

# A case for integrating human rights in public health policy

In a global environment where human rights and well-being are coming under increasing threat, both from the spectre of terrorism and from the counter-reaction to it,<sup>1</sup> and where international governance systems continue to pay lip service to poverty reduction while encouraging unbridled private accumulation of wealth resulting in huge inequalities between and within countries,<sup>2,3</sup> the need to make human rights considerations an integral part of how public health policies are formulated cannot be overemphasised. Contestation over entitlements to socio-economic rights has troubled health care systems worldwide, from resource-poor settings in Africa, where questions have been raised as to whether human rights approaches are best suited to addressing the problem of AIDS in Africa,<sup>4,5</sup> through to the over-consumptive USA where universal access to health care remains a policy objective doomed to unfulfilment under market-fixated economic systems.<sup>6,7</sup>

Part of the reason why public health policies have failed to address global, regional and local disparities adequately may lie in the lack of a coherent ethical framework for public health.<sup>8</sup> An alternative approach to making public policies ethical is to subject them to the scrutiny of a human rights framework,<sup>9,10</sup> which prioritises the needs of vulnerable individuals and groups and affords protection and agency to those most directly affected by such policies, using international standards agreed in human rights law.

Although the tensions inherent in the formulation of public health policy are not unique to South Africa, South Africa's experience with regard to national HIV policies is particularly illustrative, and has exposed deep contradictions between government's constitutional obligations to deliver socio-economic entitlements such as access to health care, and the reluctance of policy makers to recognise access to antiretroviral

treatment as a human right.<sup>11-15</sup> The ethical contradictions facing individual health care practitioners under circumstances of Dual Loyalty have been well recognised, and addressed in a range of ethical and human rights guidelines.<sup>16,17</sup> Yet when public health officials try to carry out their work under such circumstances, the choices facing health professionals seeking to do their best for their patients or communities are often severely limited, and represent a Dual Loyalty conflict of a particularly invidious type.<sup>16,18</sup>

Other examples abound in our current context. For example, health workers completing disability grant applications are required to adjudicate on the fitness of their HIV-positive patients, knowing that as they recover and their CD4 count climbs over 200 cells/ $\mu$ l, their patients will be stripped of what is possibly their only source of income. Completion of a death certificate has presented practitioners with invidious choices about protecting confidentiality in the context of 'discrimination beyond the grave',<sup>19,20</sup> while the introduction of ICD-10 coding requirements by the health insurance industry has added another challenge to confidentiality for health care providers, and to the right to privacy of medical scheme members.

Yet, in its recommendations, South Africa's Truth and Reconciliation Commission highlighted the importance of human rights as a benchmark for the training and practice of health professionals.<sup>21-23</sup> In this issue of the *SAMJ*, Mathews<sup>24</sup> provides a policy critique of proposed legislation to criminalise intentional transmission of HIV, from a human rights perspective. This research arises from a module developed specifically for the Masters Programme in Public Health at the School of Public Health and Family Medicine at the University of Cape Town that has been taught over the past 3 years. The module builds on previous experience in the School's Health



and Human Rights Programme in undergraduate teaching<sup>25,26</sup> and train-the-trainer approaches<sup>27</sup> to health and human rights teaching. A key thread of the course is to equip students with skills to critique existing policies, and/or to design new policies that better integrate human rights into public health objectives. Mathews' findings,<sup>24</sup> which may appear unpopular with some, viz. that there are serious limitations to the policy of criminalisation of deliberate HIV transmission from both a public health and a human rights perspective, would not easily emerge without careful application of a rigorous critique based on the links between public health and human rights.

The challenges facing health care providers and policy makers seeking to balance social utility against individual patient welfare are not decisions to be made outside of an ethical or human rights framework. Rather, they should be justifiable in terms of high standards of respect for human dignity. There are situations where a social benefit may justifiably trump concerns for individual autonomy (for example in the use of quarantine to control serious and contagious conditions), but these exceptions have to be based on clear criteria that meet accepted standards in a transparent and defensible manner consistent with human rights.<sup>10</sup> Too often, we are guided by short-term sensibilities that allow prejudice, assumptions and misinformation to define health policies. Instead, applying a human rights perspective to the development, implementation and monitoring of health policies may help to address the seeming gap between the intent of health programmes and their outcomes.

## Leslie London

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

1. Annas CJ. Bioterrorism, public health, and human rights. *Health Aff (Millwood)* 2002; **21**: 94-97.
2. Cornia GA. Globalization and health: results and options. *Bull World Health Organ* 2001; **79**: 834-841.

