Social Science & Medicine 74 (2012) 1–5

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Introduction

Sites for health rights: Local, national, regional and global

Background

This Part-Special Issue seeks to capitalize on emerging work at the intersection of studies of global health, the right to health and 'the spatial turn' in the social sciences. The articles included address globally applicable research from a range of disciplines. The relevance of the right to health cuts across traditional disciplinary boundaries. The Part-Special Issue contributes to debates by presenting empirical and theoretical work from public health, social policy, political science, geography, anthropology and socio-legal studies. Attention to the right to health has increased in the last three decades mainly due to HIV/AIDS. Nevertheless, the spatial component of how to implement the right to health has been neglected by researchers, policy makers and practitioners compared to other, legal aspects of the right to health.

The working definition of the right to health used here is drawn from relevant UN Instruments. While this definition and its application is not unproblematic (De Cock, Mbori-Ngacha, & Marum, 2002; Ferraz, 2009; Mchangama, 2009; Preis, 1996; Reubi, 2011), it does provide a common starting point for the discussions to follow. Article 25.1 of the 1948 Universal Declaration of Human Rights (UDHR) states that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services." (UN, 1948). Some 20 years later, in 1966, Article 12.1 of the United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR) refined and gave legal force to recognizing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." (UN, 1966). In 2000, the United Nations Committee on Economic, Social and Cultural Rights issued General Comment 14, which offered the first detailed clarification of the scope and content of the right to health. Crucially, this sets out the minimum core obligations of states to respect, protect and fulfil the right to health. It emphasizes throughout, the importance of securing the underlying determinants of health and not simply access to health care services. It focuses not only or even chiefly on individual access to litigation, but also on the collective strategic and policy measures mandated by the right in international law (UN, 2000). As such General Comment 14 offers powerful support for a new integration of the promotion of health and human rights strategies on the basis of realistic, though demanding expectations as to the obligations of states (Marks, 2002). The authoritative and comprehensive nature of General Comment 14 has allowed activists and commentators to shift the focus of debate from abstract definition to the practical question of how the right to health can be effectively invoked and implemented. In this regard Farmer (2003) challenges the academy to develop research that takes account of the complexity of health and human rights, is multi-disciplinary, applied, and sensitive to conducting research with people who are victims of their rights not being protected, respected or fulfilled.

As the papers in this Part-Special Issue demonstrate, spaces for civil society action are necessary in order to hold the state to account (Dowler & O'Connor, 2012; London & Schneider, 2012), soft law tools may assist in establishing norms and regulation (Plotnikova, 2012), formal and informal partnerships are required for supporting resource allocation decisions in remote areas (Lewando-Hundt, Hasna, Alzaroo, & Alsmeiran, 2012), a plurality of actors are establishing networks to improve governance (Khoo, 2012) and multiple scales are being taken into account in order to widen access (Jones, 2012). In addition the papers demonstrate very clearly that the implementation of the right to health, while dependent on local context, cannot be seen in isolation from norms and global networks of action. In recognition of the breadth of the field, this Part-Special Issue brings together research that pays due attention to global norms while at the same time exploring how the implementation of the right to health can be extended in particular local contexts. Furthermore, the papers describe how rights-based approaches can assist in addressing inequalities in access, availability, acceptability and quality of health care and outcomes as well as the underlying determinants of health such as food security. In this Introduction, we set the scene by outlining the importance of sites for health rights and the contribution of the papers to the field. Without attempting simply to summarise the papers, we underscore the implications for policy and practice and we identify some of the main insights the collection offers.

This Part-Special Issue aims to contribute to debates on implementing the right to health by presenting papers that examine the right to health in terms of the 'problematic of space' (Harvey, 2008). In other words we seek to show the importance of human rights for health in two ways: by attending to the places where the right is defined, enforced and experienced; and by studying the contribution of health rights to the creation of distinctive spaces of exclusion and inclusion. Acknowledging this importance, the guest editors convened an ESRC-funded seminar series entitled *Global Health and Human Rights: Theory, Process and Substance* in 2007 and 2008. This Part-Special Issue comprises papers presented as part of this series. Further papers have been published as an edited collection (Harrington & Stuttaford, 2010).

