

Four Strategic Pathways for the Realization of the Right to Health Through Civil Society Actions: Challenges and Practical Lessons Learned in the Egyptian Context

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Abstract

This article examines four distinctly different, yet fully complementary, strategic pathways adopted by the Egyptian Initiative for Personal Rights (EIPR), an Egyptian independent human rights organization, in its practical efforts to protect and guarantee the realization of the right to health to all Egyptians. It reflects upon practical experiences, covering strategic options that include proposing new legislation to policy makers, participatory formulation of new laws from the ground up, public advocacy, coalition building, and litigation. It also examines several factors that affect the decision on which strategic pathway to follow. It reflects on the politico-economic settings, the presence of political will, the scope and extent of impacted stakeholders and the degree of complexity of the cause in question.

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Introduction

THE EGYPTIAN INITIATIVE for Personal Rights (EIPR) is an independent human rights organization that has worked since 2002 to strengthen and protect basic rights and freedoms in Egypt. It does so through research, advocacy, and litigation in civil liberties; economic and social justice; democracy and political rights; and criminal justice.¹ Its right to health program has been working since 2008 on the realization and protection of the right to health in Egypt using different approaches and work paradigms, four of which we examine in this article.

The decision to litigate

Litigation is often perceived as the quintessential intervention that human rights organizations adopt in their attempts to protect and guarantee the realization of rights by the state. To handle its litigation needs, EIPR employs a group of lawyers with diverse technical and practical experience. Yet, the decision to litigate is not taken lightly. In a country where legal pathways are long, costly, and have limited enforcement capacities, resorting to litigation should be limited to cases that satisfy a number of prerequisites; careful study of the politico-economic situation is also necessary before litigation proceeds.

When litigation works: The case of the Health Insurance Holding Company

In 2007, Egyptian then-Prime Minister Ahmed Nazif issued decree 637 for the year, stipulating the establishment of the “Healthcare Holding Company” and transferring ownership of all hospitals and facilities owned by the Health Insurance Organization (HIO) to this new company. The HIO is a publicly owned insurance body funded by contributions deducted from public employees’ wages. Although the Ministry of Health and Population supervises HIO, it is not state-funded.

EIPR decided to appeal this decision on the grounds that it 1) went beyond the scope of the

prime minister’s competency, 2) was not presented to parliament, and 3) directly violated the state’s responsibilities in realizing the right to health to all, making it anti-constitutional and a direct infringement of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and the African Charter on Human and Peoples’ Rights (ACHPR), to which Egypt is signatory.²

The decision constituted a major setback to the realization of the right to health, since it granted government access to the HIO, which is funded by people’s contributions. Rather than improving HIO services or extending the insurance coverage it provided, it simply turned the HIO into a private company. The decision was made without presenting the decree to parliament or even engaging in public dialogue with the stakeholders, medical syndicates, or payers.

The EIPR appeal was backed by a large network of civil society organizations and a growing community of beneficiaries that constituted an essential pillar of public pressure on the case. This network included labor unions, pensioners, and rights activists that lead this mobilization campaign.

Eighteen months later, the Egyptian administrative court issued a historical decision in favor of EIPR’s appeal. EIPR had two goals behind its decision to litigate: the direct goal was to halt the prime minister’s decision and prevent the privatization of the HIO. The indirect goal was to obtain a verdict that would enforce the right to health and put future rules for its protection in the light of the absence, at that time, of a precise text stating this right in the Egyptian constitution. The ruling set a precedent on the legal protection of the right to health that would be impossible for the government to ignore in any future endeavors to pass a new health insurance law.³

The verdict also gave the court’s final word on the government’s justifications for its decisions, such as limited resources to satisfy the beneficiaries. The court indicated that the right of the policy makers in

adopting new management principles for the health care system, or other sectors, is conditional upon its abiding by laws governing public property and citizens' rights to accessible, affordable services.⁴

Five years after this verdict, the government finally realized the importance of including civil society in the process of designing new laws, and EIPR's right to health program director joined other civil society representatives in the new health insurance legislation-writing committee.

This case constituted a success story as it was initiated by a coalition of around 50 civil society organizations and community-based organizations, known as "The Committee to Defend the Right to Health." The coalition had led a powerful and successful public advocacy campaign. The decision to litigate was made because of a simple and blatant government mistake devoid from excessive technicalities, affecting a wide range of stakeholders and including an administrative, no-competency component (the minister's decision was not within his legal mandate). As a result, the court's decision was sharp and relatively prompt.

This alignment of preconditions is optimal when entering a litigation process. But when the decision to litigate is made in cases lacking these characteristics, the outcomes can be very different.

The less successful side of litigation

Conditions were less optimal when EIPR decided to litigate against decision number 769 for the year 2009, made by the chairman of the board of the HIO, which imposed new co-payments on outpatient services. These co-payments were to be paid through out-of-pocket payments by health service beneficiaries and through additional co-payments for medicines and diagnostic services.⁵ This case included a no-competency component and affected a wide range of stakeholders. But, there was a very limited stakeholder coalition to back the decision to litigate, the administrative mistake was limited, and most importantly, it lacked the media attention, and therefore public support, of the previous case. Five years later, the court has still not issued a verdict; only a non-binding state commissioners' report has been issued in favor of EIPR's claim. To-

day, EIPR considers the case obsolete, as new laws have now been passed rendering the HIO decision irrelevant and not applicable. The administrative court, however, is still processing the case, with no end in sight. It is difficult to know whether EIPR's decision to litigate was the driving force behind the new laws or not. Yet, the presence of a human rights organization with the capacity and readiness to litigate instances of retrogression in health must be an influencing factor in these new laws.

A similar scenario occurred with a lawsuit EIPR filed against the minister of health's decree number 373 for the year 2009, which presented new regulations to govern the pricing of medicines in Egypt. This new system relied on reference pricing of both generic and patented medications in other countries, instead of setting the medication price according to the actual national cost of production. This decision favored pharmaceutical companies over the citizens' right to access affordable medicines. In April 2010, the administrative court ruled in EIPR's favor, but the higher court accepted a government appeal in August 2011, validating the minister's decree.⁶

While this case had a wide range of affected stakeholders, it dealt with an inherently technical issue on which the Egyptian judicial system was unable to make clear decisions. Although the more recent health minister's decree number 499 for the year 2012 cancelled the decree number 373 for the year 2009 and made significant, yet partial improvements to the pricing regulations of medicines in Egypt, the lesson learnt from this experience is that the court does not necessarily have the capacity to handle excessively technical decisions. In retrospect, litigation in this case was an effort-consuming pathway with unreliable results. This particular pathway was only resorted to because of the absence of alternatives.

Policy reform through new top-down legislation

EIPR wants to promote a radical sustainable reform of the health care system in Egypt that would guarantee the right to health to all Egyptians. It becomes frustrated by policy makers and state officials

who lack a real political will to find an alternative pathway to stop the continuous waste of public resources, to enable more efficient and effective ways of maintaining citizens' health through reliable, good quality services. It believes Egypt requires policy makers that will boldly attempt long term, sustainable reforms that will transform the governance and management of the healthcare system. Decision making in the health sector in Egypt is highly dependent on the priorities and capacity of the minister of health. Over the past 30 years there have been numerous ministers, overseeing a hierarchy of stagnant bureaucrats, who have attempted to present quick cosmetic reforms that are rarely sustainable and are promptly overturned by the next minister.

The right to health program at EIPR has a core principle that real and sustainable reforms in the health sector depend upon State commitment to, and accountability for, the implementation of a clear, national strategy that has involved meaningful participation with the community and other stakeholders. Such a strategic plan will not change with periodic changes of ministers and does not depend on individual whims of decision makers.

Achievement of this vision cannot depend on litigation. Implementation of long-term strategies promising long-term deliverables can cause frustrations in societies where health rights remain unfulfilled, and basics of health care are absent. The lack of a real political will to make the necessary radical changes has resulted in EIPR undertaking advocacy work among decision-makers and the health system's middle-management, aiming at developing political will by constantly shaping the experts' discourse.

