# The Human Right to Health and the Health of Global Urban Poor Populations

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## I. Introduction

The rapid and continuous urbanization which is so characteristic of the late 20th and early 21st Centuries has led to an increasing focus on the health needs of urban populations and the urban poor in particular. Nonetheless, care for the urban poor is still lagging well behind the level that it should have achieved, constituting a clear violation of the right to health of this population group (WHO 2011:6). With the purpose of outlining a possible strategy to remedy this situation in the future, this paper will provide an overview of available literature on the right to health, the international movement for equity in health and the health challenges of the urban poor at the global level. Some of the key debates with regards to the right to health and the development of rights-based approaches (RBAs) to health will be presented. This will be followed by a discussion of the particular health challenges that the urban poor face today. The paper will then conclude with the proposition of elements of best practice for applying a RBA to improving the health of the urban poor.

## II. The right to health and rights-based approaches in global health

### 2.1 The ideas of health equity and universal health coverage and the rise of rights-based approaches to development

The idea of a right to health as an international standard dates back to its inclusion in both the constitution of the World Health organization of 1946 and the 1948 Universal Declaration of Human Rights (WHO 2002:2). It is enshrined in the Office of the High Commissioner for Human Right's (2000) general comment no. 14 and also an important number of international and regional treaties and national constitutions (Zarate 2011:57). General comment 14 stipulates the need for any nation to guarantee both access to quality health care and the provision of adequate services that address the debilitating underlying determinants of health (WHO 2002:9). As such, the right to health obliges states and local authorities to address context-specific needs of local populations in health and to work towards the provision of health for all (Marmot 2007:1155,

Meier and Mori 2005:147). The idea of equity in health is an important concept in this regard. Equity is guaranteed when access to health care and health conditions are provided in a way that does not discriminate and actively strives to overcome inequalities, wherever this is possible (Kroll et al. 2011:264, Preda 2012:17; Doyal 2000). Together with the setting of universal health coverage as a unifying goal for countries at the 1978 Alma Ata conference, these concepts have had a lasting impact on the development of international work towards a right to health (WHO 2007:10).

Rights Based Approaches (RBAs) to development came to prominence in the wake of disenchantment with neoliberal development in the mid-nineties (Hickey and Mitlin 2009:6). In opposition to previous mainstream development theories that focused on the provision of services and top-down economic programmes, RBAs were seen as a turn towards "human" development, putting the rights and aspirations of communities at the forefront of development thinking (UNDP 2012:4). As one seminal result of this, the Millennium Development Goals (MDGs) and the subsequent Sustainable Development Goals (SDGs) have included heavy emphasis on rights (WHO 2017:xi). Taking an angle that presents health care for all as a human right and a duty for the international community to achieve, the two movements outlined clear objectives to work towards. Although the MDGs in particular created considerable momentum and enthusiasm, a lack of progress towards the goal of universal health coverage is being noted today, accompanied by a call for renewed action (WHO 2017:v; Wagstaff et al. 2017).

### 2.2 What is a rights-based approach to health?

Despite efforts from the UN to clarify the term and establish a common standard for its agencies (United Nations 2003), there is until today no general agreement on what constitutes a RBA to health (d'Hollander et al. 2013:6). Nonetheless, certain basic common elements can be identified: Generally, RBAs take as a reference the body of international human rights law and seek to further the capacity or willingness of both "duty bearers" to fulfil their obligations and of "rights holders" to successfully advocate for rights (UNDP 2012:4, UNAIDS 2004:1). This means that RBAs need to be built on a sound analysis that identifies human rights violations and the concerned actors (UNDP 2010:93, Kirkeman Boesen & Martin 2007:21). Building on such analysis, organizations who apply a RBA to health primarily target their programs at health ministries and other concerned government and non-government health providers as duty bearers (Sida 2015a:6). To facilitate the capacity development among duty bearers, organizations are being provided with a large number of manuals and workshop outlines aimed at different audiences such as frontline health workers, or health policy makers (United Nations 2015). Concurrently, the ability of rights holders to claim rights are being developed through rights education and the accompaniment of legal claims for rights (Sida 2015a:7 see figure 1).

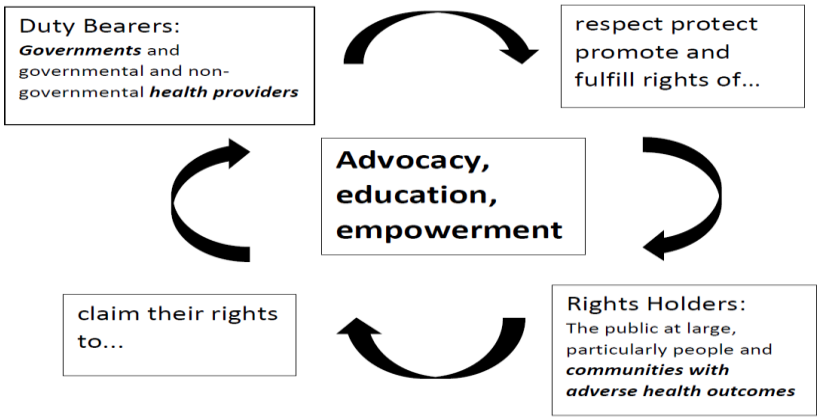


*Figure 1: Elements of a rights-based approach to health (adapted from Sida 20150)*

Beyond such basic assumptions and standards, however, the path that RBAs take has much leeway in where the focus is being placed, leading to a rather fragmented image. Gready (2013:3) usefully identifies two general strands of rights-based approaches: "transnational advocacy", which builds bridges between human rights and development and predominantly takes place between high level international actors and governments, and "North-South partnership", which is strongly focused on political empowerment and capacity building of local partners (see also Easterly 2008:16). D'Hollander (et al. 2013:8) notes in a similar vein, that a radical implementation of a RBA would imply a drastic shift away from supporting service delivery in health and towards "strengthening the capacity of the state to fulfil its human rights obligations, while promoting capacity-building processes for citizen's empowerment and state accountability". This, however, seems to have proven too drastic a change for exponents of the international development establishment such as the WHO and World Bank and has rather led to the creation of "hybrid" rights-based initiatives which deal simultaneously with service delivery and capacity building (ibid: 8-9). The UNICEFS (2015:10-12) health strategy, for instance, makes specific reference to the use of rights as a tool, albeit one among a number of mostly service delivery-oriented programmes.

This somewhat fluid and insufficiently defined status opens up RBAs to health to criticism that they too often subscribe to an opportunistic "pick and choose" mentality that strips human rights of their transformative potential (Sen and Mukherjee 2013:23, Gready 2013:4, Langford 2016:2). Whether one agrees with such criticism or not, the multitude of practices and programmes that are presented in the literature under the concept of rights-based work increases the urgency for organizations to clearly define their own interpretations of the concept and to outline how their particular RBA will contribute to positive programme outcomes.

## III. The health challenges of the urban poor

### 3.1 Environmental challenges and working and living conditions

Urban poor populations often live in precarious conditions which are potentially detrimental to their health in a multitude of ways. Much literature is consecrated to the health problems arising in slums and informal urban settlements as the most glaring indication of urban poverty (Kroll et al. 2011, Shetty 2011). The uncontrolled growth of many urban centres in the global south means that residential areas are often badly equipped for safety and that residents suffer from a lack of hygiene, as well as safe infrastructure and basic services (Ministerio de Salud 2017:12). Important examples include unsafe waste disposal, unsafe residential buildings, or the exposure of urban poor populations to the detrimental effects of air pollution (WHO 2014:4, Krämer et al.2011:10). Furthermore, urban centres are important sites of industry in many countries of the global south, where laborers work under problematic health and security conditions (see Riaduzzaman 2017, ILO 2016 for the case of Phnom Penh). Studies focusing on environmental aspects of the health of the urban poor tend to highlight the need for improved urban planning, as well as for public health and education interventions (UNDP 2014, Mercado et al 2007).

### 3.2 Insufficiencies in health care

Taking the WHO's framework for implementation of the right to health (WHO 2007:2, see figure 1 below) as a basis, further important problems for the health of urban poor populations can be identified: While the availability of health care is generally better in urban settings than in rural ones (Population Reference Bureau: 2015), the picture becomes more complicated when it comes to the framework's other core aspects of accessibility, acceptability and quality. With regards to accessibility, issues include the often-severe misdistribution of health services in cities favoring more affluent areas (Shetty 2011:627, Mercado ET al.2007:7). Acceptability on the other hand has been documented as being insufficient due to a lack of focus on the health needs of poor populations (Gilson 2007:130, WHO 2016:33). Quality of urban health care – particularly the kind to which urban poor populations have access – is also in many cases questionable, with numerous insufficiently trained health workers offering their services (Galea and Vlahov 2005:209). The "over- availability" of health services in urban centres can therefore be problematic by both distracting from other important issues and creating a confusing situation in which urban poor populations find it hard to identify healthcare of sufficient quality (Soeung et al 2012:4, Ovesen and Trankell 2010:252-255).

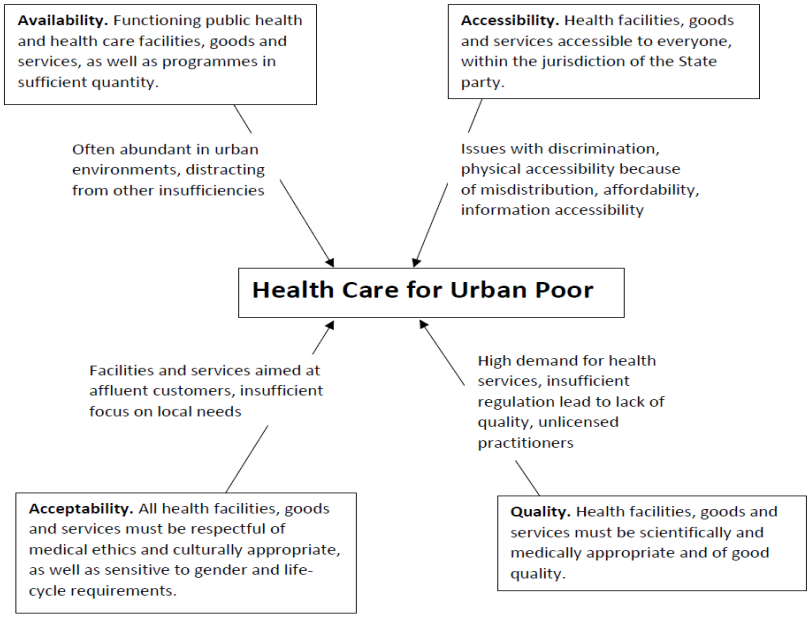


*Figure 2: Insufficiencies in health care for the urban poor (adapted from WHO 2007:2)*

Complicating this situation is the double burden of infectious as well as newly important non- transmittable diseases (NTDs) that urban populations face (Krämer et al.2011:14, Drakakis-Smith 2000:145). Infectious diseases are easily transmitted in the crowded and unhygienic living and working conditions of cities (WHO 2016:67) and the living conditions and changed patterns of urban live are conducive to the development of NTDs (Shah et al. 2010). Both the lack of financial resources, as well as the problems linked to insufficiently responsive health systems, mean that many poor inhabitants of urban areas do not receive the continued care that diseases and particularly NTDs require (Katz et al. 2012:138). The neglect of the growth of NTDs in urban areas in the global south today could mean that the future holds further severe problems for health systems when the NTDs take off in force in newly urbanized societies (Milogo et al. 2015:3).

### 3.3 Lack of political power

A common underlying theme running through the literature, is the lack of political power that urban poor populations have for changing their situation (Mercado et al. 2007, WHO 2008). This can be explained with their status as unwanted and often illegally settled inhabitants of cities (Mercado et al. 2007:7). A commonly proposed strategy is therefore to put a particular accent on the political education and empowerment of urban poor populations and on their stronger inclusion in the planning and carrying out of activities regarding their health (WHO 2010:10, People In Need 2014:48, Galea and Vlahov 2005:205-206). This leads us to the discussion of RBAs as one promising strategy for addressing the health issues of the urban poor in the global south.

