

Human rights and health: challenges for training nurses in South Africa

L London, MD

Health and Human Rights Programme, School of Public Health and Family Medicine, University of Cape Town

L Baldwin-Ragaven, MD

Henry R. Luce Professor of Health and Human Rights, Trinity College, Hartford, Connecticut, USA

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The need for health professionals to address their human rights obligations has emerged in the last decade both internationally as well as nationally following the findings of South Africa's Truth and Reconciliation Commission. Support for human rights norms has become a priority for institutions as well as practitioners within the health sector. Training plays a crucial role in shaping health professional practice. In addition to creating a clear understanding of the linkages between human rights and health, educators can role-model how health professionals should act to support human rights. This article explores human rights derived from the South African Constitution in relation to the obligation on health professionals to respect, protect, promote and fulfill human rights. The implications of this commitment to human rights training of nurses are discussed, drawing on the authors' nine years of experience in running courses for South African health professional educators. Themes include: developing core competencies for human rights in health professional curricula, identifying appropriate instructional methodologies and assessment tools suited to the content and context of human rights, and engaging the institutional environment for human rights teaching, at both the level of institutional culture and strategic implementation. At a time when there are increasing demands on the nursing profession to assume greater responsibility and develop versatility in its scope of practice, key challenges are posed for teaching and realising human rights.

Introduction: The Institutional Context

Health professionals have an ethical obligation to place the well-being of their patients at the forefront of their professional commitments. ... Responsibility for upholding these principles is left, by default, to professional organisations and statutory regulatory bodies.... This can be problematic if these institutions are themselves under the influence of the state or if they have colluded with or been complicit in violating human rights. (Truth and Reconciliation Commission 1998: 109)

The examination by the South African

Truth and Reconciliation Commission (TRC) of the health sector under apartheid has challenged both institutions and individuals to integrate universal human rights norms into the practice of health professionals in this country. A decade ago, countless testimonies to the TRC told of abuse at the hands of the security forces, with the active and passive collusion of doctors, nurses, clerks and other health workers. In one such statement, a former detainee from the Western Cape described how he overheard a district surgeon advising the security police to place porridge in his nostrils so as to cover up his torture should he die as a result of his injuries (Truth and Reconciliation Commission 1996). In another submission, a nurse

Correspondence address:

Prof Leslie London
Health and Human Rights Programme,
School of Public Health and Family Medicine,
University of Cape Town,
Health Sciences Faculty,
Anzio Rd, Observatory, 7925,
South Africa

Tel : (021) 406 6524

Fax : (021) 406 6163

E-mail: leslie.london@uct.ac.za

recounted how the police routinely arrested patients admitted to an Eastern Cape hospital for gunshot injuries (Ncanywa 1997). Nurses, doctors and administrators in the facility actively assisted this process by maintaining a separate slate of wounded patients:

Most of the cases that we attended were for gunshot wounds and tortured people and detainees with severe depression. ... Some were taken before we could treat them. The Security Police would take them from the casualty department before we could even treat them. As nurses, we were given an instruction that we mustn't obstruct the work of the security force. [...] The only thing we need to do is to just treat the patient. Even if we see people being tortured, we must just keep quiet. This was the instruction from the hospital management ... [so I thought] I must try to refrain from politics, otherwise my future would be in jeopardy. (TRC 1998: 137).

Rooted in the need to both comprehend and redress such an iniquitous past, the TRC held hearings into the health sector to probe some of the following questions. How was it that the health professions failed so abjectly to establish their independence from state influence during apartheid? How could a health care environment exist where human rights abuses were systemic and routine? Amongst responses to these questions, investigator's findings pointed to the acquiescence of health professional training institutions to an unjust, racist political and economic system. For example, although codes of conduct and ethical pledges were meant to govern the practice of health professionals, these conventions seemed easy to circumvent:

Nurses take the 'Nurses' Pledge of Service' (a local adaptation of the Florence Nightingale Pledge) when they graduate. However, the submission of the Democratic Nurses Organisation of South Africa (DENOSA) noted that: "it was confirmed during interviews that an individual could, theoretically, decide not to say the pledge. Also, those who are absent from the ceremony do not take the pledge." The same could obviously apply to graduating doctors. No system ensured or enforced the making of a commitment to ethical practice. (TRC 1998: 110)

Moreover, the nature of training did not

equip future health professionals with either the values required to undertake critical analysis of their context, nor with the practical skills to advocate for vulnerable patients and communities. As the DENOSA submission to the TRC noted:

Ethics content has always been included in nursing curricula. However, it seems that educators largely did not succeed in teaching this subject so that it had everyday application. While provision is made for the teaching of ethics in the curriculum, nurses do not seem to identify it as significant to their professional role. In one particular study, it was found that 87% of the research sample indicated that they did not regard the subject Ethos as necessary to their work as registered nurses. It also appeared from interviews that, in teaching the subject, more attention was given to the history of nursing and etiquette than to ethics and professional conduct, and that students perceived the subject as a list of 'do's and don'ts'. (TRC 1998: 110)

The conclusions of the TRC as well as other research conducted during this period were that because ethics teaching was generally both makeshift and inconsistent, students' and practitioners' performance in treating people with dignity was not properly assessed, and human rights were not integrated into curricula, training institutions played a key role in rendering the health sector complicit in widespread human rights abuses under apartheid (see *inter alia*: TRC 1998; de Gruchy, London, Baldwin-Ragaven, Lewin and the Health and Human Rights Project Support Group 1998: 975-979; du Toit 1998: 13-18; Baldwin-Ragaven, de Gruchy and London 1999: 172-181; Baldwin-Ragaven, London and de Gruchy 2000: 227-241; Ernest 2000).

