WHY WE SHOULD CARE: HEALTH AND HUMAN RIGHTS
OCTOBER 30, 2012
ABSTRACTS

Panel 1  Access to Health in Africa

9:50 – 10:10AM  At the Hospital There Are No Human Rights – Mindy Roseman

Abstract: On 30 July 2012, the Namibian High Court issued its ruling in LM&MI&NH vs. the Government of the Republic of Namibia finding that the three plaintiffs had been coercively sterilized. Welcome as the judgment was (and it was a long time in coming), the judge denied the plaintiffs’ claim of discrimination on the basis of their HIV-positive status. Monetary damages are to be awarded for their physical injuries, but not for the human rights violation. Whether there will be an appeal is an open question. There are many other questions to be asked. How can justice be served for all those living with HIV/AIDS in Namibia, especially women who have been sterilized, when the underlying fact of discriminatory animus is denied? How can such practices, globally condemned periodically and since the end of World War II still be continuing, especially in sub-Saharan Africa? And lastly, what if anything can be done to prevent, reform, and remedy these outrages? Why have the most recent spate of cases emerged from sub Saharan Africa? This paper will discuss “At the Hospital There Are No Human Rights,” a 2012 health and human rights fact finding report that uncovered pervasive discrimination against women living with HIV in Namibia in the health sector. It contends that such discriminatory attitudes contribute towards accepting, excusing and minimizing the sterilizations. It will place forced and coercive sterilizations in historical and comparative context and conclude with some thoughts about strategic interventions towards ending and rectifying such practices.

10:10 – 10:30AM  The Political Sources of Ethnic Inequality in Health Outcomes in Africa – Eric Kramon

Abstract: In many African countries, profound inequalities exist between ethnic groups on a number of health and other human development indicators. These inequalities arise from a range of geographic and historical factors, including differences in groups’ access to land and quality agricultural inputs and differences in their treatment by colonial regimes. In this presentation, I discuss the proximate political sources of these ethnic inequalities in a number of African countries, with an emphasis on inequalities in health outcomes. I present results from a number of studies which document that ethnic connections to political elites, especially presidents and key cabinet ministers, play a significant role in shaping the health of infants and children. The results shed light on the strategies that political elites use to cultivate political support and highlight the importance of politics in determining health.

10:30 – 10:50PM  The Emergency First Aid Responder Project in Western Cape Province – Jeffrey Tran

Abstract: Many countries do not have the resources to maintain public emergency medical response services to provide access to medical care in times of emergency. The Emergency First Aid Responder project, or EFAR project for short, seeks to overcome this access problem by enabling under-resourced communities to provide their own emergency medical response services. A core belief of the EFAR project is that individuals are never helpless victims, but rather an integral part of the solution. We work with the communities to develop first aid training programs that are taught and eventually run by community members. Founded at a single site in the Cape Flats of South Africa, the EFAR project has since expanded rapidly. Most recently, the METRO EMS system of the Western Cape Province adopted the model developed by the EFAR project and plans to implement it across the entire province.

This presentation will review how the EFAR model works and how it was developed into a generalizable model.
Panel Session 2  Health and Security

11:30 – 11:50AM  Living under Drones – James Cavallaro and Omar Shakir

Abstract: In late September clinics at Stanford and NYU Law Schools released “Living under Drones: Death, Injury and Trauma to Civilians from US Drone Practices in Pakistan.” The 180-page-report presents evidence of the deadly and counterproductive effects of current US drone strike policies in Pakistan. There is little doubt that despite official US statements to the contrary, drone strikes have killed significant numbers of civilians, an issue considered in the study. In particular, though, the report focuses on the psychological and social consequences of the constant presence of surveillance drones. Based on extensive interviews with Pakistanis living in the regions directly affected (70 in all), as well as humanitarian and medical workers, this report provides new and firsthand testimony about the negative impact of US policies on the wellbeing of civilians living under drones in Pakistan. Our research team gathered evidence suggesting the breakdown of social structures, as well as widespread symptoms consistent with post-traumatic stress disorder and other psychological ills. The report concludes that in light of significant evidence of harmful impacts to Pakistani civilians and to US interests, current policies to address terrorism through targeted killings and drone strikes must be carefully re-evaluated.

