COMMENTARY

Social solidarity and the right to health: essential elements for people-centred health systems

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Introduction

The right to health has been advanced as one of the key elements to creating pro-poor people-centred health systems (Hunt and Backman 2008; Gruskin et al. 2012). However, one of the challenges for realizing the right to health is the seeming conflict between public health utility and the entitlements afforded by a human rights approach to health. This dichotomy begs two sub-questions, both of which have relevance for building responsive health systems.

Firstly, human rights affords individuals important protections against state victimization; yet where the state is acting to advance a public good, including action to realize the right to health, its actions may well infringe on individual rights. How to balance these competing rights imperatives in ways that are justifiable and fair, so that health policies and programmes are responsive to people's individual freedoms presents one set of challenges to building people-centred health systems.

A second, and related challenge for rights-based approaches to health systems, is one more related to the normative content of the right to health and how it is interpreted. Here, a tension exists in the nature of the entitlement. When the right to health is interpreted and operationalized as an individual entitlement to a health benefit, it may undermine or even contradict public health efforts aimed at realizing health benefits for collectives, and so potentially limit the contribution possible to building people-centred health systems.

A second problem that this article principally seeks to address, drawing on the experience of the Learning Network for Health and Human Rights (LN) to reconceptualize the right to health in its collective dimension.

However, because there is a tremendously strong and deeply rooted utilitarian ethic in Public Health that appears to render public health decision makers deeply suspicious of claims that might redirect resources in ways inconsistent with maximizing public utility, we start by reflecting on how a human rights approach can manage the trade-off between individual freedoms and efforts to advance public health good. We then map out the contours of a debate over the nature of the entitlement contained in the right to health, drawing both on our experience through structured reflection and on the literature to problematize the individualist framing of rights in the construction of responsive health systems. We draw also on non-Western philosophical perspectives to argue that a more useful framing of health rights involves foregrounding social solidarity in claims to collective health (Stuttaford et al. 2012a), a perspective more consistent with the principles of public health, which emphasize ‘collective action by society’ as essential to ‘the art and science of promoting and protecting good health’ (Last 2007). Lastly, we conclude that if claims to the Right to Health are framed as strengthening the collective agency of the most vulnerable, then recognizing the importance of social solidarity within the right to health can be an important strategy for building responsive health systems (Hunt and Backman 2008; Meier et al. 2010).

Methods

This article presents findings from the reflective practice of researchers in the LN, Western Cape, South Africa. The LN is an assemblage of civil society and academic organizations established in 2008 to explore how Civil Society Organisations (CSOs) implement a rights-based approach to health and how such an approach can support equitable health and social care. The LN CSO members include organizations working with different vulnerable groups, including rural women farm workers, persons with disability and grassroots community groups. The LN uses a mix of methods in its work (London et al. 2012), including quantitative and qualitative methods and, as presented here, structured reflections, document reviews and
legal analyses to test several research- and practice-based interventions designed to enhance and extend the implementation of the right to health (London et al. 2012). The LN works outside of the judicial system, utilizing international, regional and national frameworks to monitor and advocate for the right to health in state policy and programs, integrate rights-based approaches in organizational work and address human rights violations in health. Rooted in critical theory, the LN research programme has followed a participatory action research design and has evolved by responding to learning and research objectives jointly identified by CSOs and academics (Stuttaford et al. 2012b).

Three examples, described in the following section, have been utilized in developing critical practice around health rights for the LN (London et al. 2012). During this reflective practice, social solidarity emerged as a key factor in how a health rights claim plays out. We present these examples to illustrate both the practical obstacles to, as well as the potential for promoting social solidarity when engaging with human rights because they give insight into how health system responsiveness can be better facilitated through adoption of a rights-based approach to health (Hunt and Backman 2008; Meier et al. 2010).

The setting of this study is the LN’s programme of action research, which has monthly team meetings in which discussion is structured around theoretical and conceptual issues informing LN research. All three examples, purposively selected for analysis in this article, are experiences in which the LN has been engaged within the past 5 years and formed part of presentations and discussion in LN research fora. Discussions in which LN participants related the examples to their own practice of health and human rights were captured in notes of meetings and used as the data for this article.

In the first two examples, external resources were presented to team participants to stimulate reflection on the nature of the human right to health. The first example involved the findings of a student survey into patient rights (Tien et al. 2011) and the second example was a documentary DVD investigating access to social security available from a non-profit community health media organization. Both resources are described in more detail below. In attendance at these reflective meetings were university-based and civil society-based researchers.

The third example presented here is the LN itself, since, as an action research project, peer researchers are in a continuous process of reflection and action (Stuttaford et al. 2012b). A programme of LN research into non-Western approaches to rights rooted in African philosophy took the form of a series of seminars held in 2010–2011, open discussions and collection of an annotated bibliography, through which a legal argument for understanding rights more collectively was derived (Himonga 2013). For the purposes of this article, reflection explored the relevance of the findings to the role of social solidarity in the work of the LN.

Public health and human rights: an uneasy co-existence?

In 2002, an article titled ‘Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century’ argued that ‘the emphasis on human rights in HIV/AIDS prevention [which] has reduced the importance of public health and social justice, which offer a framework for prevention efforts in Africa that might be more relevant to people’s daily lives and more likely to be effective’ (De Cock et al. 2002). The authors went on to argue that human rights approaches to HIV/AIDS were poorly adapted to the crisis in Africa and that the epidemic should rather be treated as a public health emergency, necessitating, amongst other steps, widespread and routine HIV testing to increase awareness and interrupt the epidemic. The authors framed human rights as ‘a legal concept focusing on the individual’ in contrast to a public health approach, which they defined as ‘what we as a society do to assure the conditions for people to be healthy’. In this conception, rights were equated with individualist freedoms that obstructed public health goals for the majority by preventing access to much-needed HIV testing by overemphasizing individual autonomy, whereas public health was equated with social processes and choices to protect populations.

International human rights law recognizes public health as one of the conditions that might justify restrictions on the derogable rights listed in the International Covenant on Civil and Political Rights. Furthermore, Section 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) enjoins State Parties to take steps aimed at the ‘improvement of all aspects of environmental and industrial hygiene’ and ‘the prevention, treatment and control of epidemic, endemic, occupational and other diseases’ as part of its obligations towards enabling everyone to enjoy ‘the highest attainable standard of physical... health’. If state steps needed for advancing public health limit some people’s rights, the question would be whether such actions were justified. Here, the Siracusa principles, an expert interpretation of the limitation and derogation clauses in the International Covenant on Civil and Political Rights (ICCPR), principles which were adopted by the United Nations (UN) Economic and Social Council in 1984 (United Nations Commission on Human Rights 1984), provide relatively clear guidance as to when policies that limit human rights in the interest of public health might be justified. Thus, to meet such a standard, the state must consider a set of factors such as the nature of the right, the importance, purpose, nature and extent of the limitation, whether the limitation is likely to achieve its intended purpose, whether any less restrictive means can achieve the same objective and whether the way the policy is applied is free from discrimination or arbitrary application.

When applied to the use of quarantine for infectious diseases such as Severe Acute Respiratory Syndrome (SARS), in which limitations of freedom of movement are used to prevent spread of serious life-threatening illness, the logic of the quarantine as a justifiable measure is hardly controversial (Fidler 1999). Even when considering the introduction of provider-led HIV testing programmes as a system-wide response to HIV, which may, in their real-life application, result in violations of patients’ autonomy, careful application of the Siracusa principles can chart a way forward that balances rights considerations as consistent with policies to promote uptake of voluntary testing for HIV (Gruskin and Lof 2002). Of course, in the real world, providers’ own values, coupled with a paternalistic culture of ‘the service knows best’ and urgency to meet targets for testing
What is the nature of the entitlement?

However, a different argument is one that asks whether the right to health is simply an individual entitlement applied to collectives or is an entitlement that is fundamentally social in nature.

The heavy emphasis on individual entitlements in the human rights discourse is the hallmark of North American libertarianism. For example, Jacobson and Soliman (2002), warning of the potential co-option of the Health and Human Rights Movement, described eloquently how the tobacco industry and the gun lobby use claims related to civil liberties to oppose public health interventions in the United States. Similarly, US debates on health care reform have, unlike European traditions, eschewed any form of social solidarity in favour of the market (Callahan and Wasunna 2006). However, these interpretations of what a human rights approach implies are themselves political choices (London 2008), akin to emphasizing the false dichotomy between civil and political rights, on the one hand, and social and economic rights, on the other, a dichotomy driven largely by ideological differences linked to the Cold War. The preoccupation with civil and political rights, at the expense of social and economic entitlements, is not uniform across the world, least of all in South Africa, where popular discourse and jurisprudence have recognized the importance and the justiciability of socioeconomic rights (Ngwena 2000; Brand and Heyns 2005; Jones and Stokke 2005; Heywood 2009; Geffen 2010).

From a public health perspective, health inequities are usually related to social processes generating discrimination (Diderichsen et al. 2001). Public health, both in theory and in practice, requires a commitment to a collective approach to well-being (Last 2007; Meier and Fox 2008). An individual solution, framed as an individual entitlement, may reinforce the unfair social relations that generated inequity in two ways. Firstly, it may shift attention away from the social solutions needed to remedy the problems of group discrimination. For example, where advocacy has been successful in securing compensation to victims of exposure to industrial pollutants in South Africa, as was the case in relation to the Cape Asbestos and Macassar sulphur fire disaster, the restitution involved establishing a screening process with individual criteria for eligibility for compensation. As a result, although some people were compensated, many community members were reported as excluded because they lacked some essential requirement for eligibility and the community as a whole remains mired in a situation of social vulnerability. Moreover, by entering the compensation process and acquiescing to a case-by-case restitution process, any possible opportunities to redress on a collective level the fundamental causes of the environmental injustice that gave rise to the exposures in the first place, were lost.

Secondly, it may allow claims for individual entitlements to be met in ways that undermine public health efforts to address population-wide priorities, thereby increasing inequalities in some contexts. For example, in Brazil (Ferraz 2009) and Colombia (Yamin and Parra-Vera 2010), there has been a series of well-documented court actions over access to medicines in the past decade. Although in the Brazilian state of Rio Grande do Sul, where the majority of plaintiffs have been poor or unemployed applicants (Biehl et al. 2012), Yamin and Parra-Vera (2010) have shown that in Colombia, the majority of court challenges lodged and won enforcing medicines access have been on behalf of contributory members (i.e. employed and/or wealthier) of the health insurance system (Yamin and Parra-Vera 2010). These developments are not necessarily associated with building health system resilience. For example, claims in Minas Gerais state in Brazil to medicines of limited effectiveness may be a barrier to rational drug use and undermine national drug policy guidelines (Machado et al. 2011). In the Colombian context of large political and social inequalities and low social mobilization around health care, court victories on access to medicine may have ended in reinforcing processes by which the bulk of the health budget is allocated to individual insurance, to the potential neglect of public health promotion and prevention plans that might provide greater benefit to a larger population (Yamin and Parra-Vera 2010).

However, there is evidence that jurisprudence in South Africa has advanced solidarity and social justice through a right to health approach (Forman 2008). The South African experience illustrates an alternative in which it has been shown that "enforcing health rights may in fact contribute to greater degrees of collective solidarity and justice. While the Court’s approach does not guarantee all rights claims, it nonetheless seeks to ensure that the basic needs of the poor are not unreasonably restricted by competing public and private interests. Achieving this balance has meant shifting from traditional liberal rights approaches that isolate individuals from their social context and focus on individual rights to the exclusion of correlatives duties. Instead the Court has adopted an approach to rights more cognizant of the realities of societal interdependence and of the socioeconomic preconditions of individual autonomy and agency. This novel rights paradigm locates individual civil and social rights within a communitarian framework drawing from the traditional African notion of ‘ubuntu’, which denotes collective solidarity, humanness and mutual responsibilities to recognize the respect, dignity and value of all members of society” (Forman 2008, p. 1–2).

What underlies the difference in these settings is the importance of rights-based claims as complemented by civil society action (London 2004, 2007, 2008; Stuttaford et al. 2012a; Haynes et al. 2013) and particularly in ways that strengthen the
agency of those most vulnerable to violations of their rights (London 2007). Forman’s analysis also surfaces the role of social solidarity, which we now examine in more detail, drawing on some of the LN’s experiences.

Social solidarity and the right to health: findings from reflective practice

Is it possible to think about rights claims helping to build social solidarity, framed as the mutual responsibility of citizens for addressing health needs of each other, through community responses (Callahan and Wasunna, 2006; Reichlin 2011), to tackle injustices? In other words, is it ever possible to conceive of rights claims and rights advocacy resonating with social solidarity?

