

The human right to health and the struggle for recognition

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Abstract. Persistent health inequalities exist globally, affecting high-income countries and blighting the developing world. Health inequalities currently are one of the greatest challenges facing realisation of the human right to health. This article argues that the struggle for the right to health in the face of such inequalities requires embracing three critical considerations: redistribution, representation, and recognition. While the analysis of the right to health has been formulated predominantly around theories of distributive justice, I suggest that a more normatively compelling account will link the politics of economic redistribution to the politics of sociocultural recognition. A recognition approach, which views rights claims as grounded on the vulnerability of the human condition, can show how rights are emergent in political action and that the ability to claim and exercise the human right to health is contingent upon recognition of diverse sociopolitical statuses. From this perspective, there are no 'neutral' constructions of the rights-bearing subject and conflict between different political framings of the right to health is a consequence of the struggle for recognition. This theme is illustrated by comparing conservative, affirmative, and transformative processes of recognition in the struggle for access to essential antiretroviral medicines by South Africa's Treatment Action Campaign.

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Action without a name, a 'who' attached to it, is meaningless.¹

Introduction

Persistent health inequalities exist globally, affecting high-income countries and blighting the developing world.² Health inequalities arise from the ways that inequalities in power, resources and status, both within and between countries, condition the ability of different individuals and groups to access adequate health care and essential

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¹ Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), pp. 180–1.

² Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva: World Health Organization, 2008). For a study of health inequalities in the UK, see Bethan Thomas, Danny Dorling, and George Davey Smith, 'Inequalities in Premature Mortality in Britain: Observational Study from 1921 to 2007', *British Medical Journal*, 341 (2010), pp. 1–6.

medicines, and to live at least reasonably healthy lives. Moreover, health inequalities are exacerbated by social discrimination and political exclusion on the grounds of race, ethnicity, gender, sexual orientation, religion, and language. Health inequalities are a matter of justice in that they influence patterns of advantage and disadvantage in society that can have significant and unfair detrimental effects on the physical and mental health of individuals and groups.³

Health inequalities are pertinent when considering the human right to health, since such inequalities have a profound impact on the unequal enjoyment of this particular right (and indeed of human rights generally). The human right to health has surged onto the international stage as one of the most pressing human rights of the twenty-first century. The World Health Organization (WHO) estimates, for instance, that at least 1.3 billion of the world's people lack access to basic health services⁴ and nearly 2 billion people lack access to essential medicines.⁵ While the problem of health inequality is especially pronounced in low-income countries, those lacking access to health care, essential medicines, and bearing the greatest burden of disease reside in all countries.⁶ Similarly, the struggle for health care justice and the human right to health and resistance to inequalities in access, power, and status that have a negative impact on health is a global phenomenon.

This article offers a conceptual reinterpretation of the human right to health which contends that the struggle for health care justice cannot be concerned only with inequalities in wealth and resources. I develop this argument by posing two central questions. First, what if realising the human right to health presupposes not only redressing maldistribution but also remedying misrepresentation and misrecognition? Second, how can recognition theory help us grasp the ways that social, economic, political, and health status are codetermined? While the analysis of socio-economic rights, including the human right to health, has been formulated predominantly around theories of distributive justice, I argue for a crucial move to link the politics of economic redistribution to the politics of sociocultural recognition. I suggest that recognition theories better address the shared experience of dehumanisation that afflicts those denied or deprived of adequate health services and essential medicines, insofar as that deprivation results as much from a failure 'to get human beings to recognize other human beings as creatures worthy of their respect, concern, and care',⁷ as it does from inequities in funding and resource distribution. In this way the constellation of injustices that crystallise around health inequalities highlights that access to adequate health services and essential medicines is a requisite not merely for life but for a *fully human existence*.

The article proceeds as follows. The first section briefly discusses the definition and scope of the human right to health (hereafter HRTH) as a basic socioeconomic right codified in several international treaties and documents. After identifying what I

³ See Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley: University of California Press, 2003).

⁴ World Health Organization, *World Health Report 2006: Working Together for Health* (Geneva: World Health Organization, 2006).

⁵ World Health Organization, *Medicines Strategy: Countries at the Core, 2004–2007* (Geneva: World Health Organization, 2004).

⁶ Alan D. Lopez, et al. (eds), *Global Burden of Disease and Risk Factors* (New York: Oxford University Press and The World Bank, 2006).

⁷ Bryan S. Turner, *Vulnerability and Human Rights* (University Park, PA: The Pennsylvania State University Press, 2006), p. 41.

think is the key weakness of the international legal formulation of HRTH – namely, that it relies upon the presumption of an inherent abstract humanity rather than the embodied self of the politically recognised human being – the next section sets out a recognition theory approach to human rights that reflects both on the vulnerability of the human condition and on what being fully human really means. This approach allows us to see human rights as sites of political struggle over what makes us the same and what makes us different from one another – struggles, in other words, for due recognition of our always precarious human status. It also indicates the significance of HRTH as a political response to forms of misrecognition or status inequality, and not only maldistribution or economic inequality. Subsequently, I argue that claims for HRTH should be seen as situational demands for social justice. From this perspective, there are no ‘neutral’ constructions of the rights-bearing subject and conflict between different political framings of HRTH is a consequence of the struggle for recognition. This theme is illustrated by comparing conservative, affirmative, and transformative processes of recognition in the struggle for the right to health and access to essential antiretroviral medicines by South Africa’s Treatment Action Campaign.

The human right to health

Is there a human right to health? In international law and policy, HRTH was first explicitly proclaimed in July 1946 as one of the founding principles of the WHO.⁸ Subsequently, Article 25(1) of the 1948 Universal Declaration of Human Rights (UDHR) provided the formal foundation of the international legal framework to health as a human right: ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care.’ While the UDHR focuses broadly on the social determinants of health, Article 12(1) of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) reiterates the right to health with the same specificity as the WHO constitution: ‘The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ In turn, HRTH is affirmed in several regional conventions, including the 1948 American Declaration of the Rights and Duties of Man (Art. 11), the 1981 African Charter on Human and Peoples’ Rights (Art. 16), and the 2000 Charter of Fundamental Rights of the European Union (Art. 35). Despite such widespread formal acknowledgment of HRTH, interpretation of its nature, scope, and substance varies widely, and practical implementation of its provisions remains woefully inadequate.⁹

Given the emphasis in principle on the ‘highest attainable standard of health’, HRTH is both extensive and complex and it can be construed in various ways: as part of a general social security right covering the pertinent social determinants of health such as safe housing, clean water and sanitation, as well as information on health care and health education; as a specific right concerning access to health

⁸ Constitution of the World Health Organization, {<http://www.who.int/governance/eb/constitution/en/index.html>} accessed 24 August 2010.