For this reason, recent attempts to grapple with integrating human rights into curricula for health professionals (London et al, 2007) represent not only an historic break with the past, but, quite simply, a professional necessity if the health professions are to keep pace with national (du Toit and Botes 1996: 75; Baldwin-Ragaven, et al 1999: 210-214) and international (Johannes Weir Foundation 1996: 9-24; British Medical Association 2001: 478-502; Program on International Health and Human Rights at the Harvard

School of Public Health and the Initiative for Health and Human Rights at the University of New South Wales 2006) developments in health sciences education. Increasingly, international bodies are examining the professional responsibilities of health workers in relation to human rights (Fox 1999: 417-423; Hannibal and Lawrence 1999: 404-413; BMA 2001: xix-xxxiii; Medical Professionalism Project 2002: 520-522; Rubenstein et al, 2002: 1-99; International Council of Nurses 2006: 3, 7, 11). Therefore, given South Africa's history of health sector complicity in and resistance to gross human rights violations as well as the current contingencies of HIV/AIDS, out-migration of health care workers, budget shortages, inter-personal violence and flagging morale, this article provides a critical overview of the challenges (and solutions) facing nursing practitioners and educators as human rights training becomes even more imperative in the new millennium.

Health Professionals and Human Rights: Making the Connection

Why should upholding human rights be the role of health professionals at all? Why shouldn't health professions focus only on the business of delivering health care to patients as best as possible under existing circumstances? Sirkin, Iacopino, Grodin and Danieli (1999: 358) argue cogently that, in fact, amongst all professionals grappling with their role in this regard, health professionals carry unique obligations. As professionals in the arena of healing, we undertake specific ethical commitments to maximise the well-being of those in our care. This means that there are special responsibilities, even if they have not traditionally been made explicit, either in training or in clinical practice, to be advocates for the protection and promotion of human rights.

Several writers (Sirkin et al 1999: 358-359; Mann, Gostin, Gruskin, Brennan, Lazzarini, and Fineberg 1999: 11-18; BMA 2001: 311-346 and 503-534) have suggested different ways in which the concept of *health* and the norms of *human rights* are inter-linked. These are:

- Human rights violations can have serious health consequences. As we have

witnessed in South Africa, human rights abuses of vulnerable groups, such as detainees, children and rural communities, resulted in horrendous impacts on physical, mental and emotional health (Baldwin-Ragaven et al 1999: 17-130; American Association for the Advancement of Sciences and Physicians for Human Rights 1998: 17-60; Skinner 1998: 207-211).

- Protecting human rights can be the most effective way to ensure positive conditions for health. For example, supporting women's rights to bodily integrity and freedom from violence in intimate relationships not only prevents physical harm, but also promotes psychological well-being, ultimately enhancing health (Guedes et al, 2002).
- The delivery of health care services is linked to clients' ability to realise their human rights. While attending health services ought to enhance people's dignity and autonomy, depending on the accessibility and quality of such services, human rights may actually be compromised. For example, seeking care at a clinic where abuse is common (Jewkes, Abrahams and Mvo 1998: 1781-1795; Carte Blanche 2002) or a trying to use a service that does not address people in their own language may lead to further disempowerment, rendering patients more vulnerable to human rights violations.
- The health care setting provides a unique opportunity for professionals to document and, if necessary, provide testimony for those whose rights have been violated. Health care professionals are often on the front lines of receiving victims of torture as well as bearing witness to the results of other kinds of trauma (such as war, genocide, famine or rape) and can therefore be effective advocates for patients' rights. (United Nations Publication 1999; Rayner 1987:

67-79; McQuoid-Mason and Dada 1999:109-120.

In summary, such linkages between health and human rights point toward many unexplored possibilities of health professional involvement in maximising human well being. Clearly, as the World Health Organization's definition of health states, when health is more than just the absence of disease and includes the notion of complete well-being, then promoting health and protecting human rights are complementary approaches. Put simply, if health professionals are in the business of promoting health, then they are also in the business of upholding human rights (Evans 1995: 27-28).

For these reasons, many commentators, both local and international (Leary 1994: 24-56; Toebes 1999: 15-19; Pillay 2000a: 1; BMA 2001: 321-323 suggest that *health* itself, or at least the underlying conditions pre-requisite for health, may be viewed as a human right, being one of a number of socio-economic rights that is indivisible from other rights (Iacopino 1995: 376-391; Chapman and Russell 2002: 185-215; Gruskin and Tarantola 2004: 311 – 335; Liebenberg and Pillay 2000: 9-105 and 219-254). This principle raises a number of further questions. Does one actually have a right to 'be healthy'? What services and from whom can one claim to enhance health, particularly if there are scarce resources? How are conflicts between individuals and groups resolved? The South African Constitution is instructive in how it deals with such linkages between health and human rights.

What does the South African Constitution say about Human Rights and Health?