## IV. The urban poor and the right to health: global experiences and best practice

### 4.1 The "urban advantage": Cities as motors of the rights struggle

Somewhat ironically, the assessment that the health of the urban poor is being neglected, coincides with a strong theme in literature proposing that the urban environment offers a uniquely promising starting-field for more sustainable development, political participation and better health outcomes (Barber 2014, WHO 2014, Alves et al.2014). This "urban advantage" is explained both with the greater availability of health services and service providers in cities, as well as with the generally energized civilian society that is characteristic of urban centres (WHO 2008: vii, Ross et al 2014). There are also disadvantages to be taken into account, however, for applying RBAs in urban environments. The complexity and chaotic nature of urban growth often means that cities are growing uncontrolled or with very little central oversight (Ministerio de Salud 2017:14, World Bank Group 2017:45-53). The involvement of numerous private and non-private, as well as national and international actors in the health landscape complicates the identification of duty bearers and their responsibilities (Lenard and Straehle 2012:7, WHO 2017: x). Furthermore, urban governments often have limited controlling powers vis-à-vis international and national private actors on whose presence they are economically dependent (Brugha and Zwi 2002:64, Lee et al. 2002:12, Lenard and Straehle 2012:3). Making good use of the advantages of the urban setting, while mitigating its disadvantages is key to the successful implementation of RBAs to improve the health of urban populations.

### 4.2 Laying the groundwork: Identifying and highlighting rights violations

RBAs can offer important contributions in two principal ways: through the identification in theory of rights-violations which arise in the situation of the urban poor, and through the provision of a framework of action to address these violations. Since all rights work has to be based on a sound understanding of the rights-context (London 2008:66), a thorough analysis needs to be carried out before any action is taken to identify rights violations. Table 1 offers some examples of how the body of rights treatises relates to the health challenges of the urban poor identified above. Beyond this basic identification of rights and rights violations, the WHO's (2010) "Urban Health Equity Assessment and Response Tool" (Urban HEART) offers an analytical tool to health ministries and cities' governments that allows for the analyses of health inequities and levels of participation of all stakeholders in urban health governance (WHO 2014:11). Importantly, urban HEART can contribute to the correct identification of duty bearers as well as their specific responsibilities in the complex urban setting (Prasad et al. 2015).

| **Health issue** | **In violation of...** |
|---|---|
| Environmental challenges and working and living conditions | |
| Unhygienic and dangerous living quarters | Article 25.1 of the Universal Declaration of Human Rights (UDHR), Article 12.2 (b) of The International Covenant on Economic, Social and Cultural Rights (ICESOCR) |
| Unsafe work conditions | Article 25.1 of UDHR, Article 12.2 (b) of ICESOCR |
| Insufficiencies in health care | |
| Lack of provision for treatment and care of dual burden of disease | Article 25.1 of UDHR, Article 12.2 (c) and (d) of ICESOCR |
| Discrimination by health providers | Article 25.1 of UDHR, Articles 2 and 3 of ICESOCR |
| Lack of access to quality medical care | Article 25.1 of UDHR, Article 12.2 (c) and (d) of ICESOCR |
| Lack of political power | |
| Urban poor are being kept from participating in planning of health programmes | Article 12.2 (c) and (d) of ICESOCR |

*Table 1: Health of the urban poor: What rights are being violated? (adapted from OHCHR 2000:4-6)*

### 4.3 Taking action: Negotiating health rights and fighting for the "right to the city"

The rights-based work of the UN bodies and other international organizations can be seen broadly as examples of Gready's (2012) "transnational advocacy" approach. In their strategies, the need for action is placed largely with the governments of cities and of the countries within which they are situated (WHO 2009, Water Aid 2012:22). These duty bearers are held accountable for rights violations that arise in the precarious living and working situation of the urban poor and for a lack of progress in remedying these (UNHCR 2008:15, WHO 2016:202). Best practice recommendations highlight the need for cross-sectoral alliances with private and non-private health actors to improve urban health services (WHO 2016:48, Water Aid 2012:29). Cross sectoral alliances can be led by the National Human Rights Institution (NHRI) as proposed by the UNFPA (2014) or by other concerned agencies. Success stories and presentations of best practice in this vein, such as those by the United Nations Development Group (2013) and the Human Rights Council Advisory Committee (HRCAC) (2012), are mostly concerned with improvements in access or service delivery. One example given is the improvement of water delivery in urban Manilla through a successful public-private partnership (HCRAC 2012:19).