A decade of sustained advocacy to this vision has finally paid off: the rapid political changes that took place in Egypt between 2011 and 2014 have witnessed an equally rapid turnover of health ministers; there have now been six ministers in three years. In July 2013, a new interim health minister was appointed who was not only the first health minister with a public health background, but she has long been involved in efforts to develop good governance in the Egyptian health sector.

This change in political context has opened the way for EIPR to again consider approaches to the government to support the introduction of new legislation.

The High Council for Healthcare Services: Structural defects, functional failure and inaction

The High Council for Healthcare Services (High Health Council) was created in the 1960s through presidential decree number 61 for the year 1966 (later modified in 1978). Its purpose is to coordinate the different actors in the healthcare system so that available resources are used efficiently and effectively to provide quality healthcare services. Yet, since its foundation, the council's role has not gone beyond providing optional, non-binding recommendations to the ministry of health, and nor has it played a role in designing or monitoring health system strategies.

This council has lacked a leadership role in health system reform. Its membership has consisted of government entities rather than civil society and the private sector. The chair is the minister of health who has the exclusive capacity to call for its meetings. These structural issues resulted in an ineffective entity which has held no more than six meetings and has slowly faded away into oblivion.

EIPR has worked to re-establish and restructure the High Health Council. It seeks a council that will activate a vision for reform, translate it into comprehensive strategies for the sector and promote the accountability of its implementers. If EIPR succeeds in doing this, there would be a governance body that guarantees a sustainable and just realization of the right to health for all Egyptians.

EIPR started the process by writing a proposal for a new presidential decree for the re-establishment of the High Health Council. In Table 1 we summarize the process to promote its use as a tool in the future.

	Activities	Additional details
1	Identifying other national and international efforts in creating governance and strategy-making bodies that are independent from government	National models included the previous High Council for Healthcare Services, the High Councils for Education, Scientific Research and Culture. International models included cases from France, the UK and Brazil
2	Conducting consultations with stakeholder representatives and experts	These included academics, field experts, patient groups, government officials, business owners and service providers
3	Formulating a primary draft for the decree	This was done through a task force that included different stakeholders' representatives
4	Going through rounds of feedback from the identified stakeholders and experts	Done through experts meetings, social media campaigns and public gatherings
5	Presenting the latest version of the formulated decree to the minister of health	Aiming at getting the minister's support for the process
6	Going through rounds of feedback from different parties and revisions of the drafted decree	Namely the minister of health, stakeholders' representatives and the legal experts at the ministry of health.
7	Presenting the final decree to the minister of health	This followed 22 different drafts of the decree
8	Following-up on the presentation of the decree to the cabinet by the minister of health	By making sure that any alterations in the decree are still consistent with its core principles that include proper stakeholders representation, a clear and binding mandate, full autonomy and independence in its functioning and other important pre-requisites
9	Following-up on the presentation of the decree to the presidency by the cabinet and issuance of the decree.	
10	Following-up on the implementation of the decree	Making sure its implementation manages to achieve its goal

TABLE 1 Activities carried out by EIPR in its work for the establishment of the re-imagined High Health Council

In late 2014, the decree was approved by the ministry of health and was being processed by the cabinet for adoption by the presidency, signaling its transformation into law.

This decree presents the new council as a body that includes beneficiaries, stakeholder representatives, sector experts and state officials in a balanced representation under an independent council chaired by an internally elected member from the civil society representatives. The minister of health is a member in the council but cannot be its chair. The council operates through its internal working bylaws and holds its general meetings at least four times per year. It has an administrative office and is allowed to create themed subcommittees to address specific issues.

This council is mandated with a number of responsibilities including:

1. Putting strategic frameworks for the Egyptian health sector that identify a vision, priorities, goals, strategic directions and plans of action that address challenges through alternative solutions
2. Supervision and evaluation on the creation of five-year and sector-specific plans proposed by the government, that follow the set frameworks and agreed timelines and their implementation
3. Creating opportunities for community participation around health sector files, enabling government accountability to the people
4. Mediating communication and coordination within the health system
5. Reforming the governance structures of the sector and designing structural reforms to promote transparency, accountability and community participation in system design and monitoring.⁷

This council has the authority to establish and devise reforms, structures, and plans to be executed by the government. It will also review and evaluate alignment of the government's actions with these strategies and plans and provide parliament with technical reports on these issues. As a result, parliament will have the information required to undertake health sector budgeting, to write appropriate legislation and to hold the government accountable.

The law also stipulates that the ministry of health and other executive authorities are required to present implementation plans and progress reports on its work to realize the visions and strategies adopted by the council according to agreed-upon timelines. In so doing, the agreed strategies and implementation plans will not be at risk of political interference as witnessed in the past.

Why this? Why now?

This mandate and structure should enable the council to stay connected to the citizens and to collaborate with stakeholders. The council will consult widely on health system reform with the goal of finding and planning solutions to resolve the real challenges, drawing on young energy and old experience. It will also provide tools for transparent and participatory monitoring of the health system to promote the full realization of the right to health to all.

EIPR took advantage of the openness of a new, interim minister of health who would support this proposal to introduce governance to the sector. EIPR also believes that the best moment to undergo radical changes is the moment of crisis, when the current systems and structure fail to deliver.

EIPR sees this proposal as a planned intervention that has the potential to restore life to a decaying body of failed bureaucracy, distraction and disappointments that is the state of the Egyptian health sector. Like all dynamic and societal complexities, full participation of the stakeholders and civil society is the most reliable and sustainable path to achieve positive change. Top-down legislation and collective work with the government seemed the most effective strategy to bring about the compre-

hensive reform required.

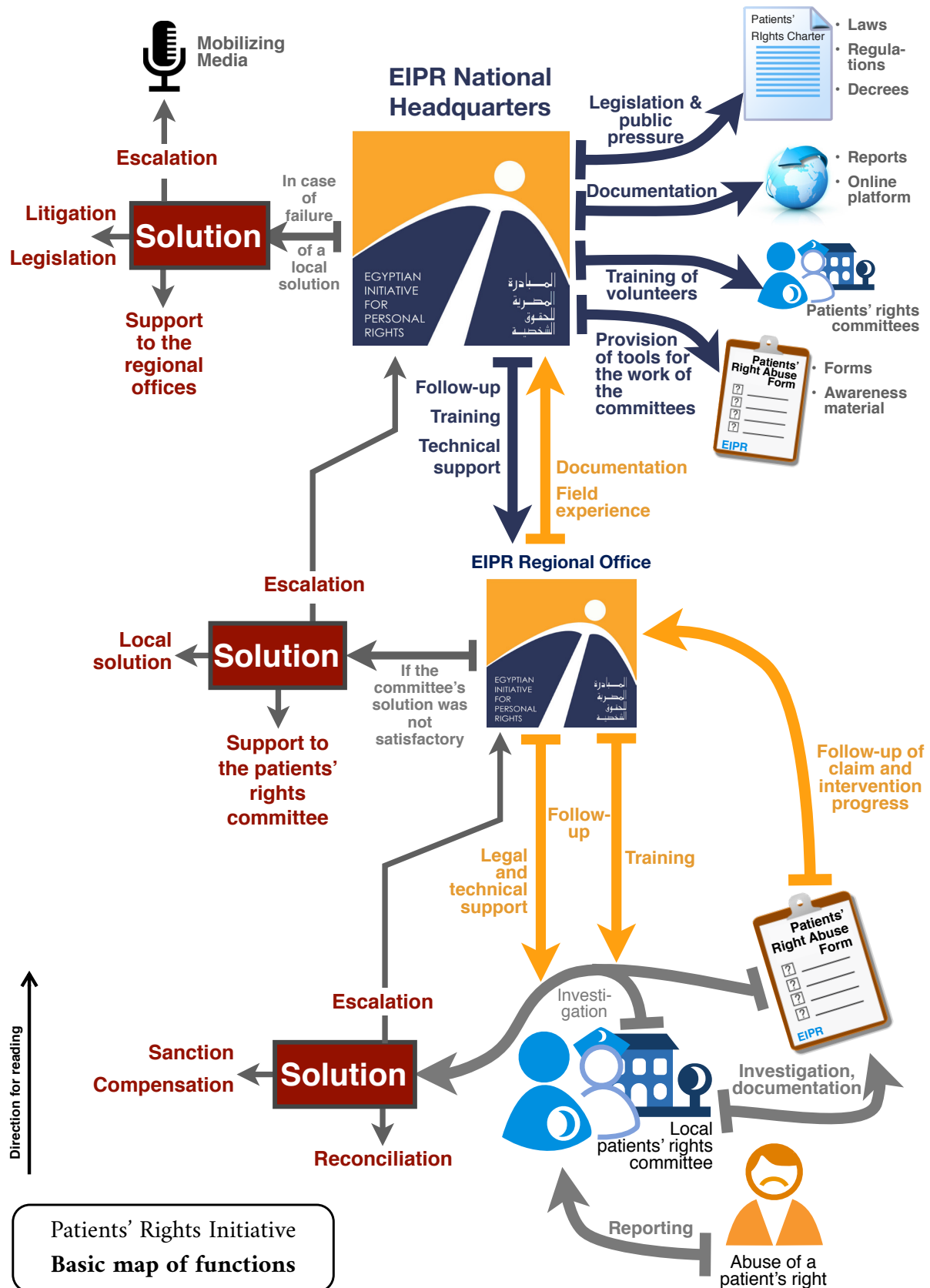
Cultivating laws from the ground up: The case of the Egyptian Charter for Patients' Rights

The work on reforming the High Health Council relied on legislative change pushed by civil society in the presence of political will. The work required was also highly technical in terms of legal processes. For these reasons, litigation was not considered, rather, EIPR concentrated on getting new legislation passed. This was not the case, however, in other aspects of EIPR's work, especially its work on patients' rights.

With the exception of the rights of the mental patients, which were stated in the new law number 71 for the year 2009, there is no legislation at any level in Egypt that defines or specifies the rights of patients. In fact, the rights of patients have never been considered a priority in Egypt and, in a state where the final beneficiaries of the health services are rarely considered in the decision-making process, their rights do not feature in the government's or legislators' priorities. Furthermore, the public lacks awareness about these rights.

It also would seem that healthcare workers see little value in patient rights. In fact, healthcare practices in Egypt could be said to rely largely on the lack of public awareness about the rights of patients. Therefore, this influential group that often constitutes the core of the decision makers in the healthcare system lacks the political will to work on advancing patient rights and might even understandably oppose EIPR's efforts.

EIPR receives complaints daily from individual patients all over the country, claiming abuses of their patients' rights. This ranges from refusal of treatment, invasion of privacy, refusal to provide information about medical conditions, discrimination in service provision and malpractice. Figure 1 shows the pathway followed by EIPR in response to patients' rights abuse claims.

FIGURE 1 Pathway followed by EIPR in response to patients' rights abuse claims⁸

There are three possible pathways to investigate and address these complaints:

1. Refer the complaint to the Egyptian Medical Syndicate's Grievances Committee which can carry out internal and informal peer investigations on medical practitioners. If the investigation finds there was severe abuse, the maximum penalty that the syndicate can impose is suspension of the physician's license for a certain period of time. The patient cannot be compensated. Since peers carry out the investigation, it is an extreme rarity for a physician to be found liable.
2. File a lawsuit against the practitioner or the healthcare facility, which enters the case into the criminal law proceedings which have no specific pathways for medical malpractice or for hearing patients' rights abuses. This process is costly, long and of limited effectiveness.
3. The patients can resort to the media, either directly or via human rights organizations.

EIPR decided to take action to end the legal silence about patients' rights. Litigation was not an option as there were no laws to build a case upon. Introducing legislation was a weak option as the matter lacked the political will needed to advance it. As the issue is not a technically complex one, and it is a concern that affects an extremely wide-range of beneficiaries, EIPR has decided to use a community-based bottom-up legislation pathway.

Benchmark: The European experience

The European Charter of Patients' Rights and the way it was created were taken as implementation benchmarks for EIPR's initiative. The European Charter was not produced by governments, parliaments or the European Union (EU). It was produced through a network of civil society organizations in different EU and non-EU states, the *Active Citizenship Network*. This dynamic network encourages active participation of citizens in European policy-making. Initiated in 2001 by an Italian organization, the network operates through partnerships with civil

society and community-based organizations to understand the aspirations of European citizens.

Through the creation of local active citizenship assemblies, this network formulated a document that states 14 fundamental rights that aim at guaranteeing the realization of Article 35 of the Charter of Fundamental Rights of the European Union in terms of a high level of human health protection. These 14 rights are an embodiment of the European fundamental rights and, as such, they must be recognized and respected in every country. They are correlated with duties and responsibilities that both citizens and healthcare stakeholders have to assume.⁹

Governments and organizations have declared their support and abidance to this charter and the Active Citizenship Network periodically produces documents describing the progress of transposition of these rights into national constitutions and laws of the different EU countries.

Inspired by this model of active citizenship, EIPR began its work on the creation of a Charter for Patients' Rights in Egypt. This work aims to create a concise, clear document, describing a list of basic fundamental patients' rights; formulated through a bottom-up participatory approach, advocated for through media, movements and individuals, supported by a general consensus of civil society organizations, grass-root movements and political parties until it becomes national law.

The field work needed for creating this document went through an initial qualitative phase where focus group discussions explored answers from a diverse range of citizens with different demographics, to the question *what would you like to see in a charter that lists your rights as patients?* When this phase is completed several rounds of feedback on the citizens' input will be conducted through social media and traditional media outlets then, the first draft of the charter will be formulated as a list of suggested rights.

After the qualitative research phase, subjects of the research were asked whether they agreed on the inclusion of each of the rights into the final document.

Finally, a charter will be created and citizens'

signatures will be collected via different platforms. This phase is expected to last for a period of three months. An awareness campaign will also take place with the goal of building a sufficiently large mass of public support compelling parliament to address the need for legislation on patients' rights.

By February 2014, the qualitative phase of the field research was completed.¹⁰ Over 300 focus group documentation forms were collected through EIPR's network of partners, including citizens aspirations, in their own words, about the rights they aspire to have. This network of partners includes a patients' organization (Cansurvive), a grass-root movement (Manifesto), a political party (the Masr El Horreya party) and the Egyptian Medical Students' Association (EMSA). EIPR finished its initial rounds of feedback and presented an initial draft of the charter through a bigger network of partners in mid 2014.

This process of bottom-up, community-based writing of new legislation is a radical new approach that requires hard work and is risky. There are no national models to follow and the political turmoil in Egypt constitutes a big risk to this network's success due to the distraction it is causing. In addition, this process will require development of new leadership, community organization in patients' groups, local patients' rights committees and other forms of grassroots movements that would make this charter meaningful in practice. Yet the newly formed network believes the result of this experience and the lessons it has learned and will continue to learn make the challenges absolutely worthwhile.

Canon of advocacy: The right to health in the new constitution

In the past two years, Egypt has gone through two consecutive processes of rewriting the constitution. Following the 2011 popular uprising, a pivotal step in the establishment of a new order that would hopefully realize the aspirations of the people was, undoubtedly, a new constitution that would state fundamental rights and cast new roles and new mandates to the different powers. Like all major socio-economic and political transitions of this

scale, the process was paved with numerous obstacles and encountered several major and minor deviations from its goals. The extent to which the resulting constitutional documents were successful in achieving the values of freedom, social justice and welfare the people fought for in their revolt, is debatable and goes beyond the scope of this paper. Yet, it was clear from the very beginning of this process that constitutional articles covering economic and social rights (being the fuel behind this massive popular movement) would have to undergo some major changes from the previous constitution. EIPR was hoping these changes would provide the opportunity to include recognition of the right to health and means of redress.