Ratified by Parliament in 1996, the Bill of Rights, Chapter 2 of the South African Constitution (Constitutional Assembly 1996), goes beyond traditional human rights concerns by institutionalising entitlements to housing, health, education, food, social security and a clean and healthy environment. South Africa's Bill of Rights is a unique attempt to break down hierarchical divisions in the implementation of human rights. Given apartheid's history of systematic socio-economic discrimination and

dispossession of black people, it is not surprising that our Bill of Rights integrates commitments to civil and political rights (so-called 'first generation' rights) with 'second and third generation rights', socio-economic and solidarity rights respectively, into a holistic approach to attaining human potential. While Article 27 guarantees everyone the right of access to health care services, thereby framing health rights as socio-economic entitlements, other articles address additional aspects of what it takes to be healthy. Together these rights form a standard around which state legislation, government programmes and public policies should be developed and implemented over time. These three categories of rights, and their inter-relationship – rights to receive health care services; rights which address the underlying conditions needed for health and that, through their fulfillment, enhance health; and, lastly, foundational rights that acknowledge our common humanity and principles of equality - are explained below (Table 1).

1. The right to receive health care services

Article 27 explicitly provides for peoples' right 'to have access to health care services, including reproductive health care'. While this is the most obvious health-related right, it, like a number of other socio-economic rights, is couched in the language of *progressive realisation*. Due to an acknowledged scarcity of resources and the fact that it takes time to build an infra-structure, a person cannot claim an absolute and immediate right to receive health care; rather, the State must, within its available resources, increasingly provide access and continue trying to improve that access.

Moreover, this human right imposes on the State a *correlate duty* to engage health professionals as partners, whether working in public or private arenas, to facilitate access to health care services. The State has an obligation to ensure that health professionals, for example, cannot act as barriers to people seeking care. The Choice on Termination of Pregnancy Act (ToP) (1997) binds health professionals to provide information on the availability of ToP to a client even when they personally object to the procedure. Here the State regulates health professional behaviour to avoid interfering with a woman's right to access

Table 1. Categories of Health Rights in the South African Constitution

| Category | Human Rights Provision | Section |
|---|---|-----------------|
| Health care services | To access health care services, including reproductive health care | Article 27.1(a) |
| | To emergency medical care | Article 27.3 |
| Underlying conditions needed for health | To access information | Article 32 |
| | To an environment that not harmful to health or well-being | Article 24 |
| | To freedom and security of person, including freedom from all forms of violence from either public or private sources | Article 12 |
| | To freedom of religion, belief and opinion | Article 15 |
| | Children have the right to basic nutrition, shelter, basic health care services and social services | Article 28 |
| | Prisoners have the right to conditions of detention consistent with human dignity, including the provision of nutrition and medical treatment | Article 35 |
| | To be free from medical experimentation without informed consent | Article 12.2(c) |
| | To have access to adequate housing | Article 26 |
| | To a basic education, including adult basic education; and progressive realization of further education | Article 29 |
| | To have access to sufficient food and water | Article 27.1(b) |
| | To language and culture | Article 30 |
| | To have access to social security | Article 27.1(c) |
| Foundational rights affecting health | To dignity | Article 10 |
| | To equality (non-discrimination) | Article 9 |
| | To life | Article 11 |
| | To lawful, reasonable and procedurally fair administrative actions | Article 33 |

reproductive health care.

Yet, what are the parameters for accessing health care services? The South African Constitution does not detail what the right of ‘access to health care services’ actually implies. However, international law, and, in particular the United Nations General Comment on the right to the highest attainable standard of health of the International Convention on Economic, Social and Cultural Rights provides some guidance (Committee on Economic, Social and Cultural Rights 2000). In terms of the General Comment, the right to health must be understood as the right to the enjoyment of a range

of facilities, goods, services and conditions necessary for the realisation of the *highest attainable standard of health* (Pillay 2000a: 1-2). The General Comment further itemises certain *core obligations* for the State in realising the right to health; the State must provide:

- functioning public health and health care facilities, with programmes available in sufficient **quantity**
- health facilities and services that are **accessible** (physically, economically and linguistically) without discrimination

- services that are respectful of medical ethics and culture
- services that are scientifically **appropriate** and of good **quality**
- services that recognise the special needs of vulnerable groups
- (adapted from Committee on Economic, Social and Cultural Rights 2000)

The enunciation of these core obligations have gone a long way in setting benchmarks to measure progress on attaining health rights as well as

holding governments accountable (see for example, Chapman and Russell 2002: 203-204).

In addition, the Constitution of South Africa has imposed duties on the State to respect, protect, promote and fulfill all human rights in the Bill of Rights. In order to *respect*, the State and its surrogates, including health professionals working for the State, must refrain from doing anything that interferes directly, or indirectly, with the enjoyment of the right to health. Thus, shouting abuse at an adolescent seeking contraception who is then discouraged from seeking further care interferes with her right to access health care, and is therefore a failing on the part of the professional to meet constitutional obligations.

In *protecting* the human right to health, the State must take steps to ensure that no *third party* interferes with people's access to health care. Thus, it may be argued that patients queuing from the early hours of the morning at a clinic, thus exposing them to gang-related criminal violence, constitutes a failure on the part of the State, through its surrogates—not only the police but also the health professionals at the clinic—to prevent a third party—the local gangs—from interfering with the person's right of access to health care. In other examples, employers who refuse workers time off, or farmers who dictate when and where farm workers can attend health services also present situations where the health worker may have to take active steps to *protect* the person's right to health care.

Promoting human rights is a uniquely South African state obligation. It is generally acknowledged that in order to claim their rights, people must first know about them. Education about entitlements (for example, to medication, to a second opinion, or to a termination of pregnancy) is key to promoting the human right to health. Health professionals, in partnership with the State have implemented the principles of Batho Pele and the Patients' Rights Charter, as well as extended access to information to patients about their health records. Such access to information can enable patients to make more informed decisions about their health as well as educate communities about the environmental impact of potentially hazardous workplace processes. Lastly, the *fulfillment* of health rights

imposes the need for proactive intervention on the State, requiring for example, the full extent of appropriate budgetary, judicial and administrative policies towards building clinics, equipping and staffing them appropriately, providing transportation to and between facilities, addressing the underlying determinants of health such as sanitation, clean water, food, housing and education as well as numerous other positive measures that promote health. To adequately *fulfill* the right to health therefore raises the problematic issue of resource constraints, as alluded to earlier with the concept of progressive realisation, and leads to debates about rationing.

Rationing is a tremendous challenge, since unlimited access to services for one group of patients may occur at the expense of access for others. The South African Constitution does not invalidate setting priorities but it does force the State to be transparent as to how such rationing occurs and what assumptions underlie rationing decisions. Most importantly from a legal perspective is the evaluation of the *reasonableness* of the rationing decision. For example, in the case of *Soobramoney v. Minister of Health: Province of KwaZulu-Natal* (Scott and Alston 2000: 233-256; Ngwena 2000: 9-24) the State's argument that it had to ration the availability of renal dialysis, a scarce resource, was not disputed, nor were the ethical assumptions of the protocol adopted by the clinicians working in the dialysis unit. The Constitutional Court judgment, however, did question the framework within which resource decisions were being made. Specifically, the provincial government assumed that the total health budget was fixed, yet it presented no evidence that this was the case, nor that, if it were the case, could such a situation be justified (Ngwena 2000: 9-24). Moreover, the Court also cast doubt on the health services' assumption that the budget at the particular hospital at which Mr Soobramoney was seeking dialysis could not be increased.

In such conflicts of allocating scarce resources, the responsibility of health professionals is to attempt to maximise access to health care, even when resource constraints expose competing rights and invoke difficult ethical dilemmas around distributive justice. At the very least, health care workers need

to be involved in setting fair criteria, which may result in limiting access to services for some, but which ultimately aim to extend health care to those most in need. This is part of the obligation in assisting the State to fulfill its duties to provide health care, even if it does so progressively over time.

As regards emergency care, sub-section 3 of Article 27 stipulates that no one may be refused emergency medical treatment. Like Article 28 dealing with children, this provision is not subject to any restriction relating to available resources or progressive realisation. The implications for health professionals in both the private and public sectors are very clear. Where a patient presents in an emergency, they must receive care, even if they do not come from the designated drainage region, or do not have money or insurance to pay for private services. Only after being stabilised may they be transferred.

2. Underlying conditions needed for health

There are many other human rights within the South African Bill of Rights that are necessary for health.

These include:

2.1 The right to an environment that is not harmful to health or well-being (Article 24)

The health care industry generates potentially hazardous biological waste; and, unless health professionals and institutions manage such waste with care, the population is exposed to potential health risks (Jameton and Pierce 2002: 285-296) and the health system has thus failed to protect the right to a safe environment. Tobacco control regulations are an example by which the public health authorities promote and fulfill people's rights to a safe environment, illustrating the positive obligations health professionals have in protecting rights.

2.2 The right to freedom and security of person, including freedom from all forms of violence from either public or private sources (Article 12)

Health services should neither be a source of violence towards patients, nor permit violence to interfere with patient care. In addition, health workers themselves have human rights to be free from violence, from users or others. This article also impacts on health care

workers' management of child abuse and intimate partner violence, as these are now framed as human rights violations.

2.3 Freedom of religion, belief and opinion (Article 15)

Because everyone is guaranteed freedom of religion and belief, health care providers must respect differing beliefs in their practice. This may result in cross-cultural challenges, as with some circumcision practices that may conflict with modern notions of hygiene and pain control or when traditional beliefs manifest in Western terms as mental illness (Swartz 1998: 162-166). Of course, this same freedom of belief also applies to health workers. Although some would argue that the freedom of conscience provisions in the ToP legislation are inadequate, these nonetheless represent an attempt to balance competing rights - those of the patient to access the full range of reproductive health care with those of the health worker to desist from performing a ToP when it conflicts with their beliefs (Mhlanga, 2003; de Roubaix.

2.4 Children have the right to basic nutrition, shelter, basic health care services and social services (Article 28)

Importantly, this right is *not* curtailed by any qualification relating to available resources or progressive realisation. This was the basis for the legal decision in *Grootboom v. Oostenberg Municipality* 2000 (3) BCLR 277 (Pillay 2000b; 2000c) to prevent the forced removal of residents from an informal settlement, without making adequate provision for the shelter of the residents' children. For those working with children, the Bill of Rights recognises their vulnerability and provides for far more stringent obligations towards meeting their needs. It is not surprising therefore that the first democratic public policy announced by President Mandela in 1994 was the provision of free primary health care for children and pregnant women. More complex now are the ethical and legal challenges facing health professionals dealing with HIV positive children, consent decisions and rationing decisions.

2.5 Other rights relating to health in the Constitution include:

a prohibition on forcible medical experimentation without informed consent (Article 12.2(c)); prisoners' rights to conditions of detention that are consistent with human dignity, including

the provision, at state expense, of nutrition and medical treatment (Article 35); and, rights to social claims for the underlying determinants of health - such as housing, education, water and social security (Articles 26, 27.1(b) and (c) and 29). These latter rights, save for basic education, are all subject to the limitation of progressive realisation. Health professionals would be expected, as far as their professional scope of practice extends, to ensure that such rights are met.

3. Foundational human rights that impact health

These generic rights have direct implications for health and health care practice.

3.1 The right to life (Article 11)

This right is at the core of health professional practice. It plays a key role in the on-going debates over ToP and is integral to proposed legislation dealing with end-of-life decision making, the so-called euthanasia legislation (South African Law Reform Commission, 1998, Euthanasia and the artificial preservation of life - Draft Bill, Project 86). Internationally, the human right to life also provides the rationale for prohibiting health worker participation in capital punishment (the death penalty) (Amnesty International 2000: 48; 66).

3.2 The right to dignity (Article 10)

is cited as another foundational principle of the South African Constitution. Health care workers have clear obligations to respect the dignity of service users, irrespective of resource constraints or conditions under which health care takes place. The notion of respecting human dignity is at the heart of ethical codes for all health professionals (Amnesty International 2000: 1-40).

3.3 Non-discrimination (Article 9)

is a central thread to the Constitution and stems from the human right to equality as a cornerstone of the Bill of Rights, together with justice, fairness and the right to dignity. This means that health professionals may not *unfairly* discriminate against users of services on the basis of gender, race, age, disability, sexual orientation and a range of other listed factors. Thus, administering an injectable contraceptive to an adolescent or cognitively impaired woman without adequately ensuring her capacity for decision making as would be expected

for an adult non-disabled woman disrespects her autonomy and would constitute discriminatory practice. Similarly, providing different and lesser care to an HIV positive patient, purely on the basis of HIV status, and without reference to clinical condition, breaches the patient's rights to non-discrimination. It is important to note that there is a distinction between *unfair* discrimination, as opposed to *fair* discrimination, a positive right recognised in the Constitution as essential for redress of past injustice. In the health care setting, positive discrimination is common in the public health context in that we invest more resources toward providing services for those with the greatest need, members of vulnerable groups such as women, children, the disabled and those with HIV.

At times, unfair discrimination may be hidden or more difficult to assess. For example, language barriers can lead to discrimination in accessing health care. In 1998, the Western Cape Health Department failed to assume the costs of running interpreter services when donor funding for a non-governmental organization pilot interpreter project ended. Paediatricians working at a university teaching hospital lodged a complaint with the provincial Human Rights Commission, arguing that the absence of interpreter services at hospitals was a material barrier to accessing health care (Ravenscroft 1999). This prompted a national investigation to explore language barriers as a violation of human rights, and to make explicit the role of government policy and civil society initiatives to combat discrimination and restore access to health care as a right (Veriava 1999).

3.4 Another foundational tenet relates to accessing information (Article 32).

The Promotion of Access to Information Act (Government Gazette 2000) makes a person's right to information about themselves held by the State almost unqualified, while a person's right to information about themselves held by a private body is constrained only in so far as the information must be shown to be needed in order for the person to exercise or protect another right (Masuku 2000: 5-6). The implications of this legislation on health care are substantial. Patients are entitled to access their medical records to gain information that they might need in order to exercise

Table 2. The Patients' Charter: Rights and Responsibilities

| Patients' Rights | Patients' Responsibilities |
|---|---|
| <p>These are entitlements to:</p> <ul style="list-style-type: none"> • A healthy and safe environment • Participation in decision-making • Access to health care • Knowledge of one's health insurance / medical aid scheme • Choice of health services • Treatment by a named provider • Confidentiality and privacy • Informed consent • Refusal of treatment • Second opinion • Continuity of care • Right to complain about the health services | <p>Everyone has the responsibility to:</p> <ul style="list-style-type: none"> • Take care of one's own health • Care for and protect the environment • Respect the rights of other patients and health care providers • Utilise the health care system 'properly and not abuse it' • Know your local health service and what is offered • Provide relevant and accurate information for diagnosis, treatment, rehabilitation or counseling • Advise the health care provider with regard to end-of-life decisions • Comply with prescribed treatments • Enquire about costs and arrange for payment • Take care of your own health records in your possession |

another right, and health care professionals cannot refuse them this access.

3.5 The last generic area in the Bill of Rights important to health is the provision for lawful, reasonable and procedurally fair administrative actions (Article 33).

In the health sphere, this has translated into provisions within the Patients' Rights Charter for a complaints procedure to ensure adequate redress of poor treatment (Department of Health 1999). Even procedures for complaint may be subject to oversight in keeping with this right. For example, the AIDS Law Project (ALP) enlisted the Public Protector's Office to investigate the failure of the Provincial Minister of Health in Mpumalanga to implement an effective post-exposure prophylaxis programme for rape survivors (Richter 2001).

The Patients' Rights Charter (PRC): Nurses and Patients on the 'Front Lines' of Health Care

One of the key mechanisms developed by the Department of Health to operationalise human rights has been the Patients' Rights Charter, released in 1999 as a common standard for achieving the range of health rights. Initially conceived of as a quality assurance instrument for Batho Pele principles, the PRC outlines

claims that patients can exert on public services. However, concomitant with these rights are *patient responsibilities* (Table 2), further reinforced in the National Health Act 2004, which codifies user responsibilities in a section dealing with 'Obligations of Users' (section 21). Hence, patients must agree to:

- observe the rules of the service
- provide accurate information, generally cooperate with the services
- treat health care providers with dignity and respect
- help to maintain a health facility in a 'habitable condition' (Department of Health 1999; 2004).

The Charter attempts to raise the quality of care by placing the onus on both providers and users to meet the standards set by our Constitution and reviewed above. However, there are some problems in the approach set out by the PRC. For example, in focusing on *access to health care services*, the rights contained in the Charter concentrate on curative services while ignoring the breadth of preventive and promotive measures required for health. Moreover, the chief obstacles highlighted by the Charter in addressing access are the ability to pay and health worker attitude. The role of language in attaining health rights is cited only in terms of receiving information about services available, so

that the patient may use the service appropriately. Nowhere does the PRC afford people the right to be spoken to by a health worker in the language of their choice, in compliance with the Constitutional recognition of 11 official languages.

Nonetheless, the Charter is a potentially useful tool to be developed to help patients actualise their right to health, within a framework that enables responsibilities to support rights.

The Future of Human Rights in South Africa: Implications for Educating and Training Health Professionals

In order to respond effectively to this range of human rights obligations framed in the South African Constitution, Bill of Rights and Patients' Rights Charter, health professional awareness, skills, values and attitudes must be addressed. The TRC made far-reaching recommendations about human rights training in the health sector:

Training in human rights [must] be a fundamental and integral aspect of all curricula for health professionals. This training should address factors affecting human rights practice, such as knowledge, skills, attitudes, and ethical

research practices. Knowledge of and competence and proficiency in the standards (both national and international) to which [health professionals] will be held accountable should be a requirement for qualification and registration. (TRC 1998)

The TRC further advised early engagement with professional oaths in ways that are effective, so that students move beyond simply seeing ethical codes of conduct as aspirational, idealistic pieces of paper. Health workers need opportunities throughout their training, as well as after graduation through continuing professional development, to question and implement the principles of professionalism, and gain human rights and ethics competencies. Though emerging from past experiences of apartheid, these recommendations are equally relevant today, where health professionals are being challenged to implement the Patients' Rights Charter, to promote access to health care, as well deal with the myriad complexities raised by the HIV/AIDS pandemic. In understanding how abuses were allowed to happen in the past, students can better appreciate their professional responsibilities to act positively in defense of the socio-economic rights of clients and patients in a democratic South Africa today.

Models of training

Given the importance of transformative teaching and learning in health and human rights, what kind of training is needed? What should the core competencies of such training be and

how should these competencies be integrated into an already over-burdened curriculum? Research published in the nursing and medical literature on this topic to date in South Africa has identified some serious deficiencies in current approaches (du Toit and Botes 1996: 79; Botes 1997: 37; Baldwin-Ragaven et al 1999: 172-184; Mtshali and Khanyile 2001: 22-30; Botes 2001: 26-31). It is against this backdrop that we now review our experiences with students and teachers from a range of health disciplines over more than a decade in this regard (London, McCarthy, van Heerden, Wadee, Walaza and Winslow 1997: 242-245; London and McCarthy 1998: 257-262; Baldwin-Ragaven 1998: 1377; London et al, 2007: 1269-1270).

From 1995 to 1998, courses in human rights at the University of Cape Town were open on a voluntary basis mainly to medical students as they began their clinical training. The learning objectives were to sensitise students to situations where human rights abuses could arise, both the egregious and the ordinary, and to give students problem solving tools to address such problems. The courses utilised an experiential learning approach, with visits to police stations, prison facilities and total psychiatric institutions, as well as interviews with torture survivors. However, it was soon evident that elective approaches to such training had severe limitations, since the weight accorded by the institution to such courses is undermined if they are not mainstreamed into the formal curriculum. Without including human rights content in summative assessments, such as final examinations, the importance of the

issues will be recognised only by an already motivated minority of students.

With this understanding, the authors shifted from teaching learners to working directly with educators. An intensive course entitled 'Human Rights Training for Health Professional Educators: Training Trainers in Health and Human Rights' was developed and continues to be held annually (Baldwin-Ragaven and London 2006). Targeting staff who teach health professionals, the aims of the training-the-trainers week-long course are summarised in Table 3. Since 1998, over 200 participants representing a range of disciplines and training institutions across the country have attended one of the nine courses held thus far. At least half of these participants were nurses.

In our experience, some of the key challenges to emerge from grappling with teaching and learning in health and human rights include the following:

1. Clarifying core, generic or discipline-specific competencies

One of the first steps in curriculum development is to identify the learning objectives or competencies to be attained. While determining what is core to all health care workers may be complex, even more difficult may be the need to distinguish competencies which are discipline-specific (i.e. germane to nursing, medicine, physiotherapy, occupational therapy or speech pathology)? Moreover, how should these learning outcomes be framed and deepened throughout the students'

Table 3. Training-the-Trainers in Health and Human Rights: Course Objectives

| |
|--|
| <p>After having completed the course, participants will:</p> <ul style="list-style-type: none"> • Understand the conceptual frameworks for human rights, locally and internationally • Understand the role of the health sector under apartheid and current implications • Recognise the crucial role of self-study/reflection to kick-start and sustain transformation • Identify processes in one's home institution which would strategically influence how human rights becomes integrated into the curriculum and institutional culture • Define common core learning objectives in health and human rights, as well as what is discipline-specific • Apply adult learning principles to promote experiential learning and employ appropriate assessment methods • Acquire knowledge of resource materials for training in health and human rights, including those available electronically • Acquire a critical understanding of the codes, laws and regulations governing health professional behaviour locally and internationally • Sustain continued professional development in relation to health and human rights training beyond this course |
|--|

Table 4. Core Competencies for Human Rights Training in Health*

| | |
|----------------------------|---|
| <p>Knowledge</p> | <p>International human rights declarations and professional ethical codes History of human rights abuses in South Africa and the role health professionals played under apartheid SA Constitution, Batho Pele and Patients’ Rights Charter Identification of vulnerable groups Clarity about forms of justice in the South African context Awareness of constitutional structures and agencies that promote democracy (e.g. Human Rights Commission, Gender Commission) Legislation pertaining to health and health care Understanding the relationship between bioethics and human rights Awareness of services for survivors of human rights abuses</p> |
| <p>Attitudes or Values</p> | <p>Seeing all people as worthy of dignity and respect Awareness of one’s own inherent prejudices or bias (i.e., race, class, sexual orientation, gender or disability) Willingness to assume an advocacy role and to work for change Approaching patients in non-judgemental and non-discriminatory ways Identification with altruistic values that underpin the healing professions Empathy and caring Appreciating and nurturing diversity</p> |
| <p>Skills</p> | <p>Inter-personal communication skills Community development skills Advocacy and lobbying skills Ability to work in interdisciplinary and diverse settings Critical thinking and problem solving skills Ability to recognise a human rights violation in one’s usual work environment Ability to report a human rights violation for investigation and redress Ability to work with trauma survivors</p> |

* This list is neither exhaustive nor definitive. It reflects the ideas of those participants on “Train-the-Trainer” courses from 1998 to 2004.

years in training? What assessment methods should be used in order to both accurately evaluate the learners’ mastery of their competencies, as well as indicate the value placed on this set of knowledge, attitudes and skills in human rights? Table 4 lists some of the competencies identified by successive groups of course participants.

2. Selecting instructional strategies (teaching methods)

The authors’ experience has been that where students engage first hand with human rights concerns, through experiential learning, that learning is most

effective. Inherent in such strategies is the de-schooling of deeply entrenched values and behaviours (Tibbitts 2002: 159-171; Andreopoulos, 2002: 239-249; Mayers 2002: personal communication). Teaching that promotes critical thinking and self-reflection, such as case studies, site visits, role plays, dramatization of Truth and Reconciliation Commission transcripts involving health professionals, small group discussion, debate and other experiential exercises have met these needs best. Supplementary instructional methods include: reflective journaling, media watch (print, radio and television), films produced by human rights organisations

as well as eye-witness reports accessible from the library and through electronic means (internet, etc.). We encourage trainers to develop their own learning materials based on these approaches with the hope of producing a locally relevant compilation of case studies based on South African experiences.

3. The hidden curriculum and the institutional environment

One of the key findings of the TRC and of our work is that institutional culture creates and perpetuates barriers that are often more subtle but sometimes as powerful as the more obvious forms of

discrimination (Baldwin-Ragaven et al 1998). Teaching human rights therefore means not only finding space in the formal curriculum for new material, but demands critical self-study of the institution. Without understanding where the culture of an institution derives, it is difficult to convey the essence of modern day human rights to students and faculty. In other words, if nothing is done to address the historical legacies of an institution, including its own discriminatory practices, the “hidden curriculum” overrides attempts to effect change, particularly if such change is to prioritise human rights teaching.

A number of institutions have seen the need for such introspection. In 1998, the University of the Witwatersrand Health Sciences Faculty established its own Internal Reconciliation Commission modeled after the TRC, which represents one attempt to come to terms with a discriminatory past (Goodman and Price 2002: 221-227). The UCT Health Sciences Faculty has similarly committed itself to a reconciliation process which will feed into curricular change and institutional policies (London and Perez 2001: 1027-8; Perez and London, 2004: 769). Statutory councils as well have undertaken self-examination in order to understand how to move forward (Anonymous 2003: 1-5; de Villiers and Stulting 2000: 301). The challenge will be how such introspection can concretely result in effective programmes.

Many people tend to think about transformation only in terms of ‘race’. Yet, the TRC and other research have shown that discriminatory hierarchies in the health sector by discipline or specialty and gender have also adversely impacted the capacity of the health sector to protect human rights. For example, unless the paradigm is altered so that male doctors by dint of their professional and gendered status cease to exert authority over nurses, we will not grasp all of the opportunities afforded by transformation.

The institutional environment also refers to the teaching platform or the facilities in which our students learn. If routine practices continue to degrade patients, no longer legally on the basis of ‘race’, but simply through use of the public services, how can students internalize the values, attitudes and skills necessary to

sustain human rights? This *hidden curriculum* has unintended consequences, often sending far more powerful messages to learners about what is important than what is formally taught (Hafferty 1998: 403-407). This poses additional duties for teachers to be at the forefront of fighting for patients’ rights, for quality health care, for a health system that reinforces rather than undermines our students’ quest to advocate for the rights of their patients and clients.

4. Curriculum implementation

Finally, the question of implementation raises many strategic considerations. Firstly, who is going to teach students? What role models do we have who can talk openly and honestly about human rights? Many academics in South Africa achieved their status under conditions where apartheid systematically favoured white staff (Baldwin-Ragaven et al 1999: 40-41; Goodman and Price, 2002: 211-227, whose promotion came at the expense of black colleagues, whether consciously or unintended (Marks, 1994: 172-178). What ethos can a training institution staffed in this way hope to inculcate in its students without careful reflection on past discrimination and its impact?

