COMMENTARY

The Right to Health: Looking beyond Health Facilities

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In 1946, the Constitution of the World Health Organization first articulated the right to health, stating that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."[1] This right was further enshrined as a human right in 1966 in article 12 of the International Covenant on Economic, Social and Cultural Rights, which communicates four core components—availability, accessibility, acceptability, and quality.[2] Furthermore, defining health as a human right insinuated the need for legal accountability, equality and nondiscrimination, and participation.

Even prior to the COVID-19 pandemic, states' commitment to the enjoyment of the highest attainable standard of health for all was unmet—at best, acknowledged—across the globe. The COVID-19 pandemic did two things. First, it undermined efforts to improve health outcomes and bridge gaps in health care delivery.[3] The interruption of health services, the rise in unemployment, and the increase in gender-based violence, to name a few indirect impacts, affected the most vulnerable.[4] Note, however, that this is not a novel realization—health crises have consistently affected the most vulnerable and have put accountability for the right to health on the back burner.

Second, and potentially one of the few silver linings of the pandemic, is the extent to which it has shone light on the necessity of enforcing the right to health and the fragility of human society in its absence. Failure to protect individuals' right to health has prolonged the pandemic and resulted in economic, social, and political chaos that has further thwarted efforts to achieve the former. The authors in this special section successfully highlight various ways in which stakeholders across the spectrum can work toward the enjoyment of the highest attainable standard of health. In this commentary, we draw from their expertise and our reflections on the right to health to discuss some strategies toward the fulfillment of this human right.

The achievement of the right to health requires patient accompaniment. Heidi Behforouz, ex-director of the Prevention and Access to Care and Treatment project at Partners In Health, describes accompaniment as follows: "Accompaniment in one sense is an easy term. You walk with the patient—not behind or in front of the patient—lending solidarity, a shoulder, a sounding board, a word of counsel or caution. Empowering not enabling."[5] Accompaniment was also highlighted by Paul Farmer, with whom we collaborated closely, and to whom this special section is dedicated. It extends beyond the delivery of quality,

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equitable health care services in health facilities and the physical accompaniment of patients to health facilities. The social, economic, and political conditions that enable individuals to access health services and maintain a healthy life must be put in place to facilitate the achievement of the highest attainable standard of health.

We can take the example of maternal and child health care to illustrate what expert patient accompaniment looks like. On the clinical side, this means holistic care provision to mothers and infants—quality antenatal care services, respectful facility-based delivery, timely postnatal care, and follow-up of the child, including the critical childhood vaccinations. Missing any step of the process will jeopardize the health of the mother or the child. But true accompaniment of patients goes beyond providing quality clinical services to addressing the social determinants of health. For instance, is the mother able to travel to the health clinic for all her antenatal care visits? Can the family afford the services for both the mother and the child? Do the mother and child have access to food and, more importantly, to a balanced diet?

Availing clinical services at health facilities is futile if patients cannot reach them or if patients are unable to keep themselves healthy due to lack of food. This is why accompaniment is critical; you address all the challenges that stand in the way of people achieving their maximum health potential. At the national level, the approach to health should shift from siloed clinical delivery to holistic maintenance of individual and population health. At the health-facility level, clinicians and managers need to be trained to identify these socioeconomic factors that prevent good health and connect patients to well-equipped resources that can address their concerns, as the framework of structural competency that is further developed in this special section emphasizes.

Training health professionals to practice medicine and lead health systems through such an equity lens requires the integration of social medicine into medical and global health curricula. Social medicine trains professionals to look beyond the bedside to understand and address social, economic, and political factors beyond the health care system that cause ill health or hinder access to health care services.[6] Students should not only learn about how the social determinants of health such as income can detrimentally impact health outcomes but also be able to think about all aspects of socioeconomic, cultural, and political well-being (the processes of social determination, as Jaime Breilh has argued), of which income is only one indicator.[7] Moreover, health professionals should also be equipped with the know-how to address these factors at all levels (intrapersonal, interpersonal, clinic, community, research, and policy).[8] This requires a mutlidisciplinary and inter-professional approach to medical and global health education, where one discipline or profession draws from others to collectively advance toward the fulfillment of the right to health.

This pedagogical approach must be accompanied by leadership, management, and communication training that will allow health care professionals to organize toward the attainment of the highest standard of health. At the same time, health professionals must be trained in structural humility: in not making assumptions about patients' lives, encouraging instead the ethical stance of collaboration with patients and communities in developing understanding of and responses to structural vulnerability.[9] Fresh graduates from medical schools sent to hospitals in remote, rural regions will often be expected to address governance, financial, and supply challenges in order to create a favorable environment for clinical care delivery. These are obstacles that hinder the achievement of the right to health; hence, health professionals must be equipped with these skills.

Critical to pushing these aforementioned strategies forward is community participation. Patient accompaniment is possible if the health system builds a trusted relationship with the community, allowing the community to openly discuss health challenges and the government to prescribe solutions that are acceptable.[10] Accountability to community demands and a commitment to the right to health build community trust in the public health system, which feeds back into improved

health outcomes, which, in turn, contributes to trust. Given that every nation-state has ratified at least one international human rights treaty recognizing the right to health, accountability mechanisms that break down this human right into clear actionable programs and policies and outlines consequences for non-adherence must be set up. This lack of specificity and clear consequences is a major reason for our stymied progress toward the attainment of the right to health—a right articulated in the World Health Organization's Constitution nearly eight decades ago.

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