We start by presenting our reflection on a study of a 151 patients surveyed over 4 days in 2011 at a Community Health Centre (CHC) on the Cape Flats (Tien et al. 2011), which determined the awareness and knowledge amongst patients attending the CHC and their practices in relation to rights and responsibilities. CHCs are primary care facilities delivering first contact curative care and are bedevilled by long waiting times and shortages of staffing. Emerging from the study was a high proportion of patients who admitted to jumping the queue at some point in the past, a practice that appeared to be unrelated to patients’ perception of respect for rights.

The reflections of the LN co-researchers confirmed that if health services are going to realize the right of access to health care, then they have to provide timely care to patients without interminable queues. But if some patients choose to jump queues, they do so at the expense of others’ rights. How do we create a sense of entitlement that is not an individualist claim at the expense of others’ similar claims? Further, could we think of rights as advancing awareness of collective solutions to problems shared by many? In other words, can rights approaches help to build a consciousness that is aware of the relational nature of rights claims—that what one person claims may well affect others or the larger group?

In the Latin American context, the analogy for queue jumping might just as well be the ability to get a court order to secure expensive medicines, which depletes the health systems capacity to provide other essential drugs to vulnerable populations. Resolving the problem of long queues in primary care or lack of access to medicines using a rights-based approach should find systemic solutions so that all those waiting can benefit, not just the person at the head of the queue (or who gets to access court), or the person who skips to the head of the queue, claiming that their illness was an emergency, or who draws on favours from the nursing or clerical staff. Building stronger and responsive health systems cannot be achieved otherwise.

The second example centres around a case involving the arbitrary withdrawal of a disability grant affecting poor families in the Eastern Cape province of South Africa. This case is contained in a documentary DVD titled Law and Freedom (see http://www.beatit.co.za/archive-people/nozozile-and-nobulelo-meltafa), which explores the place of human rights in South Africa’s democratic transformation. In 1998, in an effort to clean out fraudulent ghost claimants, the Eastern Cape Government summarily stopped all disability grants and insisted that all recipients had to re-apply for their grants. Mrs Melatafa who was the beneficiary of disability grant for her mentally disabled adult daughter was one of many people living in poverty-stricken circumstances, who depended on grants as their sole income. Despite her efforts to re-apply for the grant, the authorities did not reinstate her grant. She turned to a public interest litigation group who took the Eastern Cape government to court, arguing their action was illegal. This was a class action suit on behalf of all those grant recipients affected by the arbitrary suspension of their grants (Nzuza et al. 2001).

Because the case dragged on the courts and the Eastern Cape Government stonewalled any resolution, Mrs Melatafa suffered tremendous hardship. Despite this, when the Eastern Cape Department of Welfare offered to settle the matter with a cheque for the equivalent of $1800, she refused the offer, even after her lawyers explained that there was no guarantee of winning the case. Had she accepted the offer, she would have jeopardized the strength of the collective case. Interviewed in the documentary, she recounts that she did not hesitate, saying ‘Nombulelo’s grant problems are in your hands’. Even though a successful court case would still have meant a long wait till she saw any compensation, she reasoned that if refusing to accept the cheque was going to help thousands of other people who were in the same situation, she was ‘fine in not accepting that offer’. She and her co-applicants finally won their case, 4 years after the grants had been illegally stopped.

In our reflections, we were struck by this first-hand account of a poor and semi-literate pensioner, having both the wisdom to see the long-term benefits for herself and an unflinching sense of social solidarity that superseded any temptation to individual benefit. The law, in defending her right to fair administrative action and to social security, secured a victory not just for Mrs Melatafa but for thousands of poverty-stricken residents of the rural Eastern Cape. Circumstances afforded Mrs Melatafa the opportunity to leave the queue and settle the claim to her own personal benefit, but she chose to avoid undermining the collective claim, waiting for a settlement that would benefit not only her but also others in a similar position. In this case, resolution of the rights claim facilitated the expression and building of social solidarity in ways that the jumping CHC queues did not.

South Africa is facing one of its biggest experiments in social solidarity in the form of the phased introduction of a National Health Insurance (NHI) (McIntyre et al. 2009), which will essentially establish a pooled income source to purchase health services on an equitable basis. South Africans will be expected to pay in to the pool on the basis of their incomes but will claim on the basis of need, rather than on the basis of what they paid in to the fund. Social solidarity will be critical to the successful implementation of the NHI as a health system based on universal access (Harris et al. 2011; Goudge et al. 2012).

Therefore, a key question is whether human rights can promote solidarity? Bosco (2007), exploring the emotional linkages between participants in two social movements in Argentina established by relatives of victims of human right violations, found that the emotional connections between
network participants mobilized them and supported the creation of a collective identity. Drawing on Taylor and Rupp’s concept of ‘emotional labour’, Bosco (2007, p. 546) argued that participants ‘drew on their emotional labour to create feelings of proximity, solidarity and shared identities’. In this analysis, emotional bonds between participants underpinned collective action. The evident success of the Anti-Retroviral Treatment (ART) treatment access movement in South Africa has much to do with the powerful identity-generation arising from shared bonds within the Treatment Action Campaign, upon which grassroots human rights education and strategic leadership could build strong popular collective demands for socioeconomic rights (Heywood 2003, 2009; Mbali 2005; Geffen 2010). Moreover, the use of explicitly human rights-based arguments to both unify a marginal constituency of excluded HIV-positive patients whilst marshalling a diverse alliance of CSOs behind a claim for access to antiretroviral medicines in South Africa was ultimately achieved in ways that fundamentally transformed the health system (Heywood 2009). This experience, reinforced in other examples of rights-based health advocacy in Southern Africa (London 2007), illustrates the broader argument that where civil society adopts principles of solidarity, rights-based approaches do not exacerbate and are more likely to address health inequalities.

It is not only in social movements that adoption of human rights approaches to health by CSOs can build social solidarity. For example, within the LN, collective learning and reflection has created a sense of solidarity and trust which has enhanced LN member agency and, in turn, confidence to engage in human rights action (London et al. 2012). In the work of the LN, therefore, rights have increasingly come to be understood by participants as social in nature, achievable for collectives rather than individuals (Stuttaford et al. 2012b). For example, the contents of discussions in our Review and Reflect meetings, initially concentrating on cases of individual rights violations, has shifted to address more collective ways of working with rights, such as in the campaign of a member organization for decent sanitation for rural women farm workers as an explicitly rights-based issue or in the enhanced inclusiveness achieved by another organization in reframing disability-related advocacy in health rights language. The increased sense of collective learning has also seen organizations with the LN increasingly sharing skills and working with each other in rights advocacy (London et al. 2012). This experience mirrors the idea that participatory spaces are potential ‘schools of democracy’ where people learn critical citizenship, creating opportunities that maximize the public good, the LN undertook a programme of research aimed at surfacing African knowledge with the idea that understanding non-Eurocentric ways of thinking about human rights might challenge the hegemony of northern writings on human rights and contribute to generating new theory and practice related to the right to health, foregrounding the importance of social solidarity.

The findings proposed four axes on which the concept of ubuntu is relevant for rights analysis (Himonga 2013). Firstly, within current international human rights discourses, it is possible to identify a basis for including an ‘African-inspired and dignity-based’ principle. Secondly, it is possible to locate ubuntu within the normative framework for rights, particularly in the concepts of ‘duty’ and ‘peoples’ rights in the African Charter on Human and Peoples’ Rights’ (OAU 1986). Thirdly, in the South African context, ubuntu could be argued to be both a moral principle and a core constitutional value, reflected in both the spirit of the interim Constitution’s postamble and in some of the Constitutional Court’s rulings and interpretations (Himonga et al. 2013). Lastly, the attributes of ubuntu relating especially to interdependence and solidarity could provide a bridge for harmonizing individual rights and collective entitlements to health through the concept of dignity. As framed by former Constitutional Court judge, Albie Sachs, dignity ‘unites the right to be autonomous with the need to recognise we are all social beings. Thus, the fundamental right of all human beings to have their basic human dignity respected becomes the link between freedom and bread’ (Sachs 2004, p. 142). The idea that rights are neither totally individual nor wholly collective has been illustrated in arguments that reproductive health rights in Nigeria have resonance with values located within indigenous African culture and hence, that individual rights ‘...are not