0277-9536
doi:10.1016/j.socscimed.2011.09.038

The importance of sites for health rights

Places where human rights are invoked, protected, repressed and violated, are here referred to as sites for, and against, the right to health (Stuttaford, Lewando-Hundt, & Vostanis, 2009). Sites for health rights are physical and metaphorical spaces in which the right to health is protected, respected and fulfilled. Sites against health rights are spaces in which rights are violated. While the struggle over the right to health is often seen as pertinent and relevant to legal fora it is in fact contested and developed in a much wider range of sites. The right to health has, by definition, a spatial element in so far as the component requirements of availability, acceptability, accessibility and quality (AAAQ) include physical access to health care, goods and services and the underlying determinants of health (UN, 2000). At the simplest level, people require the capability to move through space to places to seek health care and the underlying determinants of health (as illustrated by, for example, Physicians for Human Rights and Care International's investigation into maternal mortality and safe motherhood in Peru (PHR, 2007)). These places such as clinics, drop in centres, traditional healers, food stalls, schools should provide goods and services that are available, affordable, acceptable and of sufficient quality.

When considering where the right to health is implemented, human geographers and other social scientists have to some extent contributed to debates on civil and political rights by arguing that how space is controlled can exclude marginal peoples from invoking their rights (Blomley & Pratt, 2001; Honey, 2004; Mitchell, 2003; Smith, 2000). Others have focused on spatial aspects of human rights and development (Maharaj, 2004), the implications of globalisation on human rights (Zincone & Agnew, 2000), networks for human rights (Bosco, 2007; McFarlane, 2009) and social, economic and cultural rights such as labour rights (Harvey, 2000). Links between health and human rights and geography are also emerging in research on HIV/AIDS and access to services and essential medicines (Jones, 2004; Luginaah, Yiridoe, & Taabazuing, 2005), local and global movements during the Severe Acute Respiratory Syndrome (SARS) epidemic (Teo, Yeoh, & Ong, 2005), landscapes of care (Milligan & Wiles, 2010) and the use of human rights law to build a normative approach to health geography (Carmalt & Faubion, 2010). However, on the whole, the contribution of geography and the 'spatial turn' to the right to health has not been extensive.

As the right to health becomes more prominent in day-to-day political discourse, civil society debates, and in academic research, it is important to understand where and how the right to health is translated from legislation and jurisprudence into practice. Focusing on the production of and control over space allows us to think about variation in content and enforcement of rights and to problematize the focus to date on purely legal understandings of the right to health. In particular it provides a means for understanding the role of global/local political economies as forces in establishing or blocking sites for health rights. This Part-Special Issue, therefore, not only looks at the positive and negative obligations of states in terms of the substantive right to health, but also at the positive and negative obligations of the state as regards the production of spaces where the right to health can be invoked and enjoyed. The normative content of the right to health includes availability, non-discrimination, safe physical access, affordability, access to information, acceptability and quality, all of which have spatial elements and are set out in international law (UN, 2000 para 12 of GC14). Harrington (2009: 316) investigates judicial responses to the changing global geography of health care, arguing that the national space has itself been an important common sense assumption behind judicial decisions on treatment rationing in the UK. Recent case law on migrants access to care have, however, shown that national space can no longer be "taken for granted", as European Union law and international human rights law, as well as broader phenomena of globalization, weaken the link between citizenship and welfare entitlements. Here we consider whether states have a positive obligation to provide spaces in which consumer organisations, trade unions and other civil society organisations can engage with states to ensure the fulfilment of such normative content.

Case law on the right to health needs to be looked at alongside the role of political and social action in implementing and invoking the right to health (Campbell, 1999). Successful translation of the right to health into practice requires "coordinating concepts of human rights embedded in legal and social movement channels, as well as synergies between lawyers and non-lawyers, and national and international activists." (Rosen & Yoon, 2009: 526). Heywood (2009: 15) explores the "contextual prerequisites" that either facilitate or hinder the use of human rights and illustrates how the South African Constitution provides a crucial moral and legal basis for the Treatment Action Campaign.

The political, economic and social production of space is now well understood (Harvey, 1973, 2000; Lefebvre, 1991; Massey, 2005). Massey (2005) sets out three propositions for building a case towards an alternative approach to space which is more open, heterogeneous, lively and is a multiplicity of configurations: 1) that space is recognised as the product of interrelations and interactions from the global to the local; 2) that space, being a product of interrelations, is a sphere of multiple trajectories, heterogeneity and plurality; and 3) because space is a product of interactions, space is always being created. This collection of papers illustrates the interrelations between individuals and collectives and the state. These interactions, which are creating sites for health rights, are not random and coincidental and they take place as multiple scales (Jones, 2012).

Space is no longer seen as a "fixed backcloth to the political. It is rather the sphere of multiplicity and difference, which involves tracing the lines of responsibility toward others, often across territorial boundaries." (Pugh, 2009: 579). Sometimes the physical space in which the right to health is made real, needs to be wrestled from the hegemonic power of the state or global business, and transformed (Mitchell, 2003; Stuttaford, Lewando-Hundt, & Vostanis, 2009). Authors in this collection consider spaces for civil action outside of the law courts and pay attention to the context and scales of action and influence impacting on the right to health.