⁹ Brigit Toebes, ‘Towards an Improved Understanding of the International Human Right to Health’, *Human Rights Quarterly*, 21:3 (1999), pp. 661–79.

treatment; and as a claim on governments to provide effective delivery of public health services and essential medicines. Further, the right to health also refers to several forms of special assistance or protection, such as for pregnant women and mothers,¹⁰ children¹¹ and the disabled,¹² and to closely related rights and liberties, such as freedom from racial discrimination that would lead to refusal of medical treatment.¹³ Although international treaties and declarations tend to vary in their description of HARTH and what it entails, there is no need to assume that any of these documents can or should delineate an exhaustive categorisation. As the UN Committee on Economic, Social and Cultural Rights observes in General Comment 14 on the ICESCR, because the normative content of Article 12 is broadly inclusive of factors such as the underlying determinants of health, each individual's biological and socioeconomic preconditions, each state's available resources, gender differences, and even security-related concerns such as violence and armed conflict, examples defining the content of HARTH are merely illustrative and non-exhaustive. For this reason as well, HARTH is not to be understood as a right to be 'healthy'.¹⁴ Rather, it is 'a right to the enjoyment of a variety' of diagnostic, curative, and preventive 'facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.¹⁵

This interpretation within General Comment 14 leads to a construal of HARTH that is consistent with what Henry Shue terms a 'basic right'. In Shue's well-known conceptualisation, certain rights are considered basic because they guarantee things 'essential to a normal ... life' and are vital to protect 'against a standard threat to rights generally. This is precisely why basic rights are basic. That to which they are rights is needed for the fulfilment of all other rights.'¹⁶ As formulated by the Committee on Economic, Social and Cultural Rights, HARTH is 'indispensable for the exercise of other human rights'.¹⁷ Since the highest attainable standard of health is of central importance for the full enjoyment of all human rights, both socioeconomic and civil-political, characterising HARTH as a basic right seems apt. This is especially clear when considering whether HARTH needs to be guaranteed for those facing 'formidable structural and other obstacles',¹⁸ such as poverty, violence, discrimination, inequality, and persistent burden of disease. As a basic right, HARTH cuts across the traditional negative/positive dichotomy often used to distinguish civil-political and socioeconomic rights.¹⁹ On one hand it refers to the right not to have one's health harmed by acts that infringe upon one's bodily integrity, such as torture and medical experimentation. For Shue, however, basic security and subsistence

¹⁰ Convention on the Elimination of All Forms of Discrimination Against Women (1979, Art. 12).

¹¹ Convention on the Rights of the Child (1989, Art. 24).

¹² Convention on the Rights of Persons with Disabilities (2006, Art. 26).

¹³ International Convention on the Elimination of All Forms of Racial Discrimination (1965, Art. 5).

¹⁴ Toebes, 'Towards an Improved Understanding', p. 662.

¹⁵ Committee on Economic, Social and Cultural Rights, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health', UN Doc. E/C.12/2000/4 (11 August 2000), paras 7–13.

¹⁶ Henry Shue, *Basic Rights: Subsistence, Affluence, and US Foreign Policy*, 2nd edn (Princeton: Princeton University Press, 1996), p. 34.

¹⁷ Committee on Economic, Social and Cultural Rights, 'General Comment No. 14', para. 1.

¹⁸ *Ibid.*, para. 5.

¹⁹ The inadequacies of the traditional dichotomy between negative and positive rights have been widely explored by various critics, including Stephen Holmes and Cass R. Sunstein, *The Cost of Rights* (New York and London: Norton, 1999), and Jeremy Waldron, *Liberal Rights: Collected Papers 1981–1991* (Cambridge: Cambridge University Press, 1993).

rights, including at least ‘minimal preventive health care’,²⁰ are necessary for the enjoyment of all other rights. On the other hand, then, HRTH cannot be realised adequately simply through non-interference. As a right to certain benefits, it requires positive action to be taken in order to ensure access to health services for all individuals and for public health to be protected by social measures. Failure to provide such measures and access can be a violation by omission of HRTH.

The basic rights approach clarifies the position taken by the Committee on Economic, Social and Cultural Rights with regard to the progressive realisation clause contained in Article 2(1) of the ICESCR. This clause concedes that certain elements of socioeconomic rights are only capable of realisation over a period of time. However, in order to pre-empt states invoking resource limitations as an excuse to avoid fulfilling their obligations, the Committee formulated a ‘minimum core’ scheme which holds that there are minimum levels of core or basic goods and services below which no one should be allowed to exist regardless of the state’s resource constraints. The core levels enjoy immediate priority and serve as the starting point for further progressive realisation. With regard to HRTH, the minimum core consists of the provision of primary health care services, safe drinking water, adequate food and sanitation, basic health education, reproductive and child health care services, and essential medicines.²¹ As defined by the World Health Organization, ‘essential’ medicines are those drugs ‘that satisfy the priority health care needs of the population’ and that should therefore be available ‘at all times in adequate amounts, in the appropriate dosage forms, with assured quality, and at a price the individual and the community can afford’.²²

The basic rights approach to HRTH is often assimilated to or located within a broader framework of social and economic development.²³ Just as the realisation of basic human rights is necessary for the full development of the human person, so too, it is argued, are the facilities, goods, and services necessary for the realisation of the highest attainable standard of health needed for the process of social development. The development approach establishes a link between the individual and collective dimensions of HRTH. Development depends upon a healthy and productive population, and the benefits of successful development are (ideally) reinvested in collective goods such as health care.²⁴ According to the UN Development Programme, development and human rights share the common motivation of enhancing people’s ability to pursue a life of freedom and dignity.²⁵ Construing HRTH in terms of the integration of development principles and human rights

²⁰ Shue, *Basic Rights*, p. 23.

²¹ Committee on Economic, Social and Cultural Rights, ‘General Comment No. 3: The Nature of States’ Parties Obligations (Art. 2, para. 1 of the Covenant)’, UN Doc. E/E/1991/23 (14 December 1990), para. 10. The Committee also held that states may justify non-fulfilment of core goods and services only by showing that ‘every effort has been made’ to use all available resources to satisfy core obligations ‘as a matter of priority’.

²² The WHO Model List of Essential Medicines was first published in 1977 and is updated every two years. See WHO, ‘Essential Medicines’, {http://www.who.int/medicines/services/essmedicines_def/en/index.html} accessed 14 September 2010.

²³ See, for example, Amartya Sen, *Development as Freedom* (Oxford: Oxford University Press, 1999).

²⁴ On the notion of human-centred development see Arjun Sengupta, ‘The Human Right to Development’, in Bard A. Andreassen and Stephen P. Marks (eds), *Development as a Human Right: Legal, Political and Economic Dimensions*, 2nd edn (Mortsel: Intersentia Publishing, 2010), pp. 13–44.

²⁵ United Nations Development Programme, *Human Development Report 2000: Human Development and Human Rights* (New York: Oxford University Press, 2000).

principles can be seen in the WHO's 1997 Jakarta Declaration on Leading Health Promotion into the 21st Century, which notes not only that health 'is a basic human right and is essential for social and economic development' but also that health promotion, 'through investment and action, has a marked impact on the determinants of health so as to create the greatest health gain for people'.²⁶

There are two important points to make about the preceding interpretations of HRTH. First, crafting an understanding of the right to health in the shadow of development, risks reducing the problem of health inequalities exclusively to economic terms. This is perhaps best illuminated in the UN's eight Millennium Development Goals (MDGs), which established the goal of improving mortality and morbidity rates in the developing world by targeting access to reproductive health care, immunising children, and controlling epidemic infectious diseases.²⁷ These goals are framed as part and parcel of a global programme for developing states' economic capacities, primarily through market liberalisation but also through aid, loans, and partial debt cancellation, yet without characterising the situation to be remedied as one of maldistribution much less of injustice. While the development approach commendably foregrounds the multidimensionality of HRTH – that it is a transborder issue cutting across and affecting all individuals and communities – and rightfully raises concerns about the distribution of material resources, it nevertheless marginalises the grammar of maldistributive injustice and obscures injustices of misrecognition and misrepresentation. This deflection of injustice into the prism of development is what Thomas Pogge trenchantly calls 'politics as usual'.²⁸ By couching health care inequalities in the language and imperatives of development, as something that is fundamentally an economic problem with an economic solution, defenders of the existing global economic order manage to present development and health care as one coherent policy. Yet not only is there no necessary correlation between economic growth and recognition of a universal right to health, but embedding HRTH as a component of the global free-market system reinforces the hierarchies and inequalities inherent to that system's functioning. Of course, what is meant by 'growth', 'opportunities', 'increased income', and 'resources' may be considerably different for the 'developing' and 'developed' worlds. And sometimes what takes place after 'development' can be worse for the health of the already worst-off, such as in the case of Bhopal.²⁹

Second, the standard post-1945 way of thinking about human rights in international law and international relations relies upon the acontextual figure of the presocial rights-bearing subject, whose inherent dignity transcends the contingencies of political community. The Preambles to the three foundational texts of the 'International Bill of Human Rights' – the UDHR, the ICESCR, and the 1966 International Covenant on Civil and Political Rights (ICCPR) – all justify human rights by reference to 'the inherent dignity and ... inalienable rights of all members of the human family'. The crucial normative assumption is that one possesses human

²⁶ World Health Organization, Jakarta Declaration on Leading Health Promotion into the 21st Century (25 July 1997), Preamble.

²⁷ UN Millennium Declaration (8 September 2000), General Assembly Resolution 55/2, {<http://www.un.org/millennium/declaration/ares552e.htm>} accessed 9 September 2010.

²⁸ Thomas Pogge, *Politics as Usual: What Lies Behind the Pro-Poor Rhetoric* (Cambridge: Polity Press, 2010).

²⁹ See Upendra Baxi, *The Future of Human Rights*, 2nd edn (Delhi: Oxford University Press, 2006).

rights simply 'because one is human'.³⁰ Yet in the words of Morsink, 'As far as the possession of inherent human rights is concerned, there is nothing to achieve or aim at because people possess these rights from birth.'³¹ The problem with the inherent-rights approach is that it involves a certain kind of abstracting away from the distinctive forms of power and status that condition the lives of embodied individuals and groups, and deflects attention away from the historically and politically situated nature of rights claims emerging from social struggle against injustice. One of the defining features of the recognition approach which I elaborate in the following section is that it poses as an open question the meaning of 'being human' as an interpersonal and political status. This has the advantage of bringing back into view the specifically political dimension of human rights. International organisations, agreements, agencies, commissions, courts and tribunals have dominated the prevailing view of international human rights theory and practice; and it remains an approach largely defined by reliance upon the privileged notion of inherent human rights as an authoritative ideal. However, this approach arguably neglects the ways that human rights claims are catalysed by the day-to-day experiences of the oppressed, subordinated, and marginalised. Indeed, advocates of HRTH have been increasingly vocal that the problem of health inequalities is substantially rooted in patterns and dynamics of (mis)recognition.

A recognition approach to the human right to health

The idea of reciprocal recognition as the basis for sociopolitical existence was first systematically advanced by the German philosopher G. W. F. Hegel, and it has become a prominent theme in contemporary debates about social justice since the mid-1990s.³² While the recent literature on recognition theory has had a significant impact within social and political theory, it has been mostly neglected in international studies. Yet as Jürgen Haacke stresses, the ethics and politics of recognition, including the concept of the struggle for recognition, is relevant for normative theorising about international politics.³³ This relevance is particularly apparent when considering the normative substrate of human rights claims as well as the day-to-day struggles of those seeking recognition of their human status on the simultaneously local-national-global terrain of contemporary politics.

An ethics and politics of recognition seeks to articulate the situatedness of human rights as political claims to a fully human status that we acquire through our constitutive social relationships. According to theories of recognition, the exercise of rights is closely linked to the intersubjective nature of human self-consciousness.

³⁰ Jack Donnelly, *Universal Human Rights in Theory and Practice*, 2nd edn (Ithaca, NY: Cornell University Press, 2003), p. 7.

³¹ Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (Philadelphia: University of Pennsylvania Press, 2000), p. 325.

³² See G. W. F. Hegel, *The Phenomenology of Spirit*, trans. A. V. Miller (Oxford: Oxford University Press, 1977), chap. 4. A useful discussion of Hegel on rights and recognition is Costas Douzinas, *The End of Human Rights* (Oxford: Hart Publishing, 2000), chap. 10.

³³ Jürgen Haacke, 'The Frankfurt School and International Relations: On the Centrality of Recognition', *Review of International Studies*, 31:1 (2005), pp. 181–2. For further critical discussion see Simon Thompson, *The Political Theory of Recognition: A Critical Introduction* (Cambridge: Polity Press, 2006), and Lois McNay, *Against Recognition* (Cambridge: Polity Press, 2007).

The ability to exercise rights is not only dependent upon the juridical enshrinement of rights in positive law, but even more fundamentally upon the existence of recognition relations through which individuals self-reflexively acquire their distinctive identities, needs, abilities, and talents.³⁴ This contrasts with the conventional ‘liberal consensus’ on human rights,³⁵ which reflects an overly abstract understanding of the ideal rights-bearing subject as possessing certain natural or ‘inalienable’ rights prior to and independently of all forms of social recognition.³⁶ Yet as Hannah Arendt has shown in her critique of such human rights idealism, rights can be exercised only within relationships of mutual recognition. As demonstrated by the paradigm case of the stateless person – the ultimate outsider – rights claims remain politically irrelevant or ineffective if they are unheard and unseen by others who do not recognise the claimant as sufficiently human.³⁷ To ‘be human’ is not a ‘self-evident’ or natural fact; it is a sociopolitical condition that comes from being recognised by another as human. In Arendt’s formulation, humanity is an interpersonal *status* that we mutually guarantee to one another through recognition in a public realm characterised by the conditions of plurality and frailty.³⁸ Mutual recognition, in other words, is what *makes* us human in an interpersonal sense.³⁹

Arendt’s political theory offers two insights crucial to recognition theory: first, that we must appear, in speech and action, before others in a world of plurality in order to become fully human; second, that plurality itself is constitutive of both equality and difference (or distinction). Our shared capacity for speech and action constitutes a common political world where we may appear to one another and disclose our distinct identities, that is, ‘who’ we are. The normative significance of the process of reciprocal recognition is that it is the basis of human dignity. Dignity is not simply an inner subjective disposition but a feature of worldly experience, a mode of being that is acquired by intersubjective means of equal recognition expressing due respect for the worth and particularity of others.

³⁴ Axel Honneth, ‘Redistribution as Recognition: A Response to Nancy Fraser’, in Nancy Fraser and Axel Honneth, *Redistribution or Recognition? A Political-Philosophical Exchange* (London and New York: Verso, 2003), p. 142.

³⁵ Tony Evans, ‘A Human Right to Health?’, *Third World Quarterly*, 23:2 (2002), pp. 199–200.

³⁶ See Derrick Darby, *Rights, Race, and Recognition* (Cambridge: Cambridge University Press, 2009), pp. 26–9.

³⁷ Hannah Arendt, *The Origins of Totalitarianism*, rev. edn (New York: Schocken Books, 2004), pp. 353–5.

³⁸ See Arendt, *The Human Condition*, pp. 176, 188, 222. For an extended analysis of Arendt’s connection to recognition theory see Patchen Markell, *Bound by Recognition* (Princeton and Oxford: Princeton University Press, 2003).

³⁹ Inherent (or natural) rights sceptics might argue that a recognition theory of rights is unable to provide a satisfactory account of the (intrinsic) worth of human beings, and thus is unable to offer a secure normative foundation for critiquing injustice. Defenders of a recognition theory of rights may counter that intrinsic moral worth itself, independently of active social recognition, does not give rise to the *status* of right holder. Without the mutual acknowledgement by a community of others of one’s equal standing as a human person, one is without *rights* insofar as human rights constitute a social practice formed through reciprocal recognition within the political realm. As products of social recognition, rights confer an effective political status that thereby acknowledges the justice (or conversely injustice) of certain ways of acting and being treated. The recognition approach thereby (re)politicises both rights and human status, since these can be won or lost within the continuous dynamics of recognition and misrecognition in the political realm. The danger of an inherent-rights approach is that it overlooks complex ways that inequalities in status have been and continue to be essentialised, that is, depoliticised. A fuller articulation and defense of some of these points is found in Darby, *Rights, Race, and Recognition*, chap. 5.

The suggestion that rights claims may be driven by the experience of suffering disrespect – the denial of due recognition of one’s equal worth and particularity – has been developed by Axel Honneth, drawn out of Hegel’s argument that individual self-realisation depends on a struggle for recognition from others and wider society. The crux of Honneth’s account of the intersubjective conditions for identity-formation is to show that the struggle for recognition carries within it an implicit normative ideal or moral motivation. Unlike Hobbes’s depiction of an egocentric war of all against all, the reworked Hegelian conception of social experience realises that subjects engaged in a conflictual struggle must have ‘already positively taken the other into account’ as a ‘partner to interaction’ before the struggle could even ensue.⁴⁰ Our intersubjective relationships are agonistic precisely because human interaction is structured around a ‘normative expectation that one will meet with the recognition of others’. When that expectation is not met, we then act so as ‘to *make* the others take notice’ of our not yet recognised needs, identities, and interests.⁴¹

Honneth’s theory is normatively salient because it provides a basis for understanding the motivations behind the demand for equal recognition and thus for illuminating the ‘moral grammar’ of social conflicts – such as demands for specific human rights. If mutual recognition is the prerequisite for becoming fully human, then there is a shared human interest in attempting to create and recreate sociopolitical arrangements that extend recognition to all. The struggle for recognition is, in short, a struggle for justice, for due recognition of all as equal and distinctive, yet vulnerable persons. This necessarily entails critique of those prevailing conditions that foster asymmetric relations of misrecognition, and of social, economic, and political inequalities that violate dignity and human rights.⁴² As recognition theory emphasises possessing rights is not ‘a matter of being constituted in a certain way’ but ‘of being afforded a certain sort of social recognition’.⁴³

If possessing rights is not derived from essential characteristics of ‘being constituted in a certain way’, a recognition approach to human rights nevertheless makes possible a deeper understanding of the place of embodiment in the mediation between physical being and sociopolitical existence. The embodied dimensions of sociopolitical existence condition both the agency and the vulnerability of human beings as embodied persons. All humans are ‘biologically frail’, and the ‘vulnerability of our everyday world’ makes social institutions (familial, cultural, legal, and political) necessary in order to provide stability and security.⁴⁴ From the perspective of how recognition relationships between people are bound up with the mutual interdependencies of embodiment, the purpose of rights – and here HRTH is exemplary – is to protect both ‘what’ we are as vulnerable physical beings and also ‘who’ we are as intersubjectively constituted persons in ‘a social process that is always constructed in terms of a particular experience of embodiment’.⁴⁵ Put differently, rights afforded by social recognition enable us to *become* human, to

⁴⁰ Axel Honneth, *The Struggle for Recognition: The Moral Grammar of Social Conflicts* (Cambridge: Polity Press, 1995), p. 45.

⁴¹ *Ibid.*, p. 44, emphasis added.

⁴² *Ibid.*, p. 131ff. Honneth singles out violation of the body, denial of rights, and denigration of ways of life as the key forms of disrespect. See Axel Honneth, *Disrespect: The Normative Foundations of Critical Theory* (Cambridge: Polity Press, 2007), Part I.

⁴³ Darby, *Rights, Race, and Recognition*, p. 132.

⁴⁴ Turner, *Vulnerability and Human Rights*, p. 25.

⁴⁵ *Ibid.*, p. 27.

live properly human lives in *light* of (rather than in *spite* of) our common and distinctive embodied vulnerability.

The experience of embodied intersubjectivity further illuminates that vulnerability can also be understood as a suspension of a person's socially constituted human status, imposed through power inequalities. In other words, a social process that involves the imposition of unwarranted economic, juridical, political, or cultural vulnerability implies power asymmetries that can be characterised as a failure of intersubjective recognition, that is, as non- or misrecognition. Nancy Fraser, for instance, has pointed to the need for a three dimensional account of justice sensitive to the ways that our embodied vulnerability and dependencies can be exploited through maldistribution, misrecognition, and misrepresentation. She observes that inasmuch as recognition theory ought to focus on problems of status and agency facing embodied persons in situationally specific contexts, the dimensions of redistribution, recognition, and representation all have relevance, though not always to the same degree.⁴⁶

The interplay between forms of economic exclusion and sociocultural misrecognition often is exacerbated by institutional patterns that impose unjustified status inequalities on certain individuals and groups.⁴⁷ Such institutional patterns or arrangements are constitutive of the political, defined as acts and processes of framing or representation.⁴⁸ Framing or representation is essentially a concern with the Arendtian question of 'who' as an expression of political status: who counts as a subject of justice, who determines the procedures for admitting and adjudicating justice claims, who is included in or excluded from a given political community, and indeed who is 'human'.⁴⁹ Frame-setting designates the process (the 'how') of constituting and reconstituting the 'who' of justice, insofar as the question of the 'who' presupposes the setting of boundaries and decision-rules. One cannot become a subject of justice without being recognised, that is, seen and heard as an equal member of the political community. *Misframing*, or the injustice of wrongly excluding some individuals or groups from participating in posing and contesting justice claims, can thus be grasped as a dimension of *misrecognition*.⁵⁰ Misframing falls foul of what Fraser refers to as the 'principle of participatory parity'. Parity means the condition of being on a par with others, of having the status of being respected by others as a peer.⁵¹ Participatory parity gives democratic traction to the notion of equal status, promoting sociopolitical arrangements that 'permit all to participate as peers in democratic discussion and decision-making' and ensuring 'adequate representation and equal voice for those who claim standing vis-à-vis a given issue'.⁵² Taking part in the collective practice of social norm-formation and decision-making

⁴⁶ Nancy Fraser, 'Social Justice in the Age of Identity Politics: Redistribution, Recognition, and Participation', in Fraser and Honneth, *Redistribution or Recognition?*, pp. 29, 63, 51.

⁴⁷ See Nancy Fraser, 'Heterosexism, Misrecognition, and Capitalism: A Response to Judith Butler', in Kevin Olson (ed.), *Adding Insult to Injury: Nancy Fraser Debates Her Critics* (London and New York: Verso, 2008), p. 59.

⁴⁸ Nancy Fraser, *Scales of Justice: Reimagining Political Space in a Globalizing World* (Cambridge: Polity Press, 2008), p. 17.

⁴⁹ *Ibid.*, pp. 17–18.

⁵⁰ *Ibid.*, pp. 19–20, 144.

⁵¹ Fraser, 'Social Justice in the Age of Identity Politics: Redistribution, Recognition, and Participation', in Fraser and Honneth, *Redistribution or Recognition?*, p. 10, fn. 39.

⁵² Fraser, *Scales of Justice: Reimagining Political Space in a Globalizing World*, pp. 44–5.

is an important aspect of being a person in a full-fledged sense. This is because being able to claim standing *vis-à-vis* a given issue is dependent upon mutual attitudes of recognising others as having, or being entitled to, equal voice and representation.

In sum, recognition theory demonstrates that we are plural and vulnerable beings, and that we must be able to appear before others as peers in order to recognise and be recognised as subjects of justice – or, alternatively, as victims of injustice. Reciprocal recognition discloses the possibility of how subjects of justice come to have certain rights as these emerge from political struggle.⁵³ Recognition theory also reveals how our embodied vulnerabilities can become grounds for the denial of equal human status and thus the deprivation of human rights. To be impoverished, to be a racial, ethnic, gender or sexual minority, to be disabled or suffering the pain of disease and chronic illness are conditions commonly treated as signs (or ‘symptoms’) of the despised and less-than-human.⁵⁴ Misrecognition – the imposition of unjustified status inequalities – dehumanises individuals because it is a failure to see them as dignified members of the political community. This is why the link between health status and social, economic, and political status is so crucial to HARTH. For the right to health to be effectively realised, it is not enough to appeal to the notion of inherent-rights since this begs the very ‘who’ question of political framing. Those who are diseased and ill, or who are suspected as being the ‘transmitters’ of disease and illness, are ‘unrecognizable’ precisely when an abstract model of the human rights-subject is utilised as the functional marker for framing the political world.