Ubuntu, social solidarity and the right to health

Given the potential tension between the individualism of rights and the collective nature of public health, the LN began to explore the potential for African philosophy to provide a more collective understanding of how rights can be practised as relational between people and across the community. Although a much misappropriated term in current-day South Africa, the cultural concept of ‘ubuntu’, as the understanding that one’s personhood exists only because of, and through relationships in the broader community, is a concept widely present in traditional societies throughout Africa. It presents a different normative view to the individualism of Western democracies about how people are valued as being inseparable from their place in collectives and how people relate to each other. For example, writing about poverty reduction programmes in Uganda and Nigeria, Brock (2004) points out that social systems in traditional societies protect community-based institutions, which demonstrate high levels of self-help, self-government and accountability and emphasize mutual dependence. Ubuntu, therefore, provides a kind of shorthand for a complex characterization of what it means to be human—encompassing ideas of group solidarity and interdependence, responsibility, compassion, respect, human dignity, conformity to basic norms and collective unity.

Because of the potential for ubuntu to address the tension between human rights claims and the utilitarian drive in public health to maximize the public good, the LN undertook a programme of research aimed at surfacing African knowledge with the idea that understanding non-Eurocentric ways of thinking about human rights might challenge the hegemony of northern writings on human rights and contribute to generating new theory and practice related to the right to health, foregrounding the importance of social solidarity.

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Conclusions
The objective of Universal Access looms high on the post-Millennium Development Goals (MDG) global agenda. Its realization foregrounds the willingness of their populations to commit to some form of social solidarity, and the need to think about human rights in ways more consonant with population level benefits (Meier and Fox 2008). At the same time, surfacing debate about the nature of rights claims and the place of more collective approaches to rights, including African ‘traditional’ concepts of rights, that do not necessarily involve the courts directly, can also contribute to advancing the theorization of rights. We argue that, rather than framing this conflict as a debate about individual vs collective rights, social solidarity should be seen as essential to the realization of rights that are essentially collective in nature (Stuttaford et al. 2012b). Given the nature of social determinants of health as goods which can only be effectively delivered to collectives, realizing the right to health requires programmatic and policy interventions that apply to communities, groups and collectives, not just individuals. As argued in relation to the judicialization of claims for access to medicines in Brazil, courts should be treating health as a collective entitlement, which ensures universal availability of medicines rather than reacting to individualized claims (Biehl et al. 2009). Framed as a collective interest, rights claims then become more inclusive, with social solidarity as a key mediator.

We argue, based on our joint co-researcher reflection, that more collective approaches to realizing rights offer both more sustainable opportunities to advance health equity and better conceptual frames to enhance our understanding of rights-based approaches to advancing human well-being. Realization of the right to health is contingent not only on sound legal application of human rights standards but, more particularly, on the assertion by civil society of claims facilitated by legal entitlements in ways that recognize the collective nature of socioeconomic rights. Far from being antithetical, we believe that claims to the Right to Health are essentially about strengthening the collective agency of the most vulnerable and are best served by recognizing the importance of social solidarity, a challenge that is core to the demand of building pro-poor people-centred health systems.

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Ethical approval
The research reported on in this study was approved by the Research Ethics Committee of the Faculty of Health Sciences, University of Cape Town, REC # 179/2007.

Conflict of interest statement: None declared.

Endnote
1 Victims of asbestos exposure in mining areas in the Northern Cape, Limpopo, and Mpumalanga provinces recently secured compensation for asbestos-related disease. Residents of the working class suburb Macassar near Cape Town in 1999 were exposed to combustion products of sulphur (including sulphur dioxide and sulphuric acid fumes) released from an accidental fire at a chemical factory resulting in a number of deaths and respiratory illness.

References


Nkubza and Others v Permanent Secretary, Department of Welfare, Eastern Cape, and Another. 2001. (2) SA 607 (E) 609, The Permanent Secretary, Department of Welfare, Eastern Cape Provincial Government, Member of the Executive Council for Welfare, Eastern Cape Provincial Government v MN Nkubza, NM Meltafa, S Mboya case No 493/2000 (Supreme Court of Appeal, unreported.).

SOCIAL SOLIDARITY AND THE RIGHT TO HEALTH


