MPW Course 2: Medicine, health and human rights

General objectives
This course aims to give a basic introduction to international humanitarian law, human rights and the ethical codes that regulate the health professions.

By the end of it, you will be able to recognize situations where health-related human rights are at risk of violation. You will also be able to understand the health worker’s responsibility to promote and defend the right to health.
The Medical Peace Work textbook, 2nd edition

Course 2: Medicine, health and human rights

Edited by Salvage J, Rowson M, Melf K and Birch M.

Published 2012 in UK by Medact, London.
Design: Ialessa Norris
© medicalpeacework.org 2012

All rights reserved. Permission is granted for noncommercial reproduction, translation and distribution of the whole or part of the courses, as long as medicalpeacework.org is given credit.

medicalpeacework.org does not guarantee that the information in this course is complete and correct and shall not be liable for any damages incurred as a result of its use.

The Medical Peace Work textbook was first published in 2008 as an integral part of the MPW online course with seven modules. The 2nd edition (2012) consists of seven independent, but interlinked MPW Course e-books.

Suggested citation of textbook lessons:

The Medical Peace Work textbook was funded with support from the European Commission. This publication reflects the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.
## Chapter 1: The legal context

### Lesson 1.1: Health and human rights – norms and standards

- Introduction 6
- Historical context 7
- 1. International human rights law 8
  - The right to health 10
  - UN Special Rapporteur on the right to health 10
  - National and regional recognition of the right to health 11
- Torture ban 12
  - Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment 12
  - 2. International humanitarian law 13
  - 3. Codes of conduct 13
  - Conclusion 14

### Lesson 1.2: The role of health professionals in defending health and human rights

- Three levels 15
- Case study: corporal punishment 17
- Investigation and documentation of torture 20
- Conclusion 22

### Lesson 1.3: Medical neutrality and international humanitarian law

- The Geneva Conventions 23
- Medical neutrality and human rights 24
- Violations of medical neutrality 24
- Conclusion 26

### Lesson 1.4: The health professions’ ethical codes

- Introduction 27
- The legacy of Hippocratic ethics 28
- The Nuremberg Code 29
Chapter 2: Health professionals and human rights

Lesson 2.1: Ethical dilemmas and risks of violating human rights

Introduction
Torture
Prison
Specific risks for prison health staff
Corporal punishment
The death penalty (capital punishment)
Armed conflict

Lesson 2.2: Upholding the right to health

Violations of second generation rights
Example: avoidable maternal mortality
Equity
Equity and the right to health
Gender equity
Poverty
Conclusion

Lesson 2.3: A rights-based approach to health policy

The rights-based approach to health
Grounds for restricting human rights
Conclusion

Glossary Course 2
Chapter 1: The legal context

Intermediate objectives

By the end of this chapter you will be able to:

- describe the relevance and content of some aspects of international human rights law, especially the International Covenant on Economic, Social and Cultural Rights
- discuss the importance of international humanitarian law (the Geneva Conventions)
- outline relevant professional codes of conduct.
Lesson 1.1: Health and human rights – norms and standards

Authors: Leo van Bergen and Marianne Begemann; updated by Levent Kutlu

Introduction

Health workers often face human rights violations, problems and dilemmas in their work. They witness discrimination in access to health care on the basis of gender, race, ethnicity or political faction, and increasingly they are aware of – and concerned by – these violations. They are unlikely to be enabled to monitor and report on violations of the right to health in their daily work, however. Too often health institutions pay no attention, let alone give priority, to ensuring the right to health. Many health workers perceive health not as a right, but as a commodity, act of charity or service. The level of lobbying by national health professional associations for a rights-based approach to health policy varies widely, but is more absent than visible. They may find it difficult or may not want to hold their governments accountable for non-implementation of the right to health. Little priority is given to human rights in health professional education.

Health professionals have a special role regarding the defence, promotion and execution of human rights law, international humanitarian law and professional codes of conduct. They are often the only people who are in a position to care for victims of cruel, inhumane and degrading treatment or punishment. On the other hand, medical expertise is abused by governments in countries including China, Iran, Israel and Turkey, through torture, and the preparation and execution of corporal punishment and the death penalty. The total number of countries where this occurs is debated: you can find more information in the annual reports of Amnesty International and the Organisation for Security and Co-operation in Europe (OSCE).

Doctors are regularly compelled to give up their independence: for example, to draw up false death certificates, to deny care to certain groups or individuals, to keep silent in situations where human rights have been abused, or to conduct medical experiments on children (BMA 2001).

Learning objectives

By the end of this lesson you will be able to:

• explain the difference between three sets of norms that regulate the conduct of health professionals – human rights law, international humanitarian law and codes of conduct

• discuss the meaning of the right to health and how it can be enforced.
Some health workers are at greater risk than others of finding themselves in compromising positions. Those working in prisons, with the police and in the armed forces may come under institutional pressure because of divided loyalties. Those working in humanitarian aid, in the pharmaceutical industry, with asylum seekers and in forensic science may also find their ethical values difficult to maintain because of conflicting priorities.

As individuals, in groups and in their organizations, health professionals can play an important role in the protection of human rights. Health professionals in different roles tend to focus on different types of rights. For example, some deal with social and economic rights, including the right to health, while others concentrate more on civil and political rights and prohibition of torture. The environment where they practise, government policy on health and human rights and other factors influence their choice.

**Historical context**

There is a long-standing relationship between health care, ethics and human rights. The ancient Greek doctor, Hippocrates was one of the first to deliberate on these matters in his Hippocratic Oath. Many centuries later, at the Nuremberg trials in 1946, the international community was shocked at the Nazi atrocities by doctors who had performed criminal experiments, selected people to be gassed and killed children with learning difficulties. The Nuremberg proceedings included a special doctors’ trial. The intention that such atrocities should never happen again led to the foundation of the World Medical Association in 1947. In 1948, the newly established United Nations adopted the Universal Declaration on Human Rights, the starting point of many subsequent international covenants and declarations that form the legal basis of human rights. Many of these human rights instruments underline the special role and responsibilities of health professionals.

Many years before the Second World War, rules and regulations were agreed regarding the responsibilities of states and health professionals towards prisoners of war, wounded combatants, civilians and shipwrecked persons during international conflict and civil war. Known as the Geneva Conventions, they emphasise the neutral position of health workers. Combatant parties are expected to respect their integrity and should not attack medical staff, ambulances and health facilities. These conventions are the building blocks of international humanitarian law.

Internationally agreed codes of conduct also regulate the behaviour of the health professions and overlap with the norms of human rights law and international humanitarian law. This lesson will briefly discuss all three sets of standards.
1. International human rights law

After the Universal Declaration of Human Rights in 1948, the UN Economic and Social Council proposed that human rights were interdependent and that all categories of rights should be contained in one document. Political and ideological disagreements between Western countries and socialist states led by the Soviet Union resulted in two covenants being drafted: one on civil and political rights, the International Covenant on Civil and Political Rights (ICCPR) and one on socioeconomic rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR) (Lagoutee 2007).

The main reason appears to be the reluctance of Western countries to be obliged legally to uphold their citizens’ economic and social rights.

ICCPR concerns ‘classical’ rights such as the right to life, right to a fair trial, and right to freedom of expression. Civil and political rights were understood to hold states accountable, to be relatively cheap to provide compared to economic and social rights, to be immediately obtainable through the legal system and to be clearly defined. Violations of civil and political rights could more easily be brought to court. The covenant limits the powers of state intervention in the life of its citizens and demands the state guarantees such freedoms.

ICESCR concerns states’ obligations to secure socioeconomic rights for their citizens through such means as education, housing and health (article 12). Social rights oblige governments to provide social services that are costly, and violations cannot easily be brought to court, unlike civil rights. South Africa and some countries in the former Communist bloc like Hungary and Lithuania included economic and social rights directly as justiciable rights in their constitutions – meaning they are capable of being decided by a court.

These two covenants were adopted in 1966 and came into force in 1976. This clear categorization of rights lost ground after the end of the Cold War. Indivisibility and interdependence of all human rights is the leading idea in recent official documents and public rhetoric, confirmed in the declarations of two international conferences on human rights: Teheran 1968 (UN 2009) and Vienna 1993 (UNHCHR 1993).

Why do you think there was this disagreement? Do you think it was right to categorize rights like this?