In 2012, dozens of proposed constitutional articles regarding health were submitted to the constitution writing committee. These were submitted by EIPR as well as representatives of many sectors of society including medical university professors, insurance companies, pharmaceutical industry representatives, civil society organizations, student groups and the ministry of health.¹¹

In its proposal, EIPR stressed the importance of including the right to health in the constitution as a fundamental human right to all, without discrimination. It also referenced the importance of community participation in the design and monitoring of a unified health system. This proposal stressed the state's obligation to provide health insurance protection to all citizens, without discrimination, through an equitable funding mechanism that delivers solidarity and social justice.

On November 30, 2012, the new constitution was adopted through a nation-wide referendum that achieved 63.8% approval and a 32.9% participation.¹² This new constitution featured a concise article on health that, although considered a step forward from its predecessor, failed to meet the aspirations communicated through the dozens of proposals submitted to the committee. In fact, article 62 of the constitution failed to state any of the key points featured in EIPR and others' proposals, declined to specify state obligations regarding national insurance coverage and modified the terms *right to health* to *right to healthcare services*, which dismiss-

es a whole spectrum of aspects that contribute to health, including all social determinants of health.

A description of the politico-economic context helps understand the failure to achieve the desired wording in the constitution.

The 2011 popular uprising and Hosni Mubarak's departure from power ended a 30-year reign. The overnight collapse of the leading political party, which had controlled the political scene in Egypt for decades, created a political vacuum that was quickly filled by the next most powerful and relatively organized political fronts—the different religious fundamental groups with the Muslim Brotherhood at the forefront. Working in the shadows for around eight decades, this organized community provided direct economic relief and basic services to the people most in need all over the country and managed to fill gaps created by the state's lack of capacity to address those needs. Capitalizing on a relatively large public support (for lack of other options) and a religious coating that resonates well with a sweeping majority of a seemingly conservative society, it was no surprise to see most of the new parliament's seats go to this political front.

In turn, the elected parliament was mandated to form, from its members, the constitution writing committee that would pave the way for a new president and a new government. Judging from the significant popularity of this political front, it was clear that the executive powers would soon be in their hands and, therefore, any new responsibilities of the state mandated in the new constitution would be theirs to realize.

In short, the constitution writing committee, formed from a large majority of members belonging to the same political and religious fronts, was asked to write a constitution that would determine the commitments they would have to honor once in power. The final product was therefore a document that attempted to limit any clear commitments of the state to realize social and economic rights, including the right to health. The lack of coordination in civil society's advocacy efforts made this task easier for the constitution writing committee.

In 2013, following another wave of popular and political turmoil, the political front headed by the

Muslim Brotherhood soon had to face the same fate as its predecessor in power. A revision of the constitution was in order, this time with a new writing committee that announced its commitment to amend defects in the 2012 constitution.

EIPR drew on what it had learned from the previous experience, and led a carefully crafted advocacy plan that aimed to combine all efforts from all possible stakeholders, in writing one combined proposal for the health article in the constitution.

After two months, through working groups, meetings with stakeholders groups, academics, experts, political parties, ministry officials and labor unions, EIPR managed to launch and present a proposal for the new article that combined all these views in one proposal that was presented to the writing committee and was strongly advocated for by all those different participants through press releases, media appearances and meetings with members of the writing committee.

Further work was required by EIPR when it became apparent that the writing committee was not accepting the specific wording in any of the submissions, in health or other fields. This risked important elements of the proposal being left out of the constitution.

To mitigate this risk, a tool was developed called 'The Minimal Requirements Documents'. After wide stakeholder consultation a list of simple, one-phrase minimal requirements were developed to be included in the constitution covering all human rights.

Regarding the right to health, EIPR managed to reduce its combined proposal into a list of four critical requirements. These requirements were then produced in a simple checklist and were presented to the writing committee as a tool to evaluate their final product, and for voters to evaluate the constitution it would vote for.¹³

The four minimal requirements for the right to health were:

1. The state's commitment to respect, protect and fulfill the right to health to all without discrimination and the clear allocation of its available resources to guarantee that.

2. The provision of a national solidarity insurance coverage scheme.
3. The state is mandated with the organization, regulation and licensing of all aspects of provision of health services and products and guarantees free emergency services to all.
4. Legal provisions that cover patients' rights and litigation pathways in cases of malpractice or medical errors.

By January 2014, the new constitution was passed in a public referendum by a 98.2% majority in 38.6% participation.¹⁴ In article 18, the new constitution fully met the first three minimal requirements for health in the constitution and featured, for the very first time in Egypt's history, the *right to health* to all as a fundamental right to all citizens, guaranteed by the state.¹⁵

The capacity of this latest version of the constitution to prevail is debatable due to the still ongoing political turmoil, rapidly shifting public mood and defects in the latest constitution in areas such as religious freedom and equality before the law. The relative progressiveness of the new constitution in other areas makes it detached from timely realization due to limited resources and capacity of the government. There will also be a full agenda of new operational legislation needed if Egypt is to realize these new constitutional provisions. Yet, the recent history of constitutional reforms in the country suggests that any future constitutional documents or amendments will take previous constitutions as minimal requirements to build upon. EIPR learned from this colossal experience that, in a moment of political turmoil where a country's social contract is being revisited, careful and planned coordination is a must to advance real improvements in the legal environment for the realization of the right to health. In music theory, a Canon 'is a piece in which the same melody is begun in different parts successively, so that the imitations overlap.'¹⁶ Only through this Canon of multi-stakeholder advocacy would such voices be heard.

Conclusion and recommendations

There is a wide range of strategic paths civil society organizations can resort to in their attempts to guarantee the realization of the right to health or other economic and social rights. These pathways include:

1. Coalition building and litigation
2. Proposing and advocating for new laws to decision makers
3. Participatory formulation of new laws from the ground-up
4. Multisectorial public advocacy

To achieve time- and effort-efficient results, the choice between those paths should be based on an understanding of four main variables:

1. Nature of the cause: how technical is the issue? What is the scope of diversity and size of the affected populations? How does the cause affect them? Are there other stakeholders involved? Is there a political will that can support this cause? How do people feel about this cause? Are they aware of its importance? How would they react to the advocacy to the importance of this cause? The presence of a cause with strong public support from a wide, diverse population makes public advocacy a favorable choice in contrast with causes that affect minorities.
2. State of the supporting legislation: are there laws that support the cause? What types of law are in place (constitutional articles, primary legislation, subsidiary legislation, international treaties)? Is there a history of similar cases? What are the lessons learned from these cases? Are there legal pathways that have proven their effectiveness for similar cases? Generally speaking, the presence of strong supportive legislation favors the chances of litigation to succeed. In some cases, the mere readiness of civil society to litigate provides a clear message to legislators when revisiting laws.
3. Nature of the organization: capacities,

strengths and practical experiences, network and connections, popularity, history, available human and financial resources, priorities and so forth. Some organizations' profiles enable direct communication and cooperation with decision makers in a way that can be enable hand-in-glove collaborative actions through the government.

4. Country politico-economic context: what is the general "mood" of the country? A stable parliamentary democracy during economic instabilities will impose significantly different solutions from a country passing through a transitional period where laws are being revisited.

Accordingly, organizations should plan a set of actions that follow the strategic pathway they have chosen. These actions may include advocacy, coalition-building, proposing new laws, litigation, engaging the community and its organization in order for it to lead active change. All actions should be designed to be flexible, result-oriented and account for all possible variables. All these efforts should be complementary to maximize the chances of achieving the final goal of realizing the right to health to all.

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