The contribution of the papers to the field of health and human rights

In recognition of the breadth of sites for health rights, this Part-Special Issue looks beyond courts to include, parliamentarians (London & Schneider, 2012), partnerships between state agencies (Jones, 2012; Lewando-Hundt et al., 2012), civil society organisations such as consumer associations (Dowler & O'Connor, 2012; Khoo, 2012), trade unions and professional organisations (Dowler & O'Connor, 2012; Plotnikova, 2012). While the right to health is itself normative, the interpretation of entitlements, the roles of duty-bearers and the roles of rights-holders are located in particular landscapes of power. The practical realisation of the right to health in different spaces is influenced by the social, political and economic context in which duty-bearers and rights-holders interact. The places and landscapes of health and of power are influenced by global, regional, national and local processes. "If legal plurality has broadened the legal imagination by presenting civil society actors with alternative norms and fora for contesting neoliberal designs, the heterogeneity of normative orders has led to legal uncertainty and unpredictability of rule enforcement as well." (Randeria, 2007: 2). With increasing global integration of

markets and economies, further research is required as to how human rights approaches can advance health equity (Schrecker, Chapman, Labonte, & De Vogli, 2010). This collection increases our understanding of such approaches and in particular civil society network roles in the evolving global landscape of power (Dowler & O'Connor 2012; Khoo, 2012; London & Schneider, 2012).

The papers problematize the relationship between the local and the global (Dowler & O'Connor 2012; Jones, 2012; Khoo, 2012; London & Schneider, 2012). The global and local action taken by the Treatment Action Campaign (TAC) in South Africa around access to essential medicine and HIV/AIDS therapies is a well known example of how social movements can influence access to health care. It is also an example of how collectives can find space in which to manoeuvre and claim space in which the right to health can then be exercised. London and Schneider (2012) illuminate the problematic of globalisation, but also how this has strengthened human rights. As Heywood (2009: 27) says in "the current global political conjuncture, despite the fact that the odds seem heavily stacked against the poor, there is an opportunity for human rights approaches to address issues of poverty." A "legal space for the human rights movement" has been created and at the same time, civil society has been provided, partly by globalization of the social movements, with the capacity to "create a new space" for engaging with the state (Heywood, 2009: 28). For the TAC, especially in 2003, when South Africa was a relatively new democracy, this was a "difficult space to occupy" (Heywood, 2009: 29) when attempts were made to label the TAC as opposed to the new government. However these accusations failed to find credence as the TAC focussed its action on the provisions of the new, democratic Constitution. In countries that do not have a rights-based constitution or legal framework, this is not feasible (Heywood, 2009). As Bell (2007: 1) points out, "there is a need for protected spaces in which open disagreement and debate can take place. Where that space is demonstrable, one can begin to speak of a free people." Lewando-Hundt et al. (2012) demonstrate how the existence of such space led to new partnerships between state agencies to alleviate scarce resources in remote areas. Where such a space does not exist, other mechanisms and agency need to come in to play (Jones, 2012). For example, global advocacy and solidarity to support resilient grass roots movements that are carving out new spaces (Khoo, 2012) and civil society, trade unions and academic units providing evidence bases on gaps in fulfilment of state's human rights obligations (Dowler & O'Connor, 2012).

Where potential sites for health rights are being increasingly regulated – whether at the scale of the individual body or at the global collective, what is crucial is who decides on the regulating. In an age of modern globalisation where borderless mobility of corporations exists alongside the restricted mobility of people (Plotnikova, 2012), "The real socio-political question concerns less, perhaps, the *degree* of openness/closure … than the *terms*, on which that openness/closure is established." (Massey, 2005: 179). In the post-Westphalian world citizens may become less important and membership of civil society organisations (CSOs) more important (Fraser, 2008). "Global realities mean that the nation-state is simply no longer the site at which issues of injustice can be resolved." (Bell, 2007: 2). Supranational entities such as the World Trade Organisation and UN and global food industries increasingly influence state policy related to food (Dowler & O'Connor, 2012) and health care (Harrison, 2010). New sites for rights need to be claimed. In a world in which states are accountable to international institutions and nongovernmental organizations, Fraser asks how public opinion can be an effective critical force when in fact responsibility is devolved outside of the sovereign Westphalian state (Fraser, 2008). Fraser goes on to wonder how collectives of non-citizens can influence laws and opinion? Where state spending on health is decided by international loan requirements, how can citizen opinion have an impact on health resource allocation decisions (Fraser, 2008)? In order for there to be legitimacy, there needs to be inclusiveness and participatory parity (Fraser, 2007, 2008). In terms of 'who', in a post-Westphalian world we need to rethink 'inclusiveness' beyond citizenship (Fraser, 2007). At the same time, in terms of efficacy, new forms of power are needed that transcend national boundaries and that can hold the post-Westphalian state to account (Fraser, 2007: 23). Khoo's (2012) paper on the emergence of a transnational network is perhaps one such formulation as is Dowler and O'Connor (2012) analysis of the role of civil society, in particular in relation to CSOs as providing alternatives to creating human rights norms other than the state (London & Schneider's, 2012) and Plotnikova (2012) provides an analysis of how 'soft law' assists in the implementation of international norms.

