positions limiting their human rights advocacy to certain issues and certain channels, while other NGOs more focused on advocacy have taken a more confrontational attitude toward the government.[83] Experience shows that this is not an easy balance to strike—or sustain—but it may be part of the process of Latin American human rights groups finding their

way in a complex new world that challenges their traditional identities.

In what may be a harbinger of things to come, a group of Peruvian human rights and women's rights NGOs are in the process of forming a coalition with doctors and other health professionals in the Permanent Assembly for the Protection of the Right to Health and Reproductive Rights (Asamblea Permanente para la Protección del Derecho a la Salud y los Derechos Reproductivos). The Permanent Assembly will be engaged in proactive education and outreach campaigns with communities, providers, and activists throughout the country, as well as lobbying and legal advocacy. Its aim is to develop a successful holistic model of education and interdisciplinary advocacy and promotion of the right to health that can then be replicated elsewhere in Latin America. The multidisciplinary structure of the Permanent Assembly represents a conscious effort to move beyond blaming individual health professionals for health problems toward constructing the issue in public policy debates as a systemic problem that requires government compliance with international legal obligations.

Another interesting example of interdisciplinary collaboration also comes from Perú, where the first regional health and human rights conference for medical and public health students will take place early next year. The conference, organized by students at the prominent Universidad Peruana Cayetano Heredia medical school and other universities in Perú, has received the active guidance and support of a few prominent human rights NGOs, such as the Center for Labor Counsel (Centro de Asesoría Laboral, or CEDAL). The conference and the activities surrounding it will seek to raise awareness among the students about the participation of health professionals in violations of human rights, including the right to health, as well as to enlist them in broader movements within their countries to promote the right to health and human rights more generally. Follow-up activities will include lobbying for the inclusion of human rights courses in medical school curricula and the creation of a permanent network of health sciences students engaged in human rights promotion.[84]

In sum, human rights NGOs working in this area are beginning to recognize that they must seek out the technical expertise of health professionals and collaborate with health promotion organizations. Some have chosen to adopt a case-by-case approach to interdisciplinary collaboration, while others are creating multidisciplinary coalitions and institutions. There is, however, still significant work to be done. As mentioned above, some promising new collaborations have already begun between traditional human rights NGOs and women's rights NGOs around the right to health. Yet many open questions remain about how human rights NGOs can ally themselves with service delivery organizations and health promotion groups while still retaining their unique profile and identity.

Conclusions

This article has described four of the most critical challenges faced by NGOs engaged in promoting the right to health in Latin America and the experiences of a number of NGOs in addressing those challenges and implementing the right to health. Advocacy on the right to health is a quickly evolving area in which dynamic advocacy by a few NGOs across the region has begun to undermine many of the conventional arguments that have impeded engagement by the human rights movement generally. For example, some Latin American NGOs have played a role in significant recent advances in normative clarification of the right to health at the international, regional, and national level. Although the lack of precedents and procedures for enforceability has traditionally been another major obstacle to the implementation of the right to health, several Latin American NGOs are creatively taking advantage of what regional and international procedures do exist and have made progress on the national level through the use of the *amparo* mechanism.

A number of Latin American human rights NGOs are actively working to translate these legal victories into greater public consciousness of health as a right, but much remains to be done. Some of the human rights NGOs engaged in this area are starting to address the need to begin working in an interdisciplinary fashion with health profes-

sionals and health NGOs to document violations and promote the right. These innovative human rights groups have made substantial achievements but are only at the initial stages of creating the conditions necessary for real social change and improved health and well-being.

Promoting the right to health requires nothing less than re-evaluating many of the accepted truths of the Latin American human rights movement, while at the same time building on the hard-won authority that the movement has in political circles. It requires either creating new institutions and procedures or modifying the existing ones to provide for universal, or at least collective, programmatic remedies on the part of the state. It requires recognizing the role of actors other than the state in violations, such as international financial institutions, multinational corporations, and even individuals in the case of women's rights to health. It depends upon imagining and implementing new ways of working that include health professionals at both technical and grass-roots levels, while retaining the critical independence and normative authority of a human rights approach. Finally, the long-term nature of capacity-building and coalition-forming involved in this work calls for a set of evaluation criteria that sees value in the processes of forming networks and consciousness-raising as much as in any particular product, such as successful litigation.[85]

