HEALTH RIGHTS OF THE UNDERPRIVILEGED - LOOKING AT POVERTY AND DISEASE

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ABSTRACT. Poor people in developing countries are the worst hit by disease, violence and injury. Mortality rates in the low and middle income countries (LMIC) stay unacceptably high. Risk factor ‘authorities’ and public health problems, and knowledge gaps challenge the health rights of poor people living in LMIC. High population density, illiteracy and unemployment are at the root of poverty and added to this is a long list of social and community factors driving the problem. It is no secret that many poor countries lack comprehensive health systems, provide poor education and under take very little research with a general lack of data. Prevention strategies are also not in place in these countries. Many role players concern themselves with the health rights of the poor: academics with training programs in schools and universities; the United Nations Committee on Social Economic and Cultural Rights with a right to health declaration; and the World Health Organization with a unit on health and human rights. Scientific publications on human health rights have increased five-fold over the past 45 years. Many new journals enter the field and Patients Rights Charter of the Western Cape (South Africa) gives a good exposition of what health rights are. Four models/concepts describe briefly what has been useful in striving for health rights for the poor. The models are: the building of Social Capital, Human Rights from the Grassroots up, the development of Non-government Organizations striving to provide education and health facilities to the rural and urban poor and the fourth model refers to the obligation of health facilities to render holistic care, particularly to poor communities.

Introduction: High, middle, and low income countries

It is abundantly clear by now that poor people suffer most from disease and that the low and middle income countries (LMIC) are the worst hit by violence and injuries. In developed countries it is also the people of lower socioeconomic status who are the most affected by the problem. Mortality rates are lowest in high-income countries where prevention strategies are already in place.

In stark contrast to this situation, in the majority of low and middle income countries mortality rates remain unacceptably high. The main challenges that lie ahead are risk factors, ‘authorities’ and public health problems, and knowledge gaps. These factors will subsequently be discussed. This discussion will be followed by a discussion of health rights and models that can be utilized in the development of health rights for the poor.

High risk factors

In LMIC demographic high risk factors can be identified:
• High population density
• Illiteracy and unemployment
• Poverty
Also Social factors driving the problem
• Patriarchal notions of masculinity
• Vulnerabilities of families
• Exposure to violence in childhood
• Alcohol and drug misuse

People living in informal, unplanned settlements with very little infrastructure are at risk of disease. Poverty stricken people often experience injury and violence because of relationship risk factors with family instability. There are often constant physical abuse and neglect of children. In these dysfunctional communities the presence of gangs, poor policing and drug trafficking again correlate with injury and violence.
Authorities and public health problems

It is no secret that many poor countries lack comprehensive health systems. There is also a lack of data on disease. The scarce resources for health care are seldom directed towards documentation and information. In other words, the way accident statistics are collected (or not) by State services depends a lot on the way health priorities have been established for a given country. It is the socio-economic context that is missing here. Failing to connect for instance accident statistics with socio-economic data makes it impossible to get a clear picture of the accident-poverty relationship. Often public health systems are biased towards the more educated and resourceful or towards certain cultural groups. In developing countries there may also be a lack of political will to implement sound health plans.

In rural areas health services and support systems are likely poorer, with little access to health care (clinics, hospitals, medical professionals). In poor countries the lack of individual or collective insurance is well known. But it is not only the health departments that fall short of expectations, the educational departments contribute to poor education that remains a barrier to rights.

Knowledge gaps

Poor communities are:
- Ill informed about every-day accidents and disease
- Not knowledgeable about what measures to be taken after the accident or disease strikes
- Prone to misunderstanding of awareness campaigns for the public.

Research and prevention are afforded low priority in LMIC. Scarc resources are rather devoted to the rendering of services. Inappropriate and below-standard research is worse than no research at all. The general lack of data is thus aggravated by poor quality and technical limitation.

Health rights

There are many role players who concern themselves with the health rights of the poor. Academics are involved in training programs in schools and universities. They contribute in scientific journals and at conferences on this topic.

International bodies play a major role in the development of health rights. The United Nations Committee on Social Economic and Cultural Rights contributed by, for instance, making a right to health declaration. The United Nations Millennium Declaration emphasizes health rights. The World Health Organization has created a unit on health and human rights. Many states have instituted health reforms and are looking particularly at equality for all in health care.

Scientific publications have increased five-fold over the past 45 years. New evidence about, for instance, the relationship between poverty and HIV have emerged. The new publications tend to be “politically correct” with new journals entering the field.

Mpinga, Verloo, London and Chastonay have indicated that human rights in medical journals are receiving a lot of attention (see Table I).

Table I - Classic and new research themes in the field of health and human rights

<table>
<thead>
<tr>
<th>Classical themes</th>
<th>n</th>
<th>%</th>
<th>New themes</th>
<th>n</th>
<th>%</th>
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<td>Health systems</td>
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<td>Right of patients</td>
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<td>Mental health</td>
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<td>New technologies</td>
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<td>Handicaps</td>
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<td>Reproductive health</td>
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<td>Right to health</td>
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<td>Health and Human rights</td>
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<td>Health and trade</td>
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<td>Violence</td>
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<td>HHR training</td>
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<td>Health and migration</td>
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<td>Humanitarian crisis</td>
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<td>Medical public health research</td>
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<td>3.1</td>
<td>HHR and environment</td>
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<td>1.1</td>
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<td>A Right of children</td>
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<td>3.1</td>
<td>HHR of minorities</td>
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<td>Right to food</td>
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</table>

Health and human rights in scientific literature: A systematic review over a decade (1999-2008)
Emmanuel Kabengele Mpinga, Henk Verloo, Leslie London, and Philippe Chastonay
However, from Table II it is evident that 70% of the authors are residents of industrialised nations. The reasons for this are greater availability of funding in developed countries, the pressure of urgent need to spend resources on service delivery in underdeveloped countries, and the lack of a culture of research in underdeveloped countries.

4 Models and concepts in the search for Health Rights

The Patients Rights Charter of the Western Cape (South Africa) gives a good exposition of what health rights are:

- 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
- Be treated by a named health care provider
- Confidentiality and privacy
- Informed consent
- Refusal of treatment
- Be referred for a second opinion
- Continuity of care
- Complain about health services

Four models/concepts will be described briefly that have been useful in striving for health rights for the poor.

The first model can be termed the building of Social Capital. According to Hanifan social capital can be described as “social cohesion and personal investment in the community; goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit.”

Social capital results in

- Substantial improvement of living conditions in the whole community
- Social networks and communities having a protective quality on health
- Discouraging of individuals from engaging in risky health behaviours
- Adjustment to norms of society

The second closely related model is that of Human Rights from the Grassroots up. An example of this occurred in 2008 in Vermont (USA) when the workers’ centre launched a grassroots campaign - a framework for universal health care. The center was founded by a group of low-income citizens in 1996. Campaign organizers used a human rights framework to mobilize thousands of voters in support of universal health care. Although citizens enjoyed a good standard of health care there were many poor people who were excluded from quality health care. “In response to this extraordinary grassroots effort, the state legislature passed health care legislation that incorporates human rights principles into Vermont law and provides a framework for universal health care.”

Thirdly, Non-government Organizations can contribute a lot to improving the health rights of the poor, especially the more radical of these organizations. Some of these organizations are dedicated to provide education and health facilities to the rural and urban poor, particularly disadvantaged children and women. In South Africa, the Treatment Action Campaign lobbied for the rights of patients who suffer from HIV/Aids. This en-
sured access to ARV’s and other services for HIV/AIDS patients.

The fourth model refers to the obligation of health facilities to render holistic care, particularly to poor communities. In poor communities the resources and support for after care are often non-existent. Health professionals in these settings recognize the need to socially support the patients (in our case, particularly burn victims). Professionals in health services go beyond the call of duty and establish an NGO to raise funds for the rehabilitation and retraining of patients in order to assist them to become full members of society again. This is also a tool to prevent future injury and violence.

Conclusion

Health rights globally are well recognized and developing countries realise that risk factors exist in their poor populations because of increasing evidence in the literature. Most of the risk factors are preventable. However, when one looks at indicators such as child deaths, access to clean water, and maternal deaths it is evident that many countries will not reach the Millennium Goals.

Numerous models and concepts are available, but political will power, legislation, and upliftment of the underprivileged still have a long way to go to ensure their health rights.

BIBLIOGRAPHY