A second pillar of RBAs to health in urban settings is education on rights of urban poor populations (WHO 2010). Rights education includes raising the awareness of people about rights violations when it comes to unacceptable living and working conditions or access to health care they face and equipping them with the tools to address rights claims to the concerned duty bearers (Aregbeshola 2017:45). Not only are the rights claims of the urban poor promoted and accompanied by organizations applying an RBA, the international community can also be brought in as an advocate for addressing issues of concern, ensuring that the reach of grassroots activism has an effect beyond the local actors (Ife 2008:22-23). Empowering communities for claiming their health rights is a delicate and difficult task that faces big hurdles – and often encounters failure – in situations where restrictive regimes allow for little political change (UNFPA 2014:41). It can be argued that health rights in cities can only become a reality in the wake of wider political reforms (Duni et al. 2009).

| **Recommendation** | **Sources** (e.g.) |
|---|---|
| Building a cross-sectoral urban alliance for health rights. | Gready et al. 2016, WHO 2016, Water Aid 2012, Thomas et al. 2015 |
| Carrying out programmes of human rights education among urban poor communities. | Marks et al. 2008, Cameron 2012, Aregbeshola 2017 |
| Engaging the urban poor in process through community empowerment and participatory planning. | WHO 2010, Water Aid 2012, UNDP 2011, HRCAC 2012 |
| Propagating the "right to the city", which includes a wider reform of political participation and grassroots leadership. | Ministerio de Salud 2017, Zarate 2011, Marks et al. 2008, Sugranyes and Mativet 2014 |

*Table 2: Key recommendations for best practice*

Some organizations' RBAs, therefore treat rights-based work to improve urban health as part of a social struggle to claim a broader "right to the city" (Brown and Kristiansen 2009, Marks et al. 2008). These approaches focus on the importance of interventions which fully empower the urban poor – as well as all other population groups – to participate in the process of defining a city's politics and service delivery (Mercado et al. 2007:11, Ross 2014:19, Cavallaro 2003:6). Intended outcomes are far reaching in that they lead to more inclusive forms of urban governance and to deeper participation of previously marginalized

populations in health programming (Marks et al. 2008). Key to developing such drastic changes is the adaptation to local context that the programme of a right to the city goes through in consultations with the local population (see e.g. Ministerio de Salud 2017:39-44, Santamaria 2012). The "Charter of the City of Mexico for a Right to the City" (Ciudad de México 2011, Zarate 2011:58-59) offers an example of an outcome from such consultations that outlines a broad agreement about – among other issues – health rights and participation in health planning matters. An important positive outcome can thus be, that the rights-struggle becomes truly locally owned, rather than rigid, outside imposed and potentially culturally inappropriate (Marks et al 2008:18). There is of course no rigid distinction to be made between the described variations of RBAs and they do not need to be mutually exclusive. As Alves (et al. 2017:3821) puts it, the right to health naturally "intertwines" with the right to the city. Both high-level negotiations with duty-bearers, as well as strong initiatives for empowerment to a culture of rights in cities can and should take place simultaneously. In this manner, both the insufficiencies in health services provided to the urban poor, as well as the underlying issue of their political disenfranchisement can be addressed.

## V. Conclusion

The urban poor in the global south face severe and urgent health problems which have so far been only insufficiently addressed. Those urban poor populations that continue to face obstacles to good health consist a clear violation of their human rights, making rights-based initiatives to health a pertinent and promising strategy. Although there is an abundance of literature and guidance on how to apply RBAs in development and health practice, a certain lack of unified vision has to be noted. While some organizations present rights-based work as taking place in a wider logic of economic development and service provision, more radical approaches highlight the need for profound societal change and grassroots empowerment. To work with a marginalized population such as the urban poor, in addition to hybrid RBAs that involve negotiations with local governments and service provision support, a strong push towards people-centered empowerment needs to be applied. Such comprehensive approaches that put equal emphasis on augmenting the responsiveness of urban decision makers and on enabling a more egalitarian and inclusive political system could provide the best option for translating the "urban advantage" into better health outcomes for urban poor populations.

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