The struggle for recognition and health care justice: reframing HIV/AIDS

While an inherent-rights account explains the source of rights in terms of a decontextualised and presocial abstract human nature, a recognition approach cannot conceive of rights without context-specific or situated struggles against misrecognition, from which emerge claims and claimants typically rendered invisible or silent by processes of misframing. The dynamics of misrecognition may, for instance, be associated historically with the struggles against religious intolerance and against slavery, for worker’s rights and for women’s suffrage, and, more recently, for indigenous peoples’ rights.⁵⁵ The dynamics of misrecognition and misframing also can be seen, I suggest, in the movement for health care justice.

The health care justice movement refers broadly to individuals, groups, NGOs, foundations, and coalitions that work, both intra-nationally and transnationally,

⁵³ For more on this theme see Andrew Vincent, *The Politics of Human Rights* (Oxford: Oxford University Press, 2010), chap. 7.

⁵⁴ Frantz Fanon developed a scathing critique of colonialism’s misrecognition of embodied colonised subjects in similar terms. See Fanon, *Black Skin, White Masks* (New York: Grove Press, 1967), where Fanon writes of ‘a feeling of nonexistence’ and ‘suffering in his body’ as a result of misrecognition. In the face of misrecognition, he asserts there ‘remained only one solution: to *make* myself known’ (p. 115, emphasis added).

⁵⁵ For an excellent account of historical struggles for human rights see Micheline R. Ishay, *The History of Human Rights: From Ancient Times to the Globalization Era*, 2nd edn (Berkeley and Los Angeles: University of California Press, 2008). See also Clifford Bob (ed.), *The International Struggle for New Human Rights* (Philadelphia: University of Pennsylvania Press, 2009). In these otherwise valuable works on the emergence of new rights claims in human rights movements, no mention is made of the normative grounding of such claims in the need for social recognition.

to promote equality in provision of and access to goods, services and conditions necessary for the realisation of the highest attainable standard of health. The health care justice movement is not homogeneous of course, and is perhaps best conceived in terms analogous to the alternative globalisation movement, that is, as a ‘movement of movements’.⁵⁶ Yet the common cause of those advocating for health care justice may be phrased by the question, ‘What are human rights bereft of social justice?’⁵⁷ Politically and philosophically, however, the issues of gaining or improving health care access and realising HARTH are not solely about redistributive claims. Because the phenomenon of health care inequality arises from multiple injustices, the significance of redistributive claims can be overstated if one does not also consider the dynamics and impact of sociocultural disrespect and political exclusion. Redistributive struggles over HARTH are part of, not separate from, social struggles for recognition and political struggles for representation.

There are a number of cases that we might look at for clues as to how the movement for health care justice can thematise a political challenge to maldistribution, misrecognition, and misframing. There is, for instance, the People’s Health Movement formed in Bangladesh in 2000, which is now a global network working to address health inequalities in nearly 100 countries; the Right to Health and Health Care Campaign launched in India in 2005; and the National Movement for the Defense of the Right to Health in Paraguay.⁵⁸ However, this section explores the ongoing struggle for access to antiretroviral medicines in South Africa, and how this struggle has impacted both the treatment and the status of people living there with HIV/AIDS. This is a useful case to look at for several reasons. First, the health care justice movement generally, and the health as a human right movement more particularly, only crystallised in the mid-1980s, specifically in response to the global HIV/AIDS pandemic.⁵⁹ Second, as the work of Jonathan Mann, former director of the WHO’s Global Programme on AIDS, shows, not only are health and human rights interdependent, but more importantly the major determinants of HIV/AIDS are societal, in that those who are most vulnerable to the disease are poor, disenfranchised, and culturally marginalised.⁶⁰ Mann stressed that the human rights implications of HIV/AIDS are evident when considering the social conditions that lead to individuals contracting the disease, how (if at all) they are diagnosed, and what (if any) treatment they have access to and receive.⁶¹ Third, it thus illuminates that HIV/AIDS is a human rights issue not only because of redistributive questions concerning affordable access to medicines and provision of care, but also because

⁵⁶ For more on the alternative globalisation movement see Chamsy el-Ojeili and Patrick Hayden, *Critical Theories of Globalization* (Basingstoke: Palgrave Macmillan, 2006), chap. 4.

⁵⁷ I adapt this question from Upendra Baxi, ‘The Place of the Human Right to Health and Contemporary Approaches to Global Justice’, in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (London and New York: Routledge, 2010), p. 14.

⁵⁸ See, for example, Laura Turiano and Lanny Smith, ‘The Catalytic Synergy of Health and Human Rights: The People’s Health Movement and the Right to Health and Health Care Campaign’, *Health and Human Rights*, 10:1 (2008), pp. 137–47.

⁵⁹ Paul Hunt, ‘Right to the Highest Attainable Standard of Health’, *Lancet*, 370 (2007), p. 369.

⁶⁰ Jonathan M. Mann, ‘Human Rights and AIDS: The Future of a Pandemic’, in Jonathan M. Mann, Sofia Gruskin, Michael A. Grodin, and George J. Annas (eds), *Health and Human Rights: A Reader* (New York: Routledge, 1999), p. 222.

⁶¹ Jonathan M. Mann, ‘Afterword’, in Lawrence O. Gostin and Zita Lazzarini, *Human Rights and Public Health in the AIDS Pandemic* (New York and Oxford: Oxford University Press, 1997), pp. 168–9.

of discrimination, rejection, denial, stigmatisation, and violence (both direct and structural). Social discrimination and stigmatisation are what Honneth calls ‘moral injuries’, types of injustice which make it known ‘through humiliation and disrespect’ that a person’s needs, capabilities and identity ‘do not enjoy any recognition’ and are not socially significant.⁶² Being regarded as socially insignificant means not having the full status of a person in a political community among other persons. Finally, this case allows us to discern the complex narrative that emerges through the historically situated interface between divergent forms and logics of human rights claims, their politically contested configurations or ‘frames’, and how such claims are directly rooted in the actualities of social struggle. In short, this case reveals the play of recognition and misrecognition that determines whether certain *rights claims* appear or disappear, and further whether certain *rights-bearing subjects* appear or disappear in the political realm.

What we actually have in this case are three different and often conflicting framings of the right to health in relation to HIV/AIDS and access to antiretroviral medicines. These framings reveal often deeply contradictory conceptions of HARTH, the meaning of access to treatment, and the ‘place’ of the rights-bearing subject. The first represents what Fraser calls an ‘affirmative’ politics of framing. This is exemplified by the post-apartheid South African Constitution adopted in December 1996. The Constitution’s normative vision is informed by the years of racial discrimination, sociocultural inequality, and economic exploitation that affected the vast majority of the country’s population under apartheid. As expressed in the document’s Preamble, the post-apartheid republic is meant to ‘Heal the divisions of the past and establish a society based on democratic values, social justice and fundamental human rights.’⁶³ Of special noteworthiness are the principles that guided the drafting of the Constitution, which called for inclusion of ‘all universally accepted fundamental rights’.⁶⁴ The Constitution’s Bill of Rights therefore guarantees numerous justifiable socioeconomic rights, including the right to health care services.⁶⁵ Apartheid is a paradigm example of the type of political injustice that arises when a state actively produces subordinate political statuses while claiming merely to recognise ‘natural’ or essential characteristics of ‘being constituted in a certain way’. During apartheid, this political misframing overlapped with misrecognition and maldistribution, as exclusionary racial categorisations encompassed both political-economic and cultural-valuational dimensions that became pervasively institutionalised.⁶⁶ The anti-apartheid movement and later the post-apartheid government aimed explicitly to counter this negative recognition with affirmative recognition. According to Fraser, affirmative political strategies ‘redress disrespect by revaluing unjustly devalued group identities’.⁶⁷ The incorporation of ‘the democratic values

⁶² Honneth, *Disrespect*, p. 136.

⁶³ Constitution of the Republic of South Africa (1996), {<http://www.constitutionalcourt.org.za/site/theconstitution/thetext.htm>} accessed 18 September 2010.