Other important legally binding conventions include:

- Convention on the Rights of the Child (CRC)
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)
- Convention Against Torture and other forms of cruel and inhuman treatment and punishment (CAT)
- International Convention on the Rights of All Migrant Workers and Members of their Families (ICRMW)

All conventions have supervising committees whose expert members review the progress of state parties in upholding the rights formulated in the conventions. Governments of countries party to these conventions are required to submit progress reports. The recommendations of these committees to governments are important monitoring mechanisms, and pressurize governments to comply with their commitments.

A 2005 decision of the Commission of Human Rights meant the committees started to receive parallel or shadow reports from civil society organizations such as trade unions, campaigning groups, charities and churches. This information helps the committees perform their monitoring activities.

Information from the health sector is of great importance to parallel reporting and the monitoring activities of the supervising committees, but health professionals and the health sector in general contribute little. In some countries, organizations for health and human rights such as Physicians for Human Rights mobilize them to contribute to monitoring.

The supervising committees also formulate updated interpretations of the various articles of each covenant. For instance, the Committee on Economic, Social and Cultural Rights published General Comment 14 on ICESCR Article 12 on the right to health in 2000 (CESCR 2000). This outlines the right to accessible, affordable and equitable health care and other health-sustaining services such as clean drinking water and sanitation. It also describes people’s right to have information and participate in decision-making. It outlines the accountability of duty bearers (states), and principles of transparency, progressive realization of rights and the core obligations of duty bearers.
The right to health

The ‘right to health’ is a shorthand term for ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. The definition was carefully crafted by the Committee to balance the rights of all people to have equal access to health care and health-related services with a state’s capacity to provide those services.

This right to the highest attainable standard of health in international human rights law is a claim to a set of social arrangements – norms, institutions, laws and an enabling environment – that can best secure enjoyment of this right. The most authoritative interpretation of the right to health is outlined in ICESCR Article 12, ratified by 160 countries as of 2010. Recognition of the right to health implies that a government should guarantee that health and health-sustaining services are established. It implies that individuals and groups can hold their governments accountable for non-compliance.

Nevertheless, the right to health should not be seen as a right to be healthy (Asher 2005:17). The state cannot be expected to provide people with protection against every possible cause of ill health or disability. Nor should the right to health be seen as a limitless right to receive care for any and every illness and disability. ‘Instead, the right to health should be understood as a right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.’

UN Special Rapporteur on the right to health

In 2002 the UN Committee on Human Rights (now known as the Human Rights Council) appointed a Special Rapporteur on the right to health to oversee governments’ progress in realizing the right to health. This independent expert is appointed for three years (with the possibility of an extension for another three years), and reports to the UN General Assembly and Human Rights Council.

Between 2002 and 2007 the Special Rapporteur was Paul Hunt from New Zealand. He highlighted two major themes during his mandate: discrimination and poverty. He formulated recommendations on them in reports on individual countries, as well as in international analyses on such topics as the skills drain of health workers from
poor to rich countries, the obligations of rich countries to provide aid, and the responsibilities of international financial institutions such as the World Bank and International Monetary Fund.

Other recommendations are on neglected diseases, and an integrated health care system as a core social institution. The Human Rights Council nominated Mr. Anand Grover as the next Special Rapporteur and he assumed his duties in August 2008. He emphasized access to medicines in his first report dated 31 March 2008 and discussed the relation between accessing medicine and patent issues in medicine production within the context of international agreements such as Intellectual Property Rights (TRIPS).

National and regional recognition of the right to health

The figures on countries that have ratified regional treaties and incorporated the right to health in their national constitutions date from 2002 (Figure 1). At that time 142 countries had ratified the ICESCR; 109 had strengthened their commitment to the right to health by including it in national constitutions; 83 were also bound by regional human rights instruments such as the European Social Charter of 1961, the African Charter on Human and Peoples’ Rights of 1981 and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988.

![Figure 1: National recognition of a right to health (WHO 2002)](image)
Torture ban

The word ‘torture’ is used here to indicate torture and other cruel, inhuman or degrading treatment or punishment. The right to be free from torture is firmly established under international law. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment expressly prohibit it. Several regional instruments also establish the right to be free from torture, including the American Convention on Human Rights, the African Charter on Human and Peoples’ Rights, and the European Convention for the Protection of Human Rights and Fundamental Freedoms.

Torture and ill treatment are nevertheless practised as unofficial state policy in many parts of the world. Torture is defined only in two UN instruments: the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the Convention against Torture.

Health professionals should understand the definition, especially when medical assessment is necessary to support allegations of torture. Medical involvement in torture may be active or passive, and health professionals faced with a torture case behave in different ways, from assessing torture techniques to failing to report – intentionally or through neglect, even when the victim has given informed consent for them to do so. They should be made aware of the link between professional ethics and human rights, through education and continuing professional development activities.

Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

In 1985 the UN Commission on Human Rights decided to appoint a Special Rapporteur to examine questions relevant to torture. The mandate, extended for three years by the Human Rights Council in 2008, covers all countries, irrespective of whether they have ratified the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
The Special Rapporteur asks governments for information on legislative and administrative measures taken to prevent torture, requests them to remedy any consequences and asks them to respond to allegations of torture. He or she also receives requests for urgent action and brings them to the attention of the governments concerned in order to ensure protection of an individual’s right to physical and mental integrity.

The Special Rapporteur reports to the Commission on Human Rights and to the UN General Assembly on what has been done, persistently drawing attention to the importance of prompt investigation of torture allegations.

We will discuss the relevance of human rights law for health professionals further in Lesson 1.2.

2. International humanitarian law

Originally known as the laws of war, international humanitarian law (IHL) is the body of law that regulates the conduct of armed conflict and its consequences. Its starting point is not the theoretical rights of the individual, but an acknowledgement of the existence of war and the need to have an agreed framework for regulating violent conflict in a way that does not impede military objectives but limits harm.

The underlying rationale is that it is in the interests of all parties to an armed conflict to prevent atrocities; allow the safe functioning of unarmed units such as medical units; and protect civilians and combatants who cannot discharge their military functions. IHL’s history goes back to the mid-19th century but the major conventions now regulating conflict are the four Geneva Conventions (1949) and the two additional Protocols (1977), together with the conventions regulating use of certain weapons, including chemical and biological weapons and landmines. We will look further at IHL in Lesson 1.3.

3. Codes of conduct

The final set of norms and standards regulating the conduct of health professionals comprises the professional codes health workers have devised through their national and international representative bodies.

They may have less legal authority but their moral value is significant. Ethical codes are an essential component of professional self-regulation. Examples include the Declaration of Helsinki on medical experiments, and the Declaration of Tokyo on torture. We will discuss these further in Lesson 1.4.

You will find examples of the use of these instruments in the lessons that follow.
Conclusion

Knowledge of human rights, whether they have been categorized or not, is of utmost importance for medical professionals as they may frequently be confronted with breaches of those rights.

International covenants on human rights are binding for the states that have ratified them. As health and human rights are closely related in daily life, health professionals should also act as advocates for people who suffer human rights violations while practising their profession within their ethical obligations.

References


WMA (1997), *Declaration concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*. Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997. Available at: www.wma.net/en/30publications/10policies/c19/index.html, accessed 06 December 2011.
Lesson 1.2: The role of health professionals in defending health and human rights

Authors: Leo van Bergen and Marianne Begemann

This lesson focuses on how health workers and their organizations can undertake advocacy and monitoring of human rights. Their potential to do this differs from country to country: in some countries individuals are almost powerless, while in others they are free to advocate human rights. The support of professional organizations also varies. Each health worker must be made aware of the national and local possibilities and limitations.

Three levels

Human rights advocacy and monitoring takes place at three levels:

• by the state (including organizations of states such as the European Union)
• by health professional associations, trade unions and other organizations
• by individuals, including individual health professionals.

Learning objectives

By the end of this lesson you will be able to:

• outline the roles and responsibilities of health workers and their organizations in promoting and defending human rights;
• describe the principles underlying the monitoring and reporting of human rights violations by health workers.
• understand the health worker’s responsibilities to investigate and document torture.

The primary bodies responsible for protection and promotion of human rights are the governments of state parties to covenants. States can be held responsible for the highest attainable standards of health to be available, accessible, affordable and of reasonable quality. They should comply with the UN conventions and facilitate the independent functioning of health professionals. Governments often neglect this, and sometimes commit violations. Nongovernmental organizations like health professionals’ organizations and trade unions often assume this duty.
All health professionals need support, guidance and solidarity when dealing with human rights issues in their daily work. Human rights will only be protected when the key witnesses – health workers – are themselves protected and able to investigate and denounce violations without fear.

Health professional associations should provide effective leadership on professional ethics and human rights. They can provide training, encourage universities and colleges to incorporate ethics into their core curriculum, raise awareness among their members and act as advocates.

The British Medical Association outlines actions that associations of health workers can take in the face of human rights violations (BMA 2001:92–93):

- They should consider how professionals can be helped to access ‘safe’ reporting mechanisms in their work. The development of ‘alternative’ reporting systems should be considered where existing mechanisms are unsatisfactory.
- They should ensure that clear guidance is published (for example) about the facts recorded on death certificates, and attempt to ensure that health workers know how to identify signs of abuse of human rights.
- They should make it clear to members that human rights violations are unacceptable.
- They should take a lead in standard-setting, including the dissemination of relevant codes, guidelines and international statements.
- They should have effective mechanisms for addressing evidence of abuse promptly.
- They should be involved in campaigns for the prosecution of violators of human rights.
- They should ensure legal protection for whistleblowers.
- They should take steps to raise professional awareness of human rights, such as education in professional ethics and human rights.

Every health worker is also responsible for taking the initiative to highlight abuses of human rights. They can analyse the problem and its relationship with human rights, and try to act in accordance with their findings. The following case study discusses how a health professional might react when they are asked to be complicit in corporal punishment.
Case study: corporal punishment

A doctor is working in a foreign country where corporal punishment is practised. He is working in his clinic one day when a policeman enters with a boy in handcuffs. The policeman asks the doctor if, on the basis of his medical knowledge, he can determine the boy’s age – is he older or younger than 16. The boy says he is 15, but he looks older.

The doctor faces the dilemma that whipping is an unethical practice whatever the boy has done – it violates individual integrity and professional ethics. On the other hand he is under great pressure to cooperate.

The relevant principles are the immunity of the individual and that professional ethics prevail above state interests; and, on the other hand, respect for the habits and laws of the country. The doctor must look at the factors applicable to the case:

- the definition of torture does not include corporal punishment
- UN human rights jurisprudence has determined that corporal punishment is cruel and degrading
- national law requires medical involvement
- medical ethics prohibit medical involvement
- the position or advice of the national professional association on corporal punishment.

What do you think the doctor should do? Take a moment to think about it and write down your ideas.

The unaware doctor may be inclined to adapt to the requirements of the country, but the well-informed doctor is more likely to take a ‘no’ position, aiming at non-cooperation and seeking support, for example from medical groups or even governments (Figure 1).
Lesson 1.2: The role of health professionals in defending health and human rights

Figure 1: Dutch government declaration on the participation of health professionals in corporal punishment
This case study shows that advocacy for human rights may often lead to serious dilemmas and can potentially be dangerous. The BMA cites the case of a doctor working in the disputed border region of Kashmir, between India and Pakistan (BMA 2001:503–504). In Indian Kashmir, a persistent pattern of extra-judicial abuse and impunity for perpetrators strongly suggests official policy. Dr Farooq Ahmed Ashir, chief orthopaedic surgeon at the Srinagar Bone and Joint Hospital, recorded numerous cases of torture and assault on civilians. He was shot dead at an Indian army checkpoint in 1993.

It becomes even more difficult for individual health workers to monitor abuses if they know their colleagues are violating human rights and professional ethics. Here national and international organizations can play an important role in gathering evidence. Monitoring the complicity of health professionals in human rights abuses should be linked to monitoring the underlying human rights violations (International Dual Loyalty Working Group 2002:109–110). It should aim to:

- identify countries, locales and settings where violations of human rights in the health sector or in connection with health services are common;
- provide an accessible means for individuals subject or potentially subject to a human rights violation as a result of the actions of a health professional to receive advice and guidance on how to proceed, and file complaints about the conduct of health professionals that violate their human rights with appropriate agencies, with protection from reprisal;
- monitor trends in relation to new legislation or policies, including health policies, to identify points of intervention to address the compromise of human rights by dual loyalty conflicts;
- identify weaknesses in the organization or facilities that are supposed to help individual health practitioners to report violations, and to recommend improvements.

In many cases violations of human rights by health professionals are due to divided loyalties, especially in an environment where there are regular demands or threats to practitioners to comply. These may be accompanied by legal barriers to professional independence, or circumstances where structural arrangements or institutionalized human rights violations preclude the practitioner from avoiding the conflict or changing the practice environment.
For this reason, mechanisms of collective action are needed (International Dual Loyalty Working Group 2002:113–114). They include:

- support for individual health workers subjected to reprisals, threats or demands by the state to subordinate human rights to state interests, through every means possible, including speaking out publicly;
- advocacy to change laws and regulations that prevent or impede health workers from meeting their human rights obligations to patients;
- proactive steps to prevent health professionals being placed in positions where they are at risk of participating in violations of human rights;
- advocacy to end state policies and practices that prevent health professionals from providing health care to some or all patients in need, including communities of patients, consistent with professional standards of care (these practices include a state’s failure to take adequate steps needed to attain the highest standard of health for all; inequity in allocation of health resources or benefits; discrimination or tolerance of discrimination against women, migrants and ethnic, racial and religious groups or on the basis of disease or disability);
- advocacy for policies to promote, protect and uphold human rights that avoid dual loyalty conflicts, such as patient rights’ charters, occupational health policies and public service standards.

Investigation and documentation of torture

Doctors and nurses are often the first and sometimes the only people to witness the devastating effects of torture. They play an indispensable role in its investigation and documentation. The Istanbul Protocol (1999) contains important guidelines for doctors and other investigators, and nongovernmental organizations. It was written by expert organizations and adopted by the UN High Commissioner on Human Rights as the guiding protocol on investigation and documentation. It says states that receive complaints about torture in their jurisdiction are required to conduct an independent investigation, bring perpetrators to court and find redress for the victims.

Take a couple of minutes to look at excerpts from the Istanbul Protocol in Box 1. Make sure you understand the responsibilities of health professionals.
Box 1: Extracts from the Istanbul Protocol (1999)

1 The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment (hereafter ‘torture or other ill treatment’) include:
   (i) clarification of the facts and establishment and acknowledgement of individual and state responsibility for victims and their families;
   (ii) identification of measures needed to prevent recurrence;
   (iii) facilitating prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as responsible, and demonstrating the need for full reparation and redress from the state, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2 States shall ensure that complaints and reports of torture shall be promptly and effectively investigated. The methods used to carry out such investigations shall meet the highest professional standards, and the findings shall be made public.

3 (a) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.

3 (b) Alleged victims of torture, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation.

4 Alleged victims of torture or ill treatment and their legal representatives shall be informed of, and have access to, any hearing as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5 (a) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, states shall ensure that investigations are undertaken through an independent commission of inquiry or similar procedure.

5 (b) A written report, made within a reasonable period of time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. The state shall, within a reasonable period of time, either reply to the report of the investigation or indicate the steps to be taken in response.

6 (a) Medical experts involved in the investigation of torture should behave at all times in conformity with the highest ethical standards and in particular shall obtain informed consent before any examination is undertaken.

6 (b) The medical expert should promptly prepare an accurate written report.

6 (c) The report should be confidential and communicated to the subject or his or her nominated representative. It should not be made available to any other person except with the consent of the subject or on the authorisation of a court empowered to enforce such a transfer.

For the full text see: www.ohchr.org/Documents/Publications/training8Revien.pdf
Conclusion

Health workers have an essential role to play in preventing human rights abuses. They need to be well informed and supported if they are to fulfil this role. Professional organizations at national and international level need to support their members and uphold these ethics.

References


Lesson 1.3: Medical neutrality and international humanitarian law

Authors: Leo van Bergen and Marianne Begemann

This lesson describes the provisions in international humanitarian law that relate to medical neutrality, and discusses violations of medical neutrality.

The Geneva Conventions

International humanitarian law consists mainly of the Geneva Conventions. Virtually all countries in the world are party to these conventions. International humanitarian law, formerly called ‘war law’, aims at protection of human life and human rights in armed conflict. The first agreement, the Convention for the Amelioration of the Condition of the Wounded in Armies in the Field, dates from 1864. The Red Cross played an integral part in the drafting and enforcement of the Geneva Conventions.

Several articles of the Conventions refer to health professionals. They aim to protect health workers, facilities and transport by declaring them neutral in situations of armed conflict. However, ‘such neutrality shall cease if the ambulances or hospital should be held by a military force’ (article 1, Geneva Convention number 4, 1949).

The most important article of this Convention is article 3 on the care of civilians, prisoners and wounded in combat zones (Box 1).

Box 1: Article 3 of the fourth Geneva Convention

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions:

1. Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

2. The wounded and sick shall be collected and cared for. An impartial humanitarian body, such as the International Committee of the Red Cross, may offer its services to the Parties to the conflict.

Learning objectives

By the end of this lesson you will be able to:

• describe the principles of medical neutrality
• recognize the most important violations of medical neutrality.
It was decided in 1965 that the Geneva Conventions were inadequate to protect the victims of modern conflict, such as guerrilla warfare and terror campaigns. The International Committee of the Red Cross (ICRC) began to study the possibility of filling these gaps in existing law, and providing additional protocols. This research resulted in the two additional protocols of 1977, which (again) aim to limit the use of violence and protect civilians by strengthening the rules governing the conduct of hostilities.

Despite these additions, the boundaries of humanitarian law were stretched again by the terrorist attacks in the United States on 11 September 2001 and the subsequent so-called war on terror. For example, questions remain unanswered as to whether terrorists or those suspected of terrorist activities who are in detention should be treated as prisoners of war and therefore entitled to protection under the Geneva Conventions. Precisely because these questions remain, health professionals – who are among the people with access to them – could play a crucial role in monitoring and reporting possible abuses of human rights.

Medical neutrality and human rights

Health workers in humanitarian aid projects in conflict zones are frequently caught up in human rights violations. Humanitarian laws protect aid to prisoners of war and to sick and wounded combatants and civilians, and aim to guarantee that the process of giving aid is not hindered. They form the legal or ethical basis of what is called ‘medical neutrality’. The right to (access) health care and respect for the neutral position of health workers and facilities is at the heart of this concept. It is largely based on international humanitarian law, and also underpinned by human rights regulations and international professional codes (as we saw in Lessons 1.1 and 1.2).

Violations of medical neutrality

Drawing on these fundamental principles, and other legal and professional codes, the International Commission on Medical Neutrality describes different types of violation of medical neutrality. They are used as a reference during inquiries into human rights violations, especially during armed conflict. They fall into different categories.

What do you think these categories might be? Please make a list now.
The categories are as follows:

**Murder and disappearances:**
The killing or disappearance of sick or wounded patients, or of health workers, directly or indirectly caused by one (or all) parties of the conflict.

**Torture (and inhuman or degrading treatment):**
Not treating the sick or wounded in a humane, ethically responsible manner.

**Arrest or imprisonment of sick and wounded:**
Arresting or imprisoning the sick and wounded, resulting in the interruption of necessary health care, as well as using a patient’s medical condition as an excuse for imprisonment.

**Punishing health workers:**
Punishment of health workers as a result of actions that are professionally responsible, or because of the refusal to act in a professionally unethical way.

**Military attacks on health workers or medical units:**
Military attacks on medical facilities or health workers who are clearly distinguishable as such.

**Denial of access to care:**
Deliberately delaying or obstructing medical transport or the treatment of sick and wounded, or of medical assistance to the civilian population.

**Harassment:**
Openly or implicitly threatening behaviour intended to result in the provision of inadequate health care or the failure to provide care.

**Discriminatory practice:**
Differential provision of care to sick and wounded patients based on non-medical considerations.

**Disruption of training programmes:**
The ending of health-related teaching programmes for professional and lay health workers, relief workers, and/or health education for patients and civilian populations.

**Using health workers and units for military purposes:**
The use of health workers or facilities for military purposes, such as patrolling in or around medical units and/or using medical units as command posts, observation posts, troops or weapons transport, or for any other military purpose.
Improper use of the medical emblem:
Using an emblem indicating health workers or health facilities, such as the red cross, red crescent or red crystal on a white background, or any other emblem recognizable as a medical one, for military or other non-medical purposes, such as attacking the other party (or parties), transporting uninjured troops, or supplying military units with weapons and/or ammunition. It also includes the failure to identify medical personnel or units with any distinctive medical emblem.

Violations committed by health workers:
Health workers taking part in any violation of medical neutrality listed above; unethical use of medical expertise to further the cause of a party to the conflict; unethical medical experimentation and involvement of health workers inflicting torture or concealing its signs (Van Es and de Jong 2001:21–22).

Conclusion
Medical neutrality is laid down in several articles of international humanitarian law and in professional codes of conduct. Health workers have the right to do their job at all times, treating sick and wounded without reference to race, religion, political conviction or nationality. Health facilities should only be used for medical (and therefore not military) purposes, and the sick and wounded have the right to be treated impartially and without fear of reprisal or other forms of violent treatment.

References
Lesson 1.4: The health professions’ ethical codes

Authors: Leo van Bergen and Marianne Begemann; updated by Levent Kutlu

Introduction

Professional codes of conduct are as old as the health professions themselves. Practitioners and philosophers have always reflected on professional-patient relations, the application and limits of health workers’ authority, and ethical matters related to conception, birth and dying.

While international covenants (human rights law) and the Geneva Conventions (humanitarian law) are legally binding, the majority of professional codes of conduct are not legally binding in a direct sense. However, many internationally accepted codes of conduct have influenced the content of national laws, such as legislation on medical experimentation (BMA 2001).

Ethics deal with the rights and wrongs of human behaviour, so medical ethics deals with the rights and wrongs of the behaviour of health professionals. Health care without ethics is potentially dangerous, and the first thought of every health professional should be to ‘do no harm’ to the patient.

Both professionals and public appear to believe that these ethical codes can exercise a positive influence in the human rights sphere. They provide a justification for health workers and their organizations to oppose human rights abuses, and their basic concepts can be used to provide the infrastructure of the professions’ responses to human rights violations. Their use and dissemination of ethical codes and guidelines should be supported as a framework and context within which ethical dilemmas can be considered.

In some cases professional codes take a contrary position to existing laws. For example, in Turkey it is obligatory for health professionals to report torture cases to the security officials or directly to the prosecutor’s office. On the other hand, tortured people

Learning objectives

By the end of this lesson you will be able to:

• discuss the guidance provided by the health professions’ ethical codes
• describe some relevant ethical codes.

Make sure you know about the professional code that regulates your profession. If you do not, look it up now on the internet.
do not usually wish to make an allegation against perpetrators as they fear reprisals. Even if there is no informed consent from the torture victim to report injuries, health workers should act in favour of the patient, break the existing law and not report to officials.

The legacy of Hippocratic ethics

Hippocrates (460–377 BCE) practised medicine in his birthplace, the island of Kos in the Aegean Sea, and taught his pupils to maintain high professional standards. Box 1 contains some excerpts from the oath named after him – but probably not written by him – that has guided medical practice for over 2000 years.

Box 1: Extracts from the Hippocratic oath

‘I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witnesses, that I will fulfil according to my ability and judgement this oath and this covenant:

‘I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

‘Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

‘What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.’

Hippocratic ethics continue to be the cornerstone of professional behaviour, and of ethical instruments such as the Nuremberg Code (1947), the World Medical Association’s Declaration of Helsinki (1964) on medical experimentation, the WMA Declaration of Geneva (1948) on armed conflict, and the declarations of Tokyo (1975) on torture and Malta / Marbella (1991) on hunger strikes. The Geneva Conventions of 1949 were also influenced by medical ethical codes, as were important instruments of international human rights law, such as the UN Principles of Medical Ethics (1984), the UN Minimum Standard Rules on the Treatment of Prisoners (1952), the Convention Against Torture (1975) and the Istanbul Protocol (1999).

Figure 1: Hippocrates
The Nuremburg Code

The judgment of the war crimes tribunal at Nuremberg was particularly important as it laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a code now accepted worldwide. Among other requirements, it enunciates the requirement of voluntary informed consent by the human subject.

The principle of voluntary informed consent protects the right of the individual to control his or her own body. The code also says that the risks involved in human experimentation must be weighed against the expected benefits, and that unnecessary pain and suffering must be avoided. It recognises that doctors should avoid actions that injure human patients. These principles have been extended to general codes of medical ethics.

The UN, and professional organizations like the World Medical Association and the International Council of Nurses, have written ethical codes guiding the behaviour of health professionals. They are not legally binding, but have high moral impact, and provide guidance for health professionals facing ethical dilemmas. They remain the subject of discussion and development. New dilemmas in health care constantly appear, most recently related to globalization, privatization, professional confidentiality, disaster health care, health insurance, occupational health and the beginning and end of life. Ethical debates will continue and new codes will be established to help health professionals cope with difficult situations.

Examine examples of ethical codes by looking at Amnesty International’s collection of ethical codes and declarations.

References


Chapter 2: Health professionals and human rights

Intermediate objectives
By the end of this chapter you will be able to:

• describe some of the possible problems, risks and dilemmas of health professional work where human rights could be violated

• identify the challenge of divided loyalties

• analyse the common dilemmas in situations where human rights are at risk.

• describe how health and human rights can be promoted

• suggest how to promote a rights-based approach to health.
Lesson 2.1: Ethical dilemmas and risks of violating human rights

Authors: Leo van Bergen and Marianne Begemann; updated by Levent Kutlu

Introduction

Health workers risk involvement in human rights violations in a number of situations because of their professional duties and divided loyalties. They may become involved in human rights abuses and risky situations knowingly or unknowingly, willingly or unwillingly. Abuse is often a slippery slope: a doctor might start by caring for people who are tortured and end up an accomplice of the torturer. Where does helping the victim stop and helping the perpetrator start?

The role of medicine is crucial because of its investigative nature. Reporting human rights violations can be problematic. It partly depends, for example, on how the information is acquired: as mentioned in the previous chapter, if it is through a professional-patient-relationship, the patient’s consent should be given. Furthermore, sharing information about human rights abuses could cause retaliation against those involved and their families. Nevertheless, health workers giving medical proof have obtained much evidence of human rights violations, for instance in Bosnia and Herzegovina.

Learning objectives

By the end of this lesson you will be able to:

• recognize when health professionals are at risk of violating human rights
• discuss how health professionals should deal with such situations.

Reflect on what you learned in Chapter 1. Now make a list of situations where health professionals are likely to be involved in human rights violations.

Your list may include the following situations:

Torture

Health workers taking part in investigations of torture allegations should act according to the definition of torture in the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984:

‘Torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third
person, has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.’ (OHCHR 2007a).

Does any of this surprise you? In fact there is a lot of debate about the actions that cause physical or mental pain or suffering which aim to get information or to punish when non-state actors (armed groups in different parts of the world can act in the same way without having an official responsibility given by the State) commit them. Those acts are not considered as torture according to the definition in Convention.

The definition and the words used are legally binding and have great importance. One example was at the trial of Augusto Pinochet, the former dictator of Chile who had overseen extensive human rights abuses. One of his lawyers proposed that some of the crimes of which he had been accused did not constitute torture; some deaths in detention did not involve pain or suffering, but led to immediate death. So, medical professionals may need to be aware of the UNs definition of torture when they have undertaken the responsibility of examining survivors of torture and documenting their findings for legal purposes. This example also shows the importance of accurate forensic reporting. These reports must involve the clues and patterns of the actions of torturers and enlighten the perpetrators’ intention. (BMA 2001)

Do you know a practical tool to guide medical professionals to prepare accurate and efficient reports on torture? Please go back to Lesson 1.2 and read the Istanbul Protocol again.

Health professionals are participating directly in torture when they:

- evaluate the victim’s capacity to withstand torture
- supervise torture through providing medical treatment if complications occur
- provide professional knowledge and skills to the torturer
- falsify or deliberately omit medical information when issuing health certificates or autopsy reports
- provide medical assistance in the torture system without denouncing torture or resigning from such work
- administer torture by directly participating in it
- remain silent despite knowing abuses have taken place
Indirect involvement or participation in torture might arise when a health worker is involved in a relationship with a prisoner:

- immediately before, during or after torture
- without the prisoner’s free consent
- when either the prisoner or the professional are not free to identify themselves or the professional refuses to be identified
- where the professional acts in the interests of persons other than the prisoner
- where the professional undertakes any examination, certification or forensic assessment of a tortured prisoner or ex-prisoner or remains of a prisoner

Health workers become involved in torture because:

- resisting or reporting can have grave consequences for their career or the lives and wellbeing of themselves or their families
- the health worker began with an attitude of cooperation to avoid a worse situation – a slippery slope
- health workers’ organizations in their country support or do not condemn torture
- they believe in the ideology of the state and want to play an active role in suppressing opposition.

Health professionals should bear in mind that torture can take place anywhere, even on the street, and be aware of what constitutes torture. Some actions against protesters are now defined as ‘police brutality’ or ‘excess use of force by security officers’ – actions that can be interpreted as torture if the person is deprived of liberty.

International codes of ethics can provide guidance, but may need revision to make them effective where there are legal grey areas in how prisoners are defined or what constitutes an act of torture. Box 1 describes how medical ethics may have been compromised in the US prisons at Guantanamo Bay.
Box 1: Guantanamo Bay and medical ethics (Wilks 2006:560–561)

US Senator John McCain, himself a survivor of torture, piloted legislation through the Senate requiring detainees to be treated humanely wherever they were held. This principle was enshrined in the Detainee Treatment Act 2005, whose provisions were used as the basis for a US Federal Court action by lawyers acting on behalf of four hunger strikers at Guantanamo Bay. The case centred on whether the force-feeding of detainees amounted to torture, because it is in conflict with a consistent and competent refusal, and the forcible methods used.

Four UN special rapporteurs, reporting to the UN Commission on Human Rights, declared that interrogations authorized by the US Department of Defence and force-feeding ‘amounted to torture’ as defined in article 1 of the Convention against Torture.

Until recently, international codes of ethics – particularly the World Medical Association’s codes of Tokyo and Geneva – have been thought sufficient to protect patients and to inhibit doctors from taking part in this kind of abuse. Events at Guantanamo Bay show this is no longer the case, primarily because of the legal vacuum in which detainees were held. In relation to force-feeding, the WMA Declaration of Malta (1991) is wholly inadequate. In 2001, after long hunger strikes in Turkish prisons caused many deaths, the BMA identified discrepancies between the two WMA declarations.

The Tokyo declaration – in line with general ethical rules – advises against involuntary artificial feeding of protesters who have competently refused nutrition, even if this leads to their death. The Malta declaration allows doctors to decide on the appropriateness of resuscitation and artificial feeding, based on the view that it is essential to look beyond what initially seems to be an autonomous decision to go on hunger strike, and to consider the possibility of peer pressure.

In 2001 the BMA, in an attempt to resolve these contradictions, offered a revised draft of the Malta declaration, which requires doctors to respect an informed refusal of feeding unless the refusal was coerced. The WMA refused to alter the declaration. In the light of events at Guantanamo Bay, the BMA submitted a completely new version of the Malta declaration for the WMA meeting in 2006, in an attempt to make it both relevant and effective. WMA General Assembly revised the Malta Declaration in 2006, but this will have limited effect unless national medical associations are willing to make their members accountable when practice departs from principles.
Wilks (2006) says the individual doctor-patient relationship is founded on the principles of autonomy, beneficence, and justice. That these principles apply on a wider national and international scale, and that they are articulated by a caring profession, gives doctors enormous power. They can successfully challenge authorities demanding their collusion in unethical behaviour, as illustrated by the successful, possibly permanent suspension of capital punishment in California after a refusal by doctors to administer lethal injections.

Yet doctors can easily drop their ethical guard, in ways that do not have to be as stark as the horrors of Guantanamo Bay. ‘National and international medical bodies need to understand that not only do they have more power than they generally assume, or choose to use, but that to use that power is a basic ethical duty. This duty is as basic as the application of ethical principles in the daily life of a practising doctor’ (Wilks 2006).

**Prison**

We will now look at the responsibilities and dilemmas faced by prison health workers, who faced particular difficulties, as mentioned in Chapter 1.

The state has special responsibilities towards people it has imprisoned. Some agreements protect prisoners’ rights – the so-called Standard Minimum Rules for Prisoners, the UN code covering prison circumstances (OHCHR 2007b). It is endorsed by almost all countries, including those who still violate the rules. However, prisons tend to be unhealthy places. Take a moment to list the possible characteristics of prisons that could be bad for prisoners’ health.

Prison circumstances differ from place to place and from country to country. In many countries prisons are characterized by overcrowding, poor hygiene, violence, endemic infectious diseases and drug abuse, and health care of poor quality or none at all.

In Europe, detention facilities are monitored by the European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT). Elsewhere, NGOs often take on a monitoring role.

Prison health workers have an important role to play in maintaining and improving human rights and reporting misconduct. They may witness violence, poor hygiene and the lack of health care, and their consequences. Health workers’ access to prisons may be restricted, and they should be mindful of the need to secure full access to prisoners.

The prisoners are in a confined situation, an extra reason to monitor the quality of health care, which should be at the same standard as the rest of society. There should be regulations stating that health professionals are in all circumstances primarily responsible for their patients, with no interference from non-medical personnel in the prison hierarchy.
Specific problems occur because the prison population differs from the normal population in many ways. They are involuntary patients with a higher risk of health problems such as infectious diseases and psychosocial and psychiatric problems. These occur more often and are more severe according to the severity of the prison regime.

When in the prison service, health workers are subordinate to the prison director, which leads to divided loyalties. To guard their independence, it is preferable that a third party employs the health worker – not the prison itself. Furthermore, the trust of the prisoner can only be won with an independent contract.

A prison health worker has several functions, and must differentiate between curative tasks (for prisoners or prison personnel), forensic tasks, and organizational medical tasks. When this differentiation is not made, severe clashes of interests ensue.

Specific risks for prison health staff

The main problem is divided or dual loyalties. The prison health worker is responsible for public health and health care in the prison, to individual prisoners and to the prison hierarchy.

This means there are risks attached to their duty to uphold human rights and report violations. This dual loyalty may contribute to apathy about human rights violations and the mental and physical problems of prisoners that result from them. It may also contribute to naïveté or lack of knowledge and attention on the part of the health worker.

Certain tasks involve specific risks. These include:

- examining patients while handcuffed or blindfolded, unless the patient is a risk to themselves or others
- violating confidentiality as part of interrogation and prison discipline
- reporting health information without the patient’s consent when it has no immediate public health risk (except in particular circumstances, such as the need to report infectious diseases like tuberculosis because of the health risk to others)
- evaluating and cooperating with solitary confinement, unless it is in the patient’s interest, as in a severe psychological disorder
- not reporting children being taken away from their mothers soon after birth
- not looking after women in hygienic circumstances during and after birth
- not reporting the presence of youth prisoners in a facility for adult convicts.
Corporal punishment

UN jurisprudence indicates that corporal punishment is an act of cruel and inhuman treatment, but it falls outside the definition of torture because it is, judicially speaking, violence sanctioned by government. Medically speaking, however, there are similarities because, like torture, corporal punishment means inflicting physical and psychological damage, sometimes permanent. Corporal punishment is illegal in western countries but not everywhere; penalties can vary from whipping to amputation of a limb. It is in conflict with many medical ethical codes. Health professionals are involved when they:

- inspect the prisoner and determine if they are fit to receive the punishment
- are present when the punishment is carried out
- play an active role in the punishment (‘waking up’ a prisoner when he or she has passed out).

Health professionals become involved for similar reasons to why they become involved in torture, but also because they:

- feel they must obey national laws
- share the (political or religious) beliefs underlying these laws
- are not familiar with international laws condemning corporal punishment as inhumane and cruel.

The death penalty (capital punishment)

Like corporal punishment, there is a judicial difference between the death penalty and torture, because it can be part of the national legal system.

There is a close link between medical research and the death penalty. The guillotine, the electric chair and the intravenous injection were medical innovations. The gas chamber, and the right proportion in hangings between the drop and the length of the rope resulted partly from medical advice. This is not as strange as it seems: both the guillotine and the electric chair where devised as a modern, humane alternatives to hanging.

The ‘humane character’ of the intravenous lethal injection as an execution method was seriously challenged by the findings of autopsies of 44 people executed in Miami, Florida, USA. In a very high percentage the level of barbiturate was too low to induce unconsciousness, leading to suffocation and suffering when respiration stopped.
The finding confirmed testimonies of lawyers and others that some prisoners showed anguish during execution or wrestled with the straps that bound them. Box 2 gives a further example of medical involvement in execution by lethal injection.

**Box 2: Medical involvement in the death penalty (Human Rights Watch 2006)**

Doctors have participated directly in the execution process in the US. In 1990, three doctors administered the first lethal injection execution in Illinois. For a number of years anaesthesiologists injected the drugs in lethal injection executions in Arizona.

During the first lethal injection execution in Texas, state prison medical director Dr Ralph Gray and private physician Dr Bascom Bentley were present to pronounce the prisoner’s death. They watched as execution team members struggled to find intravenous access. Eventually, the team convinced Gray to examine the prisoner and point out the best injection site.

He had also watched the warden mix the chemical agents. When the warden tried to push them through the syringe, he saw that because the warden had accidentally mixed all the chemical agents together, they had ‘precipitated into a clot of white sludge’. When Gray went to pronounce the prisoner dead, he found the prisoner was still alive. Gray and Bentley suggested allowing more time for the drugs to circulate.

A related compromise of medical ethics is becoming apparent in China due to the intimate relationship between the execution ‘industry’ and the organ transplant market. Illegal international organ trading includes organs removed from prisoners immediately after execution, in mobile clinics brought to the execution facility (Amnesty International 2010).

**Armed conflict**

Health professionals working in areas affected by armed conflict face a number of challenges. Some of these are discussed in Course 1, Lesson 2.1. Others will be elaborated in Course 5, Chapter 1. Health professionals may take sides, leaving enemy wounded unattended. Health professionals may be forced by military leaders to leave enemy wounded unattended. Health professionals may be knowingly or unknowingly used by military and political authorities to win the support of the civilian population by giving medical aid – the ‘carrot’ in the ‘carrot and stick’ strategy (Dutch doctors functioned like this in Indonesia, and American doctors in Vietnam).
The risk of health professionals violating human rights in armed conflict exists at individual and organizational levels, for example a government department, military unit or aid organization. Giving aid where it is most needed can conflict with the need to protect human rights or report violations of human rights. Reporting human rights violations can lead to a conflict with the organization that employs the health worker. These issues are explored in Course 1, Lesson 2.4.

References


Lesson 2.2: Upholding the right to health

Authors: Leo van Bergen and Marianne Begemann

Violations of second generation rights

Human rights are derived from an internationally agreed set of principles and norms embodied in international legal instruments. As we saw in Chapter 1, the right to health is part of the set of economic, social and cultural rights sometimes called ‘second generation rights’. These have been downplayed in human rights discourse, partly because they are more complex to uphold. Political and civil rights such as freedom of expression, the right to vote, and the right to a fair trial are clearer and easier to defend in legal terms. Campaigners have successfully used traditional human rights techniques such as naming and shaming, letter campaigns, test cases and demonstrations in the struggle for these rights in different countries.

Two covenants define and protect separate sets of human rights. The indivisibility and interdependence of all rights is becoming accepted by a broad spectrum of organizations and activists (UNHCHR 1993). In daily life, there is a close connection between enjoyment of first generation rights and appreciation of economic needs. The categories are interlinked, and preferring one set of rights over another is unhelpful and divisive; states and other actors can ignore one type of right at the expense of others. The main goal must be to achieve a balance between them. Different campaigners may concentrate on specific rights, but should coordinate their work so that attention is given to all types of right.

One problem with economic, social and cultural rights – like the right to health – is that when they are violated it is not always easy to identify the violator, and traditional advocacy appears less effective.
Example: avoidable maternal mortality

Who is responsible for upholding the right to avoid maternal death?

Think about the risk of maternal mortality and right to health. Who are the actors responsible for upholding a woman’s right to health and life during childbirth?

Avoidable maternal mortality is a clear violation of a woman’s right to health and life, but it is not easy to say who is responsible. There may be many different causative factors, often acting in combination (Hunt 2005):

- The family or community discourage the woman from seeking timely and appropriate help.
- The health facility cannot provide the necessary care, owing to mismanagement or corruption.
- The government cannot or will not provide sufficient funds to the health facility.
- The international community does not provide the government with adequate technical and financial assistance.

The difficulty of identifying who is responsible does not stop avoidable maternal mortality from being a human rights violation. The right to health provides a tool to identify violations of the right to health made during the pre- and postnatal periods and during labour.

This means there is more possibility of identifying precisely where the responsibility lies, so ‘as to better ensure that the appropriate changes are introduced as a matter of urgency’ (Hunt 2005).

The case of avoidable maternal mortality shows that human rights campaigns should focus not only on creating legitimate and non-corrupt legal and political systems, but also on constructing effective health systems accessible to all.

Effective health systems not only provide good health services, but also tackle the social and environmental factors that may be even more crucial in creating and maintaining health. Clean water, good housing, food, education, security from violence and freedom from unjust discrimination are also key to public health.
Equity

If the right to health is to be upheld it has to be protected for everyone and the needs of the disadvantaged members of society have to be prioritized. It is only in this way that inequity will be reduced. Below we will consider equity in relation to the right to health. We will also consider two other areas in which equity is essential if the right to health is to be realized: gender and economic level.

Equity and the right to health

The right to health is one of the areas in which human rights and ethics meet, principally because the ethical value of equity also underpins the right to health. Equity means that people’s needs should guide the distribution of opportunities for wellbeing, rather than their privileges.

In policy terms, valuing equity entails eliminating inequalities in health and its major determinants that are systematically associated with underlying social disadvantage. In human rights discourse, the principle of equity is increasingly serving as an important non-legal generic policy term aimed at ensuring fairness (WHO 2002).

Equity allows discrimination as long as there are grounds for distinguishing between people. Contrary to this, in most countries there is an unequal distribution of general benefits and unfair discrimination in access to health services, for example in the cases of street children, migrant workers, asylum seekers, homeless people and people belonging to oppressed ethnic groups – say the Roma worldwide, or Kurdish people in Turkey.

Gender equity

The right to health may be a powerful tool to highlight gender inequity. Women are often denied independent income-earning opportunities and confined to household work. This may put them at unfair risk of particular diseases. For example, women responsible for washing clothes in rivers, lakes, ponds and dirty water sources are more vulnerable to water-related diseases. To take another example, women with learning disabilities are especially vulnerable to sexual violence. By highlighting unequal health risks, a right to health approach has ‘the potential to expose and tackle gender discrimination’ (Hunt 2005).

Poverty

The UN Committee on Economic, Social and Cultural Rights defined poverty as a human condition characterized by sustained or chronic deprivation of the resources, capabilities, choices, security and power necessary for the enjoyment of an adequate standard of living and other civil, cultural, economic, political and social rights. This means poverty reduction is essential for good health, as acknowledged in the Universal Declaration of Human Rights in 1948.
A human rights approach to poverty reduction adds emphasis to its political aspects, something that other approaches, such as the needs based approach, tend to minimize. The human rights approach requires ‘the active and informed participation of the poor in the formulation, implementation and monitoring of strategies which may affect them’ (WHO 2002). In the same document it says ‘addressing poverty and ill health therefore requires accountability, transparency, democracy and good governance’ – referring precisely to those ‘first generation’ political and civil rights that are often separated from economic, social and cultural rights.

The combination of human rights and health, within the concept of the right to health, does not, according to Hunt, provide magic solutions. It does however bring precise, practical and constructive policy proposals to serious, complex health issues, such as women’s health. Arguably, by showing the links between poverty, equity and health, the right to health also raises the profile of these important underlying issues amongst health professionals themselves (Hunt 2005).

The right to health is instinctively understood in strong societies. If people understand they have a right, they will be more confident in fighting to uphold it. The right to health is significantly affected by access to sufficient water for daily needs: Box 1 gives a powerful example of upholding the right to have water at an accessible price.

**Box 1: The right to water**

In 1999, at the insistence of the World Bank, the government of Bolivia awarded a concession to a private company to manage and supply water in Cochabamba. The local press reported that foreign investors acquired the city water system, worth millions of dollars, for less than US$ 20 000 of up-front capital, in a sale in which they were the only bidder.

The government had promised no more than a 10% rise in prices as a result of the privatization, but Aguas del Tunari, a subsidiary of the Bechtel Corporation, implemented massive hikes up to three times higher. Families earning a minimum wage of US$ 60 a month suddenly faced water bills of US$ 20 a month.

Cochabamba residents shut down their city for four days in 2000, with a general strike led by a new alliance of labour community leaders and academics. The government was forced to agree to a price cut.

When nothing happened, the residents took to the streets again. In response, the government declared martial law, arrested protest leaders and shut down radio stations. Protesters were shot at and even killed. But finally the government agreed to every demand. Bechtel’s contract was cancelled and replaced with a community-controlled water system that is providing water more equitably and universally than before. Bechtel responded with an unsuccessful US$ 25 million lawsuit for lost profits.

Five years later a new privatization scheme was attempted in the city of El Alto, again with the full backing of the World Bank. Civil society fought back and once again won the battle through mass mobilizations (Public Citizen 2003).
Conclusion

Violation of second generation rights affects more people and even causes more deaths than the violation of first generation rights. Although the two separate sets of human rights have close connection in daily life, defending and campaigning on second generation rights is hard to manage and more complicated. It is also more expensive for States to achieve those rights. The right to health is one of the complex components in second generation rights and can be affected by different factors. It is not uncommon to meet violations of the right to health in daily life even in developed countries. It needs more awareness and attention from the public.

References


Lesson 2.3: A rights-based approach to health policy

Authors: Leo van Bergen and Marianne Begemann; updated by Levent Kutlu

The rights-based approach to health

A rights-based approach to health includes the following processes (WHO 2002):

- using human rights as a framework for health development;
- assessing and addressing the human rights implications of any health policy, programme or legislation;
- making human rights an integral dimension of the design, implementation, monitoring and evaluation of health-related policies and programmes in all spheres, including political, economic and social ones.

This approach emphasises three important areas of health policy: equity, participation and accountability.

Equity: A focus on rights, as we saw in Lesson 2.2, steers health policy-makers to focus on the most vulnerable groups; ensures that health systems are accessible to all; and that there is equality and freedom from discrimination, intentional or unintentional, in the way health programmes are designed and implemented.

Participation: The rights-based approach places great value on ensuring free, meaningful and effective participation by beneficiaries of policies and programmes in the decision-making processes that affects them. It focuses on maintaining human dignity.

Accountability: The rights-based approach helps governments articulate their obligations to respect the right to health. It gives governments and campaigners linkages to international human rights norms and standards that can highlight how human rights relate to a health policy, programme or legislation. It promotes government accountability. The standards contained in human rights law can help people make legitimate claims on health care and other health-sustaining goods and services. International organizations like WHO, the World Bank and the International Monetary Fund can also be held accountable on human rights grounds.

Learning objectives

By the end of this lesson you will be able to:

- describe the benefits of using a rights-based approach to health.
**Grounds for restricting human rights**

Some human rights should never be restricted under any circumstance, including the right to freedom from torture and slavery, and the right to freedom of thought, conscience and religion.

Nevertheless there are some clauses in international human rights instruments that recognize the need to limit some rights at certain times. Protecting public health may be one reason, for instance limitation of freedom of movement when introducing quarantine or isolation for serious communicable diseases like Ebola fever, plague and multi-drug-resistant tuberculosis. Denying human rights should only be a last resort, and only considered and justified if the provisions of the Siracusa principles are met (UNHCR 2010).

- the restriction is created by and carried out in accordance with the law;
- the restriction has a legitimate objective of general public interest;
- the restriction is strictly necessary to achieve the objective;
- no less intrusive and restrictive means are available to reach the same objective;
- the restriction is not drafted or imposed arbitrarily (i.e. in an unreasonable or otherwise discriminatory manner).

Even in circumstances where human rights limitations on the grounds of protecting public health are permitted and all five criteria are met, they should still be of limited duration and subject to review (WHO 2002).

Even in emergencies assistance can be based on the right to health. The Sphere Project, a collaboration of international NGOs and the Red Cross Movement to improve the quality of disaster response, outlines best practices in food aid, nutrition, health, water and sanitation and emergency shelter provision. Its humanitarian charter and minimum standards in disaster response were initiated after the Rwanda/Democratic Republic of Congo humanitarian emergency in 1994 because of concerns about the quality of humanitarian aid. The standards are underpinned by the rights-based approach to health.

*Take a moment to read the humanitarian charter on which the standards are based, Available at: www.sphereproject.org/*

Why is this different from just responding to the needs of affected people? As mentioned above, assistance is given as a right, not as charity, so there is a duty to provide it to these minimum standards. A rights-based approach can also be used to highlight when minimum standards are not being met, as in Box 1.
Box 1: Meeting minimum standards (IREN 2009)

Sphere standards at camps for internally displaced persons (IDP) in northern Sri Lanka were undermined by overcrowding, said aid workers.

“We are missing Sphere standards by a long way, particularly in the WASH [water, sanitation and hygiene] cluster,” said David White, Oxfam’s country director in Colombo. He cited instances of people going without water for washing for up to three days.

“We’re not even close,” said another international aid worker. “With the monsoon rains, it’s going to get worse.”

Close to 300,000 people now languish in 30 government camps in Vavuniya, Mannar, Jaffna and Trincomalee districts, after fleeing fighting between government forces and the now defeated Liberation Tigers of Tamil Eelam (LTTE), who had been fighting for an independent Tamil homeland for more than two decades.

“The issue has been recognized by the government already in late May during the UN Secretary-General’s visit, as reflected in the joint statement made by President Rajapakse and [Ban Ki-moon], and work is ongoing to resettle people as well as to permit vulnerable people to leave,” Neil Buhne, the UN resident representative in Colombo, said.

“Concerns about security are recognized by everyone, but from all my discussions with everyone involved with the camps – from government to UN to NGOs, everyone also recognizes that the sooner people can get back to their homes or with host families, the better.”

“Schools [and] health clinics had been or were being established; access to water and sanitation had improved and most people now had the calorie intake they needed,” he said.

“UNHCR [the UN Refugee Agency] and its shelter partners are supporting the government’s decongestion efforts to ensure that the conditions in the emergency shelter sites reach international standards,” said Elizabeth Tan, officer-in-charge for UNHCR Sri Lanka, which is working with the government to prepare the site as best as possible to withstand the upcoming monsoon season.

Read more about this case at the Sphere Project website, www.sphereproject.org
Conclusion

You have now completed **Course 2** on medicine, health and human rights. Health professionals in general have low awareness of the challenges of upholding human rights and the professional responsibilities involved. This is especially true of the second-generation human rights – economic, cultural and social rights – including the right to the highest attainable standard of health. These lessons may inspire and inform you how to tackle this vital issue.

References


Glossary Course 2

**Armed conflict:**
Similar to violent conflict, but denoting conflicts where parties on both sides resort to the use of physical violence and weapons.

**Civil society:**
The United Nations defines civil society as “associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit-making activity (the private sector) or governing (the public sector)”. Civil society might therefore include labour unions, faith-based groups, business and professional associations, academic and research institutions, human rights networks, consumer rights coalitions, social movements, social and sports clubs, philanthropic foundations, and other forms of ‘associational life’.

**Codes of conduct:**
The moral principles that are implicit or explicit in (inter-) national codes and which reflect good clinical practice.

**Conflict:**
Perception of incompatible goals in a goal-seeking system. Conflict is not necessarily violent. In fact, parties who have incompatible goals may deal with them in productive and non-violent ways.

**Convention on the Elimination of All Forms of Discrimination:**
The Convention on the Elimination of All Forms of Discrimination Against Women was adopted in 1979 by the UN General Assembly and entered into force in 1981. Established an international bill of rights for women, and an agenda for action to promote enjoyment of those rights.

**Development:**
Alan Thomas says that the term development is commonly used in three ways: as a vision of how we would like the world to be; to describe a process of historical change; and to mean the actual interventions of governments, international agencies and others make to bring development about.

**Ethnicity:**
The Office of National Statistics in the UK describes ethnicity as “a multi-faceted concept covering many different aspects of identity, including racial group, skin colour, country of birth and parental country of birth, language spoken at home, religion and nationality”. However a person’s ethnicity can be often defined (by themselves and others) differently, and (subjective and objective) definitions change over time. It is a complex concept that is difficult to measure.

**Gender:**
Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (World Health Organisation).
General Comment:
The committees of independent experts responsible for monitoring the implementation of each of the international human rights treaties publish their interpretation of the content of human rights provisions in the form General Comments on thematic issues.

Geneva Conventions:
The Geneva Conventions were established by governments under the auspices of the International Committee of the Red Cross to regulate the conduct of war. The first Convention (1864) focused on the rights of the armed sick and wounded as well as medical personnel. The second (1906) included those fighting at sea. The third (1929) set up rules for the treatment of prisoners of war and the fourth (1949) protected civilian populations. Two additional protocols were formulated in 1977 to protect victims of international and non-international conflicts.

Health:
The World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

Humanitarian aid:
Aid which is concerned with or seeking to promote human welfare.

Impartial:
In the context of humanitarian aid, this refers to assistance that is ‘guided solely’ by the needs of individuals.

Independence:
In the context of humanitarian aid this has been defined by Joanna Macrae as the ‘endeavour not to act as instruments of government foreign policy’.

Inequality:
Inequalities represent disparities in income, health, education, ownership of land, access to power and so on. Some inequalities are unavoidable: not all of us have the genetic make-up that will help us run the 100 metres as fast as Olympic sprinters. But many inequalities, such as those listed above, can be avoided. These avoidable inequalities are sometimes called inequities.

International Committee of the Red Cross:
An organisation set up in 1863 by five Swiss citizens from Geneva: Henry Dunant was the leading figure. It strives to regulate the conduct of war firstly, by taking care of the sick and wounded and secondly, by establishing rules for the conduct of violent conflict.

International Convention on the Elimination of All Forms of Racial Discrimination (ICERD):
The ICERD was adopted by the UN General Assembly in 1965 and entered into force in 1969. The Committee on the Elimination of Racial Discrimination is the body of independent experts that monitors implementation of the Convention. The Convention ‘resolved to adopt all necessary measures for speedily eliminating racial discrimination in all its forms and manifestations, and to prevent and combat racist doctrines and practices in order to promote understanding between races and to build an international community free from all forms of racial segregation and racial discrimination’.
**International Covenant on Civil and Political Rights (ICCPR):**
The International Covenant on Civil and Political Rights (ICCPR) was adopted by the UN General Assembly in 1966 and entered into force in 1976. It describes core political and civil rights, such as the right to life, the right to liberty and and security of person, and the right to freedom from torture and cruel, inhuman or degrading treatment or punishment. The implementation of the Covenant is monitored by the Human Rights Committee, a body of independent experts.

**International Human Rights Law:**
International Human Rights Law lays down obligations which states are bound to respect. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (plus their optional protocols) form the so-called International Bill of Human Rights. These core instruments are supplemented by a battery of other treaties adopted to guarantee human rights (such as the Covenant on the Elimination of all forms of Discrimination Against Women).

**International Humanitarian Law:**
See the Geneva Conventions

**Migrant:**
A migrant is ‘any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country’ (UNESCO).

**Parallel or shadow reports:**
Parallel to a state’s report to a UN treaty monitoring committee, NGOs and other interested parties can also submit their report to the committee, in the form of a parallel or shadow report. These reports help to provide another perspective on the state’s implementation of treaty obligations.

**Poverty:**
Poverty has many dimensions. It can include lack of income and material goods, as well as lack of the things that we all have reason to value, such as the ability to lead a healthy life, be educated, to have political or spiritual liberty. The World Bank has set an international poverty line at about US$1 per day. The 1.2 billion people who live below this line are said to be in a state of “absolute poverty”, in other words “a condition of life so characterised by malnutrition, illiteracy and disease as to be beneath any reasonable definition of human decency” (World Bank). But poverty is also a relative concept: all societies – at different levels of economic and social development – have different standards for what constitutes living in poverty.

**Protection:**
In the context of humanitarian aid this refers to the protection efforts of humanitarian agencies in conflict areas (but not including physical armed protection).

For humanitarian agencies, protection refers to ‘all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. human rights law, international humanitarian law and refugee law)’ (Inter-agency Standing Committee 1999).
Right to health:
The right to health or – more precisely – the right to the highest attainable standard of physical and mental health is established in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Measures states should take to fulfill the right are laid down in Article 12 and have been further elaborated in General Comments by the treaty’s monitoring committee. The right to health is subject to the principle of progressive realisation outlined in the Covenant.

Second world war:
Armed conflict beginning in September 1939 with the invasion of Poland by Nazi Germany (although Japan had invaded China in 1937). It became a ‘world war’ in a truer sense in 1941 after the bombardment of Pearl Harbour by the Japanese and the consequent declaration of war by the US on Japan and Germany. Although in terms of the percentage of soldiers killed it was a less bloody war than the first world war, the total sum of the dead – approximately 40 million – was devastating. For the first time in history in a major war the civilian dead outnumbered those within the fighting forces. The war is also infamous for Nazi Germany’s medical experiments on human beings, and its sterilisation and so-called ‘euthanasia’ programmes.

Sex:
Sex refers to the biological and physiological characteristics that define men and women. (World Health Organisation).

Special Rapporteur:
An independent UN expert employed to examine questions relevant to a particular UN Convention. There is a Special Rapporteur on the right to health.

Violence:
Unnecessary insult of basic human needs (J. Galtung).

Violent conflict:
The use of physical and psychological force or power to ‘solve’ a conflict.

War:
Extreme form of violence. Used as a means to solve conflicts between nation states, or between groups within a nation state (civil war).

World Bank:
From the World Bank website: “The World Bank is a vital source of financial and technical assistance to developing countries around the world. [...] We are not a bank in the common sense; we are made up of two unique development institutions owned by 187 member countries: the International Bank for Reconstruction and Development (IBRD) and the International Development Association (IDA). [...] The IBRD aims to reduce poverty in middle-income and creditworthy poorer countries, while IDA focuses on the world’s poorest countries. [...] Together, we provide low-interest loans, interest-free credit and grants to developing countries for a wide array of purposes that include investments in education, health, public administration, infrastructure, financial and private sector development, agriculture and environmental and natural resource management.”