3. Weisbrot M, Baker D, Kraev E, Chen J. The scorecard on globalization 1980 - 2000: its consequences for economic and social well-being. *Int J Health Serv* 2002; **32**: 229-253.
4. De Cock KM, Mbori-Ngacha D, Marum E. Shadow on the continent: public health and HIV/AIDS in Africa in the 21st century. *Lancet* 2002; **360**: 67-72.
5. Holmes W. 3 by 5 but at what cost? *Lancet* 2004; **363**: 1072-1073.
6. Navarro V. Policy without politics: the limits of social engineering. *Am J Public Health* 2003; **93**: 64-67.
7. Geyman JP. Privatization of medicare: Toward disenfranchisement and betrayal of a social contract. *Int J Health Serv* 2004; **34**: 573-595.
8. Reich MJ, Roberts MR. Ethical analysis in public health. *Lancet* 2002; **359**: 1055-1059.
9. Heymann SJ, Sell RL. Mandatory public health programs: To what standards should they be held? *Health and Human Rights* 1999; **4**: 193-203.
10. Gruskin S, Tarantola D. Health and human rights. In: Last J, ed. *Oxford Textbook of Public Health*. New York: Oxford University Press, 2002: 311-335.
11. Haywood M, Allman D. Confronting AIDS: Human rights, law and social transformation. *Health and Human Rights* 2000; **5**(1): 149-179.
12. Cameron E. The deafening silence of AIDS. *Health and Human Rights* 2000; **5**: 7-24.
13. Schneider H, Fassin D. Denial and defiance: a socio-political analysis of AIDS in South Africa. *AIDS* 2002; **16**: Suppl 4, S45-51.
14. Schneider H, Fassin D. The politics of AIDS in South Africa: beyond the controversies. *BMJ* 2003; **326**: 495-497.
15. Benatar SR. Health care reform and the crisis of HIV and AIDS in South Africa. *N Engl J Med* 2004; **351**(1): 81-92.
16. Dual Loyalty Working Group. *Dual Loyalty and Human Rights in Health Professional Practice. Proposed Guidelines and Institutional Mechanisms*. May 2005. Physicians for Human Rights, Washington. <http://www.wma.net/e/policy/c8.htm> (last accessed 22 February 2006).
17. World Medical Association. International Code of Medical Ethics: Declaration of Geneva. Adopted by the 3rd General Assembly of the World Medical Association. London, England, October 1949. Amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968, and the 35th World Medical Assembly, Venice, Italy, October 1983. [www.wma.net/e/policy/17-a\\_e.html](http://www.wma.net/e/policy/17-a_e.html) (last accessed 22 February 2006).
18. London L. Dual loyalties and HIV policy in South Africa - a challenge to the institutions of our professions. *S Afr Med J* 2002; **92**: 882-883.
19. Bateman C. Discrimination beyond the grave (Izindaba). *S Afr Med J* 2000; **90**: 1072-1073.
20. Dhai A, Dada MA, Kirk GM, McQuoid-Mason DJ. Confidentiality - a dying wish? *S Afr Med J* 2001; **91**: 123-127.
21. Truth and Reconciliation Commission Report. Vol 4. Chapter 5. Institutional hearings: The health sector. Cape Town: Juta, 1998: 109-164.
22. Baldwin-Ragaven L, de Gruchy J, London L. *An Ambulance of the Wrong Colour. Health Professionals, Human Rights and Ethics in South Africa*. Cape Town: UCT Press, 1999.
23. Baldwin-Ragaven L, London L, de Gruchy J. Learning from our apartheid past: Human rights challenges for health professionals in contemporary South Africa. *Ethn Health* 2000; **5**: 227-241.
24. Mathews S. Criminalising deliberate HIV transmission - is this good public health? *S Afr Med J* 2006; **96**: 312-314 (this issue).
25. London L, McCarthy G, van Heerden J, Wade S, Walaza N, Winslow T. Preparing future doctors to meet ethical challenges: A training course for medical students in health and human rights. *Southern African Journal of Public Health*, in *S Afr Med J* 1997; **87**: 242-245.
26. London L, McCarthy G. Teaching medical students on the ethical dimensions of human rights: Meeting the challenge in South Africa. *J Med Ethics* 1998; **24**: 257-262.
27. Baldwin-Ragaven L. Prioritising human rights training for health professionals (reportage). *S Afr Med J* 1998; **88**: 1377.