While advocacy on the right to health faces many challenges in Latin America, the risks of *not* undertaking this work are greater. As we enter the new millennium, the World Health Organization's slogan of "Health for All by the Year 2000" appears to have been a wishful fantasy.[86] In Latin America, where entrenched health disparities have been exacerbated by increasing income inequality, it has never been more urgent for human rights NGOs to assume work on the right to health. Although some prominent northern NGOs have argued that economic and social rights advocacy is equivalent to advancing a particular political agenda, Latin American NGOs do not have the luxury of advocating civil and political rights alone.[87] Human rights advocacy in Latin America—whether against arbitrary detention or against the criminalization of abortion—has

always been "political." Today more and more NGOs in the region are recognizing that the human rights movement risks becoming marginal to the concerns of those it claims to represent if it does not address their fundamental health and well-being. Put in a positive light, these groups also recognize that there is a broad potential grassroots constituency for advocacy on the right to health in the region, which will allow them to use the hard-won authority and legitimacy of the Latin American human rights movement to transform struggles for social justice and improved well-being in the new century.

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References

1. See A. E. Yamin, *Facing the 21st Century: Challenges and Strategies for the Latin American Human Rights Community* (Lima, Perú: Instituto de Defensa Legal/Washington Office on Latin America, 1999).
2. See K. Heggenhougen, "Are the Marginalized the Slag-Heap of Economic Growth and Globalization? Disparity, Health, and Human Rights," *Health and Human Rights* 1999, 4(2): 208. For the variability of austerity programs' effects on inequality in the region, see A. Fizbein and G. Psacharopoulis, "Income Inequality Trends in Latin America," in: N. Lustig (ed.), *Coping with Austerity: Poverty and Inequality in Latin America* (Washington, DC: Brookings Institution, 1995). Even where health statistics have improved, disparities have remained entrenched. See, for example, Minnesota Advocates for Human Rights, "Mexico," in: *Child Survival: A Global Human Rights Priority* (Minneapolis: Minnesota Advocates for Human Rights, 1998), pp. 120–64.
3. This article does not pretend to be a comprehensive review of all of the work that human rights NGOs are doing with respect to the right to health in Latin America. Rather, it draws heavily upon the experiences of NGOs represented at Facing the 21st Century: Challenges and Strategies for the Latin American Human Rights Community, a conference convened in 1999 in Lima, Perú by the Washington Office on Latin America (WOLA) and the Instituto de Defensa Legal (IDL), for which the author served as rapporteur, as well as other work in the field with which the author is personally familiar or involved. See Yamin (note 1).
4. See B. Toebes, "Towards an Improved Understanding of the International Right to Health," *Human Rights Quarterly* 1999, 21: 662.
5. International Covenant on Economic, Social and Cultural Rights, G.A.

Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966), art. 12.

6. See A. E. Yamin and D. P. Maine, "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations," *Human Rights Quarterly* 1999, 21: 563–607.

7. Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, E/C. 12/2000/4, 22nd Sess. (2000).

8. Committee on the Elimination of All Forms of Discrimination Against Women, General Recommendation on Article 12: Women and Health, CEDAW/C/1999/I/WG.II/WP.2/Rev.1, 20th Sess. (1999).

9. Programme of Action of the International Conference on Population and Development, *Report of the International Conference on Population and Development*, UN Doc A/Conf. 171/13 (18 October 1994); Beijing Declaration and Platform for Action of the Fourth World Conference on Women, September 1995, UN Doc. A/CONF.177/20 (17 October 1995).

Previous General Comments and meetings of bodies of experts had clarified the principle of progressivity and ensuing immediate obligations entailed in economic and social rights commitments, including health, which had posed a significant problem for advocates. See, for example, the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.41987/17, annex, reprinted in *Human Rights Quarterly* 1987, 9(2): 122, and Committeee on Economic, Social and Cultural Rights, General Comment No. 3: The Nature of States Parties' Obligations, 5th Sess. (1990), available from the UN High Commissioner for Human Rights at http://www.unhchr.ch/tbs/doc.nsf, art. 2, para. 1.

10. E.g., the Center for Labor Counsel (Centro de Asesoría Laboral, or CEDAL) in Perú and the Venezuelan Program for Education and Action (Programa Venezolano de Educación y Acción en Derechos Humanos, or PROVEA).

11. See J. Pitanguy, "From Mexico to Beijing: A New Paradigm," *Health and Human Rights* 1995, 1(4): 461–70.

12. Declaration of Quito Relating to the Enforceability and Realization of Economic, Social and Cultural Rights in Latin America and the Caribbean (1998). See also Plataforma Sudamericana de Derechos Humanos, Democracia y Desarrollo/CEDAL, Desafios para la Exibilidad de los Derechos Economicos, Sociales y Culturales (Challenges in the enforceability of economic, social and cultural rights), Balance de la Estrategia (July 1999), pp. 5–7.

13. Declaration of Quito (see note 12), paras. 1–2.

14. Roxana Vasquez of CLADEM, interview by the author, Lima, Perú, July 8, 2000.

15. PROVEA, *La salud como derecho: marco nacional e internacional de proteccion del derecho humano a la salud* (Health as a right: national and international framework for the protection of the right to health) (Caracas, Venezuela: PROVEA, 1998), pp. 40–41. See also CESCR (note 7).

16. CESCR (note 7), para. 41.

17. Maria Isabel Bertone, "En defensa de los derechos económicos,

sociales y culturales: aprendizaje desde el camino recorrido" (In defense of economic, social and cultural rights: lessons from the journey taken), presented at the conference Facing the 21st Century (see note 3). Note that these activities relate to consciousness-raising (see below) as well as normative clarifications.

18. Human rights NGOs are also taking the lead in championing new legislation at the national level for the implementation of the right to health. For example, the Miguel Agustín Pro Juárez Human Rights Center (Centro de Derechos Humanos Miguel Agustín Pro Juárez, or PRODH) in Mexico created a special program called Propositivo that has been a pioneer in efforts to promote new legislation on HIV/AIDS to bring Mexico into compliance with international norms. See PRODH, *El SIDA en México: Un problema de derechos humanos* (AIDS in Mexico: a problem of human rights) (Mexico City: PRODH, 1999), p. 17.

19. This has been the case elsewhere as well. See B. Toebes, *The Right to Health as a Human Right in International Law* (Amsterdam: Hart/Intersentia, 1999), pp. 167–240.

20. Pan-American Health Organization, *The Right to Health in the Americas: A Comparative Constitutional Study* (Washington, DC: PAHO, 1989), p. 607.

21. Toebes (see note 4), p. 665.

22. Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, adopted by G.A. Res. A/54/4 on October 6, 1999, and opened for signature on December 19, 1999.

23. See, for example, Working Group on Economic, Social and Cultural Rights of National Coordinating Committee for Human Rights of Perú, Parallel Report on the Situation in Perú, presented at the 14th Sess. of the United Nations Committee on Economic, Social and Cultural Rights, May 1997.

24. See Toebes (note 4), p. 671.

25. American Declaration on the Rights and Duties of Man, adopted on May 2, 1948 by the Ninth International Conference of American States, OEA/Ser.L/V/II.82, doc. 6, rev. 1, at 25 (1948), art. 11. The Inter-American Commission has heard cases involving the right to health that have been brought explicitly under the American Declaration, such as denial of medical attention and medicine to indigenous laborers during an epidemic. See Inter-Am Comm H.R. Case No. 2006 (Paraguay), in: *Annual Report of the Inter-American Commission on Human Rights 1977*, OEA/Ser.L/V/II.43 doc. 21 corr.1, at 35–37.

26. Optional Protocol to the American Convention on Human Rights, in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), adopted by the OAS on November 17, 1988, and entered into force on November 16, 1999, art. 10.

27. Compare the different language in the Protocol of San Salvador (see note 26), art. 19 and 29.

28. CLADEM and Center for Reproductive Law and Policy, *Silence and Complicity: Violence Against Women in the Public Health Services of Perú* (New York: CRLP/CLADEM, 1999), and CLADEM, *Nada personal: reporte de derechos humanos sobre la aplicación de la anticoncepción*

quirúrgica en el Perú 1996–1998 (Nothing personal: report on the application of surgical sterilization in Perú 1996–1998) (Lima, Perú: CLADEM, 1999).

29. The rape victim received some compensation and aid in relocating her home and obtaining counseling. A number of other remedial and punitive measures demanded by her attorneys, however, were not granted. In the involuntary sterilization case, the Peruvian Ministry of Health changed its policies to require certification for health centers performing sterilization, to eliminate quotas for sterilization, and to desist from using rural "health fairs" to round women up for sterilization. Women's rights groups, however, have found evidence that some of these policy changes have not been implemented. Nevertheless, there is no doubt that the case raised awareness in the general population of the health and health care conditions faced by rural indigenous women. Giulia Tamayo of CLADEM, interview by the author, July 8, 2000.

30. PAHO (see note 20), p. 608.

31. PAHO (see note 20), p. 607.

32. PAHO (see note 20), p. 591.

33. PAHO (see note 20), p. 591.

34. Causa No. 31, Viceconte, Mariela Cecilia c/Estado Nacional—Ministerio de Salud y Acción Social, s/Amparo Ley 16.986. Cámara Nacional en lo Contencioso-Administrativo Federal, Sala IX Jun. 2, 1998.

35. Viceconte case (see note 34).

36. The judges based their findings of this obligation on the American Declaration, the Universal Declaration of Human Rights (UDHR), and Article 12 of the Argentine Constitution, which incorporates these international documents into domestic law. Article 12 of the Argentine Constitution clearly specifies a government obligation to prevent and treat epidemic and endemic diseases. See CELS, *Informe sobre las actividades realizadas por el CELS en relación al derecho a la salud* (CELS report on activities relating to the right to health) (document prepared for PROVEA, 1999), p. 2.

37. Solicita se intime cumplimiento, en el caso Viceconte, Mariela Cecilia c/Estado Nacional-Ministerio de Salud y Acción Social s/Amparo Ley 16.986 (Compliance sought in the case of Viceconte Mariela Cecilia V. National Government Ministry of Health through social action brought pursuant to Amparo Law 16-986) (exp. 31777/96), 2000.

38. CELS (see note 36), p. 2.

39. The National Institutes of Social Security provide health care and other benefits to full-time employees who do not work directly for the state.

40. Comments of Maria Isabel Bertone at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 42.

41. For example, a Venezuelan organization that defends the human rights of people who live with HIV/AIDS brought a successful *amparo* against the Venezuelan Institute of Social Security, claiming that it regularly denied patients anti-retroviral medication and refused to prescribe other medications that would improve patients' quality of life. See Bertone (note 17).

42. The *amparo* was recognized as a collective remedy in Argentina in the

1994 Consitution, but the previous judicial framework continues to coexist and be applied with this one. This case was particularly important in establishing the *amparo* as a collective remedy, if not a general or "diffuse" remedy.

43. The Declaration of Quito (see note 12) reflects this regional consensus.

44. Declaration of Quito (see note 12), art. 19.

45. Declaration of Quito (see note 12), art. 23.

46. A. Teitelbaum, "Derecho al desarrollo y los derechos economicos, sociales y culturales: culminalización de su violación" (The right to development and economic, social and cultural rights) (Asociación Andina de Juristas), p. 33. Cited in Plataforma Sudamericana de Derechos Humanos, Democracia y Desarrollo/CEDAL (see note 12), p. 11.

47. For the effects on AIDS funding, see PRODH (note 18), pp. 28–29.

48. UNICEF, *Progress of Nations 1998* (Oxford: Oxford University Press, 1999), p. 31.

49. United Nations Development Programme, *Human Development Report 1998* (Oxford: Oxford University Press, 1998), p. 29.

50. UNICEF (see note 48), p. 33.

51. V. de Correa-Lugo, "La salud: de la caridad al negocio, sin pasar por el derecho" (Health: from charity to business, without passing through right) (unpublished manuscript on file with author, 1999), p. 18.

52. Correa-Lugo (see note 51). This moralistic-charity view has had disastrous consequences for reproductive health rights in particular.