Secondly, if teachers will be introducing human rights in their curricula, who will be their allies? Course participants’ experience is that voices of change at their institutions are generally few in number. Asking for space for human rights inevitably leads to competition for resources and time. It is therefore important to anticipate where resistance is likely to come from and how to manage that resistance by identifying potential sources of support, both within and outside their institutions. Some observers have suggested that student activism has declined substantially and human rights advocacy is not as attractive to students as in the past. However, this is probably situational, since there is still evidence of student mobilisation in many areas of work in health – HIV/AIDS (Treatment Action Campaign, Undated), rural health needs (London et al, 2002: 29-31) and health policy.

Adapting strategies for change that have worked in the past and building on what is already in place can create the conditions for novel approaches. For example, a big issue is the belief that

ethics or Ethos is already taught and has been so for many years. This reflects a very real perception that human rights and medical ethics are somehow the same thing, or more precisely, that human rights is one aspect of a broader conception of medical ethics (Benatar 2006: 17-20). While there is clearly a close relationship between the two, health professional ethics and human rights cannot be conflated into the same set of ideas, concepts or behaviours. Indeed, as highlighted by the TRC in South Africa, clinicians can remain highly ‘ethical’ in a narrow sense (on a one-to-one patient basis) without ever tackling the core human rights dilemmas that face societies in conflict, nor addressing their obligations to act as advocates for the realisation of socio-economic rights (Rubenstein and London 1998: 160-175). Framed in a manner that made no effort to engage with the social and political context or address the gross violations of human rights taking place in the health sector under apartheid, medical ethics teaching actually served to protect health care workers behind a veneer of ‘professionalism’. This distancing worked to substitute the main objective (to sensitise students to human rights dilemmas and equip them with necessary skills to confront those challenges) with either rote learning of codes or a methodology that allowed philosophical but not directly practical (*real politick*) engagement with highly problematic ethical issues in health facing our country. Rather than substituting for human rights, health professional ethics needs to be taught in complementary ways that further ground bioethics in a human rights foundation (Rubenstein and London 1998: 160-175). In this way, students can be trained to question and engage as actors in the morally difficult situations they are bound to encounter.

Reflecting on our near-decade of experience in training trainers, we also acknowledge the steep learning curve that embarking on this terrain entails. In a period of great strain in the health sector—with staff shortages, resource constraints, disease burdens such as HIV/AIDS and XDR-TB and high levels of violence—human rights training may not appear to be a pressing priority. Yet, perhaps paradoxically, it can be through such a process of struggling with these most difficult challenges within a human rights framework that validates both the sacrifices and gains that working as a

health professional in South Africa entails today.

Conclusion and future challenges

The institutionalization of human rights training to health professionals has already begun in South Africa with the HPCSA driving the incorporation of human rights learning outcomes in the accreditation of training institutions (HPCSA, 2007a) and confirming the role of both ethics and human rights as mandatory components of Continuing Professional Development requirements (HPCSA, 2007b: 7). In this regard, South Africa is a world leader.

However, there remain key areas of concern for health professionals engaged in human rights promotion and education.

Firstly, it is one thing to refrain from participating in torture. It is quite another to use professional skills positively and proactively to empower others to achieve to their rights. Developing a cadre of health professionals who see their professional responsibility as facilitating the positive realisation of rights is a new arena. As argued earlier, it is only through health professionals acting as advocates for their patients that human rights will be progressively realised. Effective human rights advocacy needs to become as much part of the scope of competent practice as the appropriate diagnosis and management of disease.

Secondly, the Constitution seeks to shape how the law and policies of government are enacted; and, professionals must certainly take cognizance of the law in conducting themselves ethically. However, national laws may not always be consistent with the Constitution or international human rights norms, or may suffer from a lag period between their formulation and implementation and the jurisprudence to fully interpret the Constitution has yet to be developed. For these reasons, health professionals need to be vigilant in analysing how policies, albeit legal, may actually infringe human rights. For example, current legal provisions for death certification mandate that medical information normally considered confidential be entered on a death notification. In practice, this information is not kept confidential by a system where

undertakers and family members are given these notification forms without modification (Bateman 2000: 1072-3). Thus, while human rights, law and ethics are all closely related, they are not always consistent. Ethical obligations may sometimes bring us into conflict with the law if we are to protect human rights, a tension which need to be reflected in our teaching.

Thirdly, the relationship between professional ethical codes and human rights is not always that clear. For example, when health professionals face situations of dual loyalty, where a health professional has an explicit or implicit obligation to a third party other than their patient (such as an employer, the State or a private company), he or she may be subject to choices, the consequences of which have ramifications for the human rights of their patient/client. Ethical guidelines have not given us tools to balance rights easily, or to manage role conflict arising from dual loyalty very well (Rubenstein et al, 2002). For example, when is it permitted to place the interests of the collective members of an insurance fund ahead of the needs of an individual member for a very expensive treatment for a rare condition? Managed care removes that decision from health care providers in ways that may compromise their ability to meet their obligation to protect the human rights of their patients. Health care providers in prisons may find themselves under pressures related not to the clinical needs of their patients but to those of the authorities, with potential human rights implications for the prisoner. There are many other examples of dual loyalty that highlight political, ideological and financial tensions (Bloche 1999: 268-274).

These conflicts challenge us to ensure that not only do our professional codes meet human rights standards but also that our teaching reflects these realities and their nuances. Expanding the scope of graduate competencies to include a core set of knowledge, attitudes, values and skills in human rights for all South African health professionals is an urgent priority for our country.

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