Lewando-Hundt et al. (2012) focus particularly on access to health services for women in rural remote areas. While all space is regulated in some way by written and unwritten rules (Massey, 2005), there are increasing attempts to control public space (Mitchell, 2003). This is apparent in contexts where the presence of women in public is highly regulated. Huq (2005) provides an account of the absence of women in public spaces in Bangladesh. She identifies women's bodies as "sites of struggle" (Huq, 2005: 164). Huq (2005) explains how Bangladeshi women experienced discrimination first as women, then as human beings and then as citizens and that overcoming discrimination was linked to women becoming aware of themselves as citizens with rights. Heywood (2009) also points to the importance of the legal context for the emergence of and capacity building of Treatment Literacy Practitioners at a local level. The capabilities approach set out by Nussbaum (2006) and Sen (1999) has gained prominence in the human rights literature. Nussbaum (2006) explains how the capabilities approach is particularly well placed to address inequalities experienced by women which have been neglected by human rights-based approaches. Fluri (2009) through her account of the Revolutionary Association of the Women of Afghanistan (RAWA) investigates the geopolitics of violence and constructions of scale from the site of the individual body to transnational networks and international discourse, politics and action. Individual bodies are sites of situated knowledge and of resistance to violence which are scaled to transnational networks (Fluri, 2009). Jones (2012) and Khoo (2012) illustrate the power of scaling local issues up to include transnational networks and Lewando-Hundt et al. (2012) discusses how a human rights approach links to issues of health social justice for people living in remote settings.

Conclusions

This collection increases our understanding of where and how the right to health is invoked. As historical boundaries are increasingly challenged by, for example, globalisation, new spaces for civil society action emerges (London & Schneider, 2012). Important insights are derived from analysing states as sites of struggle for power and the right to health and how decisions are taken by states on which spaces to control (London & Schneider, 2012). While on the one hand globalisation may seem to be disempowering nation states, states still have obligations to address human rights violations. Neo-liberal globalization is associated with a reconfiguration of the state – assigning the state new tasks while blocking others. A role for right to health approaches may be to remind states of essential obligations, like health care, which some bilateral donors (for example the International Monetary Fund and World Bank) have limited. The development of 'soft law' through codes of practice and regulation are emerging as ways in which states are able to still fulfil their obligations (Plotnikova, 2012). The papers highlight how civil society organisations, such as alternative consumer activists (Khoo, 2012) are able to

hold states and transnational corporations to account (Dowler & O'Connor, 2012). By combining disciplinary perspectives and being mindful of the inter-linkages between scales we can shed light on the unevenness of local implementation of the right to health and highlight the importance of taking into account the local context of global norms (Jones, 2012). The right to health provides a way of implementing social justice and ensuring acceptable, accessible and quality health services are available, especially to vulnerable populations who may have previously been discriminated against (Lewando-Hundt et al., 2012).

There are, of course, aspects of the right to health not covered by the papers in this Part-Special Issue such as relatively little attention being given to gender and in particular the domestic private sphere. Attention is not specifically paid to methods and in particular methods for assessing the progressive realisation of the right to health, for evaluating achievement of state obligations and for eliciting local understandings of global norms. This Part-Special Issue does contribute to our understanding of the implementation of the right to health, according to global norms but within local contexts. It identifies sites outside of courts operating across boundaries and scales in which civil society organisations and elected representatives can hold the state accountable as well as confront situations in which not-state actors violate the right to health. Sites for health rights exist at the local, national, regional and international levels and our understanding of these sites assists in the implementation of the right to health.

Acknowledgements

The guest editors were co-convenors of the ESRC-funded seminar series *Global Health and Human Rights: Theory, Process and Substance* (2007-2008) (RES-451-25-4320) and papers in this collection were presented as part of the series. We would like to thank all participants of the seminars, held at Liverpool, Edinburgh and Warwick, and especially the authors of papers in this Part-Special Issue for their contributions. Ms Karen van Rompaey administered the series efficiently and enabled the co-convenors to focus on the academic content of the series. Kayte Kelley of the Liverpool Law School ensured the success of the seminar at Liverpool.

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Available online 17 November 2011