53. Correa-Lugo (see note 51).

54. Correa-Lugo (see note 51), p. 18.

55. For example, in order to affiliate with ESSalud, the semi-privatized social security provider in Perú, one needs to have an income of more than double the basic food basket. Given that almost 60% of the Peruvian population lives below the poverty line, access to health care is very limited. Proyecto INEI-PNUD, Informe sobre el desarrollo humano del Perú/índices e indicadores (Report on human development in Perú: indices and indicators) (Lima, Perú: Proyecto INEI-PNUD, 1997).

56. See, for example, A. Ugalde and J. Jackson, "Las políticas de salud del Banco Mundial: una visión crítica" (The health policies of the World Bank: a critical vision), *Cuadernos Médico Sociales* 1997, 73: 45–60. See also the particular example of Mexico in United Nations Development Programme, *Human Development Report 1997* (Oxford: Oxford University Press, 1997), p. 88.

57. In some countries, although not all, the private sector has historically played a significant role in the provision of health care.

58. See, for example, A. Figueroa, "Perú: Social Policies and Economic Adjustment in the 1980s," in: Lustig (see note 2), pp. 387–88.

59. See C. Vilas, "Neoliberal Social Policy: Managing Poverty (Somehow)," in *North America Committee on Latin America Report on the Americas* 1996, 24: 24. For the concrete consequences of targeting programs in Bolivia, see the World Bank, "Evaluación del seguro básico de salud" (Evaluation of the basic insurance system) (La Paz, Bolivia: URS-MSPS/World Bank, 2000).

60. See S. Russell and L. Gibson, "User Fee Policies to Promote Health

Service Access for the Poor: A Wolf in Sheep's Clothing?" *International Journal of Health Services* 1997, 27: 367–69.

61. John Sheahan, Searching for a Better Society: The Peruvian Economy from 1950 (University Park, PA: Pennsylvania State University Press, 1999), p. 115. See also World Bank, World Development Report: Investing in Health (Washington, DC: World Bank, 1993).

62. This assessment is based on personal observation as well as interviews with the following human rights advocates: Flor Maria Perez and Carlos Burquete, Coordinación de Organizaciones No-gubernamentales por la Paz, San Cristobal de las Casas, Chiapas, México, August 5, 1997, and Giulia Tamayo, CLADEM-Perú, Lima, Perú, September 1999–May 2000 (multiple interviews).

63. For a recent study by the national medical association of the Peruvian government's ten-year-old policy of "Increasing Self-Generated Resources," see J. A. Sarmiento, "Mas de cinco millones de peruanos no tienen accesso ni a los curanderos" (More than five million Peruvians don't even have access to witch doctors), *El Comercio* (Lima, Perú), 25 July 2000, sec. A2. See also Russell and Gibson (note 60).

64. Comments of Maria Isabel Bertone at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 42.

65. See Sarmiento (note 63) and Russell and Gibson (note 60).

66. Government spending on health in Latin America in 1997 averaged 7.3% of the national budget, compared with 14.3% in the United States and 9.8% in Canada. In Perú, the amount was 5.3% of the national budget. Pan American Health Organization, La Salud en las Américas (Health in the Americas) (Washington DC: PAHO, 1998), p. 333.

67. See Vilas (note 59).

68. See, for example, J. Mujica, "Derechos económicos, sociales y culturales y políticos de ajuste en América Latina" (Economic, social and cultural rights and structural adjustment policies in Latin America), in: APRODEH/CEDAL, Informe annual sobre los derechos económicos y sociales en el Perú: enfrentando un mar de pobreza y exclusiún social (Annual report on economic, social and cultural rights in Perú: confronting a sea of poverty and social exclusión) (Lima, Perú: APRODEH/CEDAL, 1998).

69. The Zapatista uprising in Chiapas, Mexico, which coincided with the entry into force of the North American Free Trade Agreement, and the national indigenous marches in Ecuador in 1999 to protest the government's economic program, which led to the removal of President Mahuad from office, brought public attention to the effects of prevailing economic models. Other campaigns within those indigenous communities, less publicized but more sustained, have sought to expand and transform the rights discourse for advocacy relating to community health and well-being, among other goals. For example, the San Andrés Accords, negotiated between the Zapatistas and the Mexican government although not yet signed, include as a core commitment specific language relating to the right to health that mirrors international standards. See Pronunciamiento conjunto que el Gobierno Federal y el EZLN enviarán a las instalaciones de Debate y Decisión Nacional, San Andrés, Chiapas, México, February

16, 1996 (Compromisos del Gobierno Federal en los Pueblos Indígenas, para. 6) [Joint statement that the Federal Government and the EZLN will send to institutions of national debate and discussion, San Andrés, Chiapas, Mexico, February 16, 1996 (commitments by federal government to indigenous peoples, para. 6)]. See also Physicians for Human Rights, *Health Care Held Hostage: Human Rights Violations and Violations of Medical Neutrality in Chiapas, Mexico* (Boston, MA: PHR, 1999).

70. Aguinda et al. v. Texaco, Inc., complaint filed in the U.S. District Court for the Southern District of New York (1996).

71. Comments of Christopher Jochnick at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 41. For a multidisciplinary case study of the Peruvian government's policies with respect to oil exploration and exploitation and their damaging impact on indigenous rights, see R. Witzig and M. Ascencios, "The Road to Indigenous Extinction: Case Study of Resource Exportation, Disease Imporation, and Human Rights Violations against the Urarina in the Peruvian Amazon," *Health and Human Rights* 1999, 4(1): 60–81.

72. Comments of Christopher Jochnick at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 41.

73. Texaco alone is responsible for 50% of the country's external exchange. Christopher Jochnick, "Promoting the Rights to Health and a Healthy Environment in the Ecuadorian Amazon: A Case Study in Advocacy in Economic, Social and Cultural Rights," presented at the conference Facing the 21st Century (see note 3).

74. See Yamin and Maine (note 6).

75. See A. E. Yamin, "Dignidad y bienestar: el valor de las técnicas y metodologías médicas en la promoción de los derechos humanos: el caso estudio de México" (Dignity and well-being: the value of medical techniques and methods in the promotion of human rights: the case of Mexico), *Cuadernos Médico Sociales* 1998, 74: 5–24.

76. See, for example, Minnesota Advocates for Human Rights (note 2) and Human Rights Watch/Physicians for Human Rights, *Waiting for Justice in Chiapas* (New York: Human Rights Watch/PHR, 1994).

77. Comments of Christopher Jochnick at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 40.

78. Paragraph 57 of the CESCR General Comment (see note 7) calls for the use of indicators to be developed by WHO and UNICEF.

79. See Yamin and Maine (note 6).

80. Comments of Isabel Bertone at the conference Facing the 21st Century, quoted in Yamin (see note 1), p. 42.

81. For example, the author has been approached by CARE-Perú for advice on incorporating human rights into its programs.

82. These NGOs have had to be especially careful in their association with the government because of the Zapatistas' mistrust and rejection of government health institutions and financial support. See Physicans for Human Rights (note 69).

83. For example, the Movimiento Manuela Ramos in Perú, which receives a large amount of funding from USAID, is prohibited from pro-

viding abortion services or engaging in advocacy relating to abortion. Other women's rights groups in Perú have actively campaigned for the decriminalization of abortion in that country.

84. For more information about this conference and the pre- and post-conference activities, please contact the organizers at edhucas@yahoo.es or EDHUCASalud, Armendariz 445, Lima 18, Perú.

85. Here the mainstream human rights movement can learn from the experiences of the women's rights movement in Latin America, which has long been engaged in coalition-building processes.

86. World Health Organization, *Global Strategy for Health for All by the Year 2000*, WHO Resolution W.H.A. 34.36 (Geneva: World Health Organization, 1985).

87. Amnesty International, for example, is limited by its mandate. Others, such as Human Rights Watch, have focused almost exclusively on civil and political rights, with the exception of the Women's Rights Division in some cases. See, for example, the statement by A. Neier in: J. Krieger (ed.), *The Oxford Companion to the Politics of the World* (Oxford: Oxford University Press, 1993), p. 403; also cited in H. Steiner and P. Alston, *International Human Rights in Context: Law, Politics and Morals* (Oxford: Oxford University Press, 1996), pp. 269–70.