⁶⁴ Interim Constitution of South Africa, 1993, Schedule IV(II), {<http://www.constitutionalcourt.org.za/site/constitution/english-web/interim/schedules.html#sched4>} accessed 18 September 2010.

⁶⁵ For a detailed account of the intersection of racial discrimination, poverty, and ‘medical apartheid’ in South Africa from 1948–94, and their lingering legacy for the post-apartheid population, see Audrey R. Chapman and Leonard S. Rubenstein (eds), *Human Rights and Health: The Legacy of Apartheid* (Washington, DC: American Association for the Advancement of Science, 1998).

⁶⁶ See Nancy Fraser, *Justice Interruptus: Critical Reflections on the ‘Postsocialist’ Condition* (New York and London: Routledge, 1997), p. 22.

⁶⁷ *Ibid.*, p. 24.

of human dignity, equality and freedom' in the new Constitution thereby formally reframed the political space and social status of all South Africans, governing and shaping the legal interrelationships in which they are now to be recognised.

However, while the affirmative politics of framing embodied in the post-apartheid constitutional order contests the racist and highly exclusionary legacy of apartheid misframing, it nevertheless replicates the 'Wesphalian grammar of frame-setting'.⁶⁸ With regard to HRTH and HIV/AIDS in the post-apartheid state, this has meant situating the right to health within the legal framework of citizenship entitlement.⁶⁹ Although this provides an extremely important first step in acknowledging the equal rights of each citizen, and empowers individuals to use the legal process to pursue rights claims and seek redress for violations of their rights, it can also displace rights claims from the political struggles for social justice from which they emerge. The affirmative politics of framing still assumes that 'the territorial state', and its authoritative meaning of sociopolitical space and of 'who' are the legitimate political subjects in that space, 'is the appropriate unit within which to pose and resolve disputes about justice'.⁷⁰ This approach has the tendency to prioritise the official 'legitimizing recognition'⁷¹ of state institutions such as the judiciary, which 'sees' and adjudicates rights claims in terms of individualised claimants and their relationship to positive law and state policy, while divorcing these claims from their social, political, and economic contexts. 'Delivering' rights then becomes a function of the state, a matter of distributing benefits and entitlements to citizens conceived as passive recipients, according to the proper application of formal principles of state-based justice. This does not mean that more extensive forms of social recognition and demands for emancipatory social transformation are precluded from the political order. But it does overly simplify the complexity of injustice and potentially weakens our understanding of the plurality of needs and experiences motivating rights claims and the corresponding demands for recognition. It also makes it easier to overlook ways in which state policies are enmeshed in and influenced by 'the structural causes of many injustices in a globalizing world, which are not territorial in character',⁷² such as the governance structures of global trade, finance, and intellectual property.

This last point takes us to a second mode of framing at play in this case. Some of the problems and limitations of the affirmative approach are evident when considering how, on the international and global levels, the Constitution's framework

⁶⁸ Fraser, *Scales of Justice*, p. 22.

⁶⁹ It is worth noting there is some ambiguity in the text of the Constitution regarding its application to non-citizens. While the Constitution's language in the Preamble and Chapter 1 explicitly refers to the legal equality and equal rights of all South African citizens, the Bill of Rights set out in Chapter 2 expressly 'enshrines the rights of all people in our country'. This phrasing raises the prospect of extending rights, including the right to health care services, to non-citizens who happen to reside in South African territory. Yet such a claim is always susceptible to political contestation and debates about how to frame 'national membership'. See, for instance, the Constitutional Court's ruling in *Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development* (CCT 13/03, CCT 12/03) [2004] ZACC 11; 2004 (6) SA 505 (CC); 2004 (6) BCLR 569 (CC) (4 March 2004), {<http://www.saflii.org/za/cases/ZACC/2004/11.html>} accessed 20 March 2011.

⁷⁰ Ibid.

⁷¹ Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York and London: Routledge, 1999), p. xix.

⁷² Fraser, *Scales of Justice*, p. 23.

of ‘universally accepted’ basic rights is disrupted by what I call a *conservative* framing constructed around the WTO’s multilateral Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), negotiated at the end of the Uruguay Round of the General Agreement on Tariffs and Trade (GATT) in 1994.⁷³ A main factor behind the high price and limited accessibility of antiretroviral drugs is the unwillingness of major pharmaceutical companies (located primarily in the United States, United Kingdom, Switzerland, and Japan) to lower the costs of their patented medicines and allow production of generic equivalents.⁷⁴ This position is buttressed by the TRIPS Agreement. TRIPS allows for the unprecedented introduction of patents in all fields of technology and requires all signatories (members of the WTO are automatically bound by the agreement) to grant twenty-year monopoly patents for innovations such as advanced medicines. Under the Agreement, all drug patents created after 1995 cannot be produced generically for at least twenty years and signatory states are obligated to prevent domestic pharmaceutical companies from producing generic forms of patented medicines.

The TRIPS Agreement not only is part of the WTO’s effort to decisively shape global trade governance, it is also indicative of the conservative framing of institutional space that is unable to address the changing aspirations and needs of a pluralistic world. This conservative framing represents intellectual property as an inherent human right inscribed within the category of socioeconomic rights as a whole. As Philippe Cullet notes, the fields of human rights and intellectual property rights have largely evolved separately.⁷⁵ Yet in recent years the WTO has attempted to merge intellectual property rights into human rights, thereby asserting a hierarchy of ‘economic’ rights that prioritises market-friendly intellectual property rights and subordinates more socially-oriented rights such as HARTH.⁷⁶ The WTO’s concern, in other words, is not for *health* as such but rather for an *exceptional property right* regime which is thought to trump the right to health.⁷⁷ Given the absence of a binding global consensus that the right to health has normative priority over intellectual property rights, conflict between competing transnational and local political framings of these rights is unavoidable.⁷⁸

The question is, then, how can this impasse be broken in favour of HARTH? The answer depends on whether the claim for HARTH can be *reframed* in ways that

⁷³ Agreement on Trade-Related Aspects of Intellectual Property Rights, Annex 1C of the Marrakesh Agreement Establishing the World Trade Organization, Marrakesh (15 April 1994), {http://www.wto.org/english/docs_e/legal_e/27-trips_01_e.htm} accessed 14 September 2010.

⁷⁴ Sara E. Davies, *Global Politics of Health* (Cambridge: Polity Press, 2009), p. 162; and Pogge, *Politics as Usual*, p. 20.

⁷⁵ Philippe Cullet, ‘Human Rights and Intellectual Property Protection in the TRIPS Era’, *Human Rights Quarterly*, 29:2 (2009), pp. 403–30.

⁷⁶ Philippe Cullet, ‘Patents and Medicines: The Relationship between TRIPS and the Human Right to Health’, in Sofia Gruskin, Michael A. Grodin, Stephen P. Marks and George J. Annas (eds), *Perspectives on Health and Human Rights* (New York and London: Routledge, 2005), pp. 179–202.

⁷⁷ On the conflict between TRIPS and international human rights law see Sub-Commission on the Promotion and Protection of Human Rights, ‘Intellectual Property Rights and Human Rights’, UN Doc. E/CN.4/Sub.2/Res/2000/7 (2000).

⁷⁸ Some flexibilities in TRIPS were acknowledged by the 2001 Doha Declaration, which led to adoption of a 2005 Annex attached to TRIPS concerning limited exemptions from patent regulations, and the use of parallel importing and compulsory licensing; the Annex has yet to be approved by the required two-thirds of WTO member states. World Trade Organization, Declaration on the TRIPS Agreement and Public Health, Doha, Qatar (14 November 2001), paras 4 and 2, {http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm} accessed 14 September 2010.

foreground processes of recognition which adopt a third mode of framing, namely, a *transformative* politics of framing. A transformative approach to framing, unlike an affirmative approach, regards the state-territorial principle as inadequately demanding when it comes to ensuring 'adequate representation and equal voice for those who claim standing vis-à-vis a given issue',⁷⁹ but who are excluded either by the normal internal political structures of domestic society or by the international and transnational structures of the global political economy. The transformative approach does not eschew affirmative framing since, for instance, the constitutional entrenchment of the universalist principles of equality, freedom, and human rights provides an empowering official acknowledgement of positive claims and potential mechanisms for seeking remedies for rights violations. Yet the promise of formal equality and official recognition of equal status does not necessarily translate into socially efficacious recognition of the most vulnerable and marginalised individuals and groups or into accurate representation of their specific experiences of status injustice. And unlike the conservative framing, which inscribes the right to health within a hierarchy of market-driven and exclusionary interests that sanction global financial governance, a transformative politics of framing seeks to deeply democratise the frame-setting process.⁸⁰ It aims to connect the universality implicit in official recognition of equal rights with the plurality of needs, experiences and identities given voice by those who suffer misrecognition and misrepresentation.

This third mode of framing is exemplified by the Treatment Action Campaign (TAC), a South African health care movement launched on 10 December 1998 by a group of activists led by Zackie Achmat, a HIV-positive gay rights and former anti-apartheid activist. Sub-Saharan Africa is the region of the world most affected by the HIV/AIDS epidemic, accounting for 67 per cent of all people living with HIV, and the nine countries with the highest HIV prevalence worldwide are all located in the subregion of Southern Africa. South Africa is the country with the world's largest population of people living with HIV, estimated at 5.7 million people in 2008.⁸¹ TAC has garnered significant international attention for its strategy of pursuing claims for access to adequate medical treatment and essential medicines through rights-based public interest litigation. In 1998, for instance, the Pharmaceutical Manufacturers Association (PMA) representing 41 multinational pharmaceutical companies and their subsidiaries took the South African government to court to block the passing of the Medicines and Related Substances Control Amendment Act of 1997 (Medicines Act). The Medicines Act authorised the generic substitution of off-patent medicines and parallel importation of lower-priced patented medicines, as well as the establishment of a national pricing committee to ensure a transparent medicine pricing system. The PMA alleged that the Medicines Act undermines TRIPS-mandated patent protection for pharmaceuticals. TAC supported the government by helping to prepare legal arguments against the lawsuit, drawing upon Section 27 of the South African Constitution which provides the right to health care services and emergency medical treatment. Due to public pressure and negative publicity, the PMA withdrew their lawsuit in April 2001.

⁷⁹ Fraser, *Scales of Justice*, p. 44. See also Nancy Fraser, 'Recognition, Redistribution and Representation in Capitalist Global Society: An Interview with Nancy Fraser', *Acta Sociologica*, 47:4 (2004), pp. 374–82.

⁸⁰ Fraser, *Scales of Justice*, pp. 23–4.

⁸¹ UNAIDS, *AIDS Epidemic Update: December 2009* (Geneva: UNAIDS and WHO, 2009), pp. 21, 27.

This case represented a crucial, though only partial success for TAC, since it cleared the way for the production and importation in South Africa of cheaper generic essential medicines, including antiretroviral drugs. Antiretroviral drugs have proven effective in suppressing HIV replication, mutation, and disease progression in persons infected with or exposed to the virus. Antiretrovirals remain expensive, however, and their prohibitive cost has restricted distribution to 'resource-limited settings' such as South Africa and other developing countries. UNAIDS estimated at the end of 2008 that of the nearly 30 million HIV-infected individuals living in low- and middle-income countries, only 4 million of them had access to antiretroviral treatment.⁸² On one hand, then, TAC has been able to partially counter the conservative framing implicit in the PMA's defence of intellectual property rights and thus gain greater access to essential medicines. On the other hand, however, the South African government's own affirmative framing, which assumes the necessity of state-level representation that substitutes for the agency of specific individuals and groups, has been detrimental through its own forms of misrepresentation, maldistribution, and misrecognition.

Under the Thabo Mbeki administration (1999–2008), for instance, the government was reluctant to pursue the limited licensing and importation exemptions permitted by TRIPS. This was partly due to pressures applied by the United States, which placed South Africa on its 'Trade Watch List' and threatened to impose sanctions unless South Africa repealed the Medicines Act or otherwise ensured the 'interests' of American pharmaceutical companies.⁸³ But this reluctance became politically notable when TAC's first campaign called for the government to establish a national programme for prevention of mother-to-child transmission (PMTCT) of HIV which would provide pregnant women with a short course of the antiretroviral drug, AZT.⁸⁴ The government rejected the demand on the grounds of AZT's high price – even though the door had been opened to offers of reduced price and even donated supplies, offers rejected by the government.

A lack of resources may not have been, then, such a significant reason for government inaction as is commonly assumed. Nor was it a case of benign indifference. Subsequent events and numerous public statements illuminate how the government's antiretroviral drugs policies were instead structured by a complex web of discriminatory attitudes and denialism on the part of President Mbeki and leading government officials. Mbeki not only questioned the efficacy of antiretrovirals such as AZT and nevirapine, he publicly denied that HIV causes AIDs, and portrayed the disease as the deserved consequence of deviant 'lifestyle' choices.⁸⁵ The Health Minister, Manto Tshabala-Msiminag, also maintained that antiretroviral drugs were toxic,

⁸² UNAIDS, *AIDS Epidemic Update*, p. 7. See also WHO, United Nations Children's Fund, UNAIDS, *Towards Universal Access: Scaling up Priority HIV/AIDS Interventions in the Health Sector* (Geneva: WHO, 2009).

⁸³ Davies, *Global Politics of Health*, p. 167. See also Sarah Joseph, 'Pharmaceutical Corporations and Access to Drugs: The "Fourth Wave" of Corporate Human Rights Scrutiny', *Human Rights Quarterly*, 25:2 (2003), pp. 425–52.

⁸⁴ For more information on this and other TAC campaigns, consult the group's web site at: {<http://www.tac.org.za/community/>}

⁸⁵ Virginia van der Vliet, 'South Africa Divided against AIDS: A Crisis of Leadership', in Kyle D. Kauffman and David L. Lindauer (eds), *AIDS and South Africa: The Social Expression of a Pandemic* (Basingstoke: Palgrave Macmillan, 2004), pp. 48–96.

calling them ‘poison’ at the 2002 International AIDS Conference in Barcelona.⁸⁶ This position of willed ignorance and condemnation subsequently was deployed by other public officials. Such misrecognition via denial, denunciation, and outright rejection effectively contributes to systemic disavowal of the social determinants of health, feeding official narratives that the fate of those living with HIV/AIDS is merely a matter of personal misfortune or bad luck. Determined to create a counter-narrative, however, TAC launched litigation against the government in 2001 to compel it to introduce the PMTCT programme. The South African Constitutional Court ruled in favour of TAC, leading the government to grudgingly initiate public antiretroviral provision.⁸⁷ It has been estimated that more than 330,000 excess AIDS deaths and 35,000 infant infections resulted from the Mbeki administration’s refusal to extend substantive rather than merely formal recognition specifically to South Africans living with HIV/AIDS.⁸⁸

From the start, then, TAC has engaged in a political campaign for the right to health and social justice, as a means to mediate and shape the relations of South Africans living with HIV/AIDS to and within the post-apartheid state. While it has successfully pursued several legal cases against the government and multinational pharmaceutical companies, it has strategically and tactically combined litigation with negotiation and, most importantly, political mobilisation. By making mobilisation the cornerstone of the campaign, TAC foregrounds the political status of individuals and groups living with HIV/AIDS and creates participatory mechanisms that mirror their plurality of needs and experiences. Even though TAC’s litigation addresses primarily economic concerns and has tangible redistributive effects – such as bringing down the price of essential medicines, creating new health services, and investing in infrastructure – these are realised only by insistently mooring redistributive claims within a broader reframing of representation and recognition. As Mark Heywood explains, TAC is a movement for the universal right to health, but its claims for HARTH are articulated situationally ‘as demands in relation to specific social and political issues’.⁸⁹ For example, rather than simply advocating for a general antiretroviral programme that would in principle be accessible to all South Africans as a generic category, TAC’s PMTCT campaign focused on the socially specific

⁸⁶ Sarah Boseley, ‘AIDS Groups Condemn South Africa’s “Dr Garlic”’, *The Guardian* (6 May 2005), {<http://www.guardian.co.uk/world/2005/may/06/internationalaidanddevelopment.southafrica>} accessed 17 September 2010.

⁸⁷ Even after the Constitutional Court ruling, the government restricted the use of donated nevirapine and blocked funds for more than a year from the Global Fund to Fight AIDS. The first drug treatments were not made available until 2005 and, ironically, used more expensive brand-name rather than generic drugs. See Nicoli Nattrass, *Mortal Combat: AIDS Denialism and the Struggle for Antiretrovirals in South Africa* (Pietermaritzburg: University of KwaZulu-Natal Press, 2007). The situation is further complicated by the fact that the Constitution’s principles (see sections 8(2) and 239) apply not only ‘vertically’ but also ‘horizontally’ to ‘natural and juristic persons’, including private bodies such as corporations. See Stephen J. Ellmann, ‘A Constitutional Confluence: American “State Action” Law and the Application of South Africa’s Socioeconomic Rights Guarantees to Private Actors’, in Penelope Andrews and Stephen J. Ellmann (eds), *The Post-Apartheid Constitutions: Perspectives on South Africa’s Basic Law* (Johannesburg: Witwatersrand University Press, 2001), pp. 444–80.

⁸⁸ Pride Chigwedere, et al., ‘Estimating the Lost Benefits of Antiretroviral Drug Use in South Africa’, *Journal of Acquired Immune Deficiency Syndromes*, 49:4 (2008), pp. 410–15. See also Nicoli Nattrass, ‘AIDS and the Scientific Governance of Medicine in Post-Apartheid South Africa’, *African Affairs*, 107:427 (2008), pp. 157–76.

⁸⁹ Mark Heywood, ‘South Africa’s Treatment Action Campaign: Combining Law and Social Mobilisation to Realize the Right to Health’, *Journal of Human Rights Practice*, 1:1 (2009), p. 17.

vulnerability of pregnant women and girls infected with HIV, who are predominantly poor and black, and hence on their actual health and social inequalities.⁹⁰ TAC also emphasises the ‘shared experience of vulnerability and precariousness’⁹¹ on the part of people living with HIV/AIDS, who often are excluded from their families, communities, employment, and political participation. The TAC slogan ‘HIV Positive’ is prominently displayed on T-shirts, signs and banners, symbolically and discursively politicising the identity of people living with HIV/AIDS so as to construct a non-stigmatised status and thereby resist their sociocultural subordination and disrespect. This also helps to forge relations of solidarity and mutual recognition of equal human status among those with HIV/AIDS and between those with and without HIV – such as when Nelson Mandela famously wore a TAC T-shirt and embraced Zackie Achmat at a demonstration in 2002.

Beyond gaining positive recognition of vulnerable and marginalised identities, TAC further disrupts the government’s statist and the WTO’s conservative framings of HRTM by visibly contesting the question of ‘who’ may act and speak in existing public spheres of participation. TAC’s aim is to foster a political movement ‘led by people with HIV’, where the most vulnerable individuals and groups can become their own advocates. Marginalised people can then represent their own needs, experiences and histories, and ‘assume both a public voice and visibility’.⁹² In this way they cease to be ‘silent victims’ passively awaiting either benefits to be paternalistically distributed by the state or more affordable drugs to be charitably marketed by pharmaceutical companies. TAC’s process of reframing political space, reconstructing the ‘who’ of political speech and action, and rearticulating the content and scope of HRTM hinges on the idea of treatment literacy. Treatment literacy simultaneously educates and empowers people with AIDS by creating community-level networks of ‘Treatment Literacy Practitioners’ and volunteers who provide health education about HIV, research, and treatment. This information is not taught in a neutral fashion, but is framed politically around questions about the social determinants of health such as poverty, inequality and injustice, and linked to positive discourses about human rights, equality, respect, and esteem. Treatment literacy thus functions as ‘the base for both self-help and social mobilization’.⁹³

This approach illustrates how TAC effectively reframes public space to enhance participatory parity, enabling those living with HIV/AIDS to seek political recognition as a particularly vulnerable yet no longer invisible or stigmatised group. As a result, TAC’s method of constructing its political movement delivers not only ‘tangible’ redistributive change, but also ‘intangible’ recognition transformation – such as empowerment, self-respect, and self-esteem – that acknowledges the distinct yet fully human status of people living with HIV/AIDS. Those living with HIV/AIDS remake themselves as both citizens and humans, asserting ‘who’ they are through meaningful appearance in the public realm. The strategy adopted by TAC to emphasise the recognition and reframing dimensions of health and social justice, in

⁹⁰ The situational specificity of PMTCT continues into related issues. For instance, in many countries young people under the age of 18 require parental consent in order to obtain HIV/AIDS diagnostic testing. Consent may be withheld for various social, cultural or religious reasons, and diagnosis of HIV status may then serve as grounds for discrimination or denial rather than meaningful treatment.

⁹¹ Turner, *Vulnerability and Human Rights*, p. 27.

⁹² Heywood, ‘South Africa’s Treatment Action Campaign’, p. 18.

⁹³ *Ibid.*, pp. 17–18.

conjunction with but not subsidiary to that of redistribution, has been the difference in achieving at least some success for people living with HIV/AIDS and needing medical treatment as demanded by the claim for a universal right to health.

Conclusion

The promotion of the right to health is part of a global struggle against the social injustices of health inequalities. Health inequalities and lack of access to adequate health care services, treatment and essential medicines are problems that affect individuals and groups in all countries. This article has argued, however, that HARTH is best conceived not as an inherent pre-political right but as an emergent political claim that is realised as the result of struggles for more (or more equal) recognition. From the perspective of critical recognition theory, the demand for HARTH must be contextualised both in the shared vulnerability of the embodied human condition – everyone can become injured, ill, or infected – and in the specific struggles for recognition of the plural ways of acting and being treated that enable individuals and groups to attain fully human status. Seen in this light, human rights are not only historical artefacts, even less are they merely the codification of rights that humans ‘already’ possess independently of social recognition. They are perhaps most importantly the affirmation of a never ending process of *becoming* human, the normative force of an always unfinished political project of building mutual recognition in the face of failures to accord meaningful recognition to specific individuals and groups.

Yet, as I have shown using the example of people living with HIV/AIDS, the complex codetermination of maldistribution, misframing, and misrecognition that prevents effective realisation of HARTH remains largely unacknowledged. The problem of lack of access to suitable health care services and essential medicines has its roots in a refusal to recognise the social determinants of health inequalities – including poverty, denialism, discrimination, and stigmatisation – and their situational specificity for marginalised groups deemed not fully human. This problem is exacerbated by a general failure to grasp the socially-mediated nature of human rights, and the way that HARTH is contingent upon particular political framings that either are more exclusionary and hierarchical or more inclusive and egalitarian. These political framings influence how rights-bearing subjects are defined and how the needs and experiences of different individuals and groups are or are not recognised. Yet many accounts of the struggle for health care justice overlook how health inequalities are at least in part rooted in dynamics of misrecognition and misframing, and displace the task of resolving such inequalities almost entirely onto redistributive claims. In this way the redistributive dimension of social justice becomes overburdened with expectations that lack the capacity to diagnose and challenge the multifaceted nature of subordination and exclusion. A more effective and normatively compelling approach to the ongoing struggle for the right to health would give renewed attention to how routine forms of misrepresentation and misrecognition, alongside maldistribution, diminish or deny the human status of those most vulnerable to health disparities.