11:50 – 12:10PM  Searching for Dignity – Rajaie Batniji

Abstract: What is the definition of Dignity? Jonathan Mann made the case that violations of dignity have “devastating” effects on physical, mental, and social wellbeing and he sought to create a taxonomy of dignity violations that included: not being seen or being incompletely seen; being subsumed into a group identity; invasion of personal space (including physical violence); and humiliation. Mann’s persuasive ideas seem to resonate in Gaza where I observed an absence of dignity. The constant surveillance from the sky, collective punishment through blockade and isolation, the intrusion into homes and communications, and restrictions on those trying to travel, or marry, or work make it difficult to live a dignified life.

Panel Session 3  The Right to Health in India

1:00 – 1:20PM  Making Hunger a Political Priority in India – Vivek Srinivasan

Abstract: The Right to Food Campaign in India has had a tremendous impact in putting hunger on the policy agenda. The campaign played a critical role in expanding school feeding, early childhood care, subsidised food for the destitute, and employment programmes for the poor. In this paper, I look at the success of this campaign in the context of a long history of social mobilisation on hunger in India. I argue that while the rights based approach has an impressive record in the recent past, some of the most far reaching programmes to combat hunger in India came through different forms of mobilisation. I evaluate the merits of taking the rights-based approach to food in this comparative framework.

1:20 – 1:40PM  The Role of Right to Information in the Right to Health – Suchi Pande

Abstract: Amongst other economic and social rights, the right to health in India continues to be a non-issue for politicians and the government. The right to health in India - rarely discussed outside specialist circles - is yet to be accepted as a basic right for all Indian citizens. Despite an array of healthcare programmes especially targeted to the poor - in particular women and children - information on many of these government run programmes is rarely made available, and the rural poor remain unaware of their entitlements. Access to basic healthcare is one of the biggest burdens for poor Indians; unless bribes are paid basic healthcare is denied. Drawing on the MKSS experience with organizing jan sunwais or rural public hearings in central Rajasthan I explain the role of the right to information and its supporting mechanism - the jan sunwai - in facilitating access to public health in rural India.
Panel Session 4 Where has the HIV/AIDS debate gone?

2:10 – 2:30PM  What's pregnancy got to do with it? The impact of pregnancy on the likelihood of receiving HIV/AIDS testing with consent, counseling and confidentiality – Sarah MacCarthy

Abstract: Background: Testing guidelines, both international and national, identify consent, counseling, and confidentiality (the 3Cs) as critical requirements for quality HIV/AIDS testing. A review of the literature identified persistent challenges to ensuring true consent. Further, there were multiple examples of ways in which proper counseling and confidentiality were not provided during pregnancy, with additional difficulties in offering appropriate counseling during labor and delivery. Brazil has led the way in many areas of the HIV response. Thus, we sought to examine pregnant women's experiences and receipt of the 3Cs, to explore whether, under this definition, pregnant women in Salvador, Brazil receive quality HIV testing services.

Methods: Seventeen semi-structured interviews were conducted with HIV-positive pregnant women receiving care at the State Reference Center. Interviews were transcribed, translated, and coded for analysis. Deductive codes were applied to confirm factors identified in the literature review. Inductive codes were then added, to identify new factors emerging from the initial coding process. All interviews were individually conducted and were recorded, transcribed, and translated from Portuguese into English for analysis.

Results: The results showed that no pregnant woman experienced the 3Cs in combination and, further, that three women did not experience any of the 3Cs. Few women provided consent and none received pre-test counseling. Post-test counseling and confidentiality of services were more consistently offered.

Conclusion: These findings suggest that in Brazil, testing services for HIV-positive pregnant women remain limited to the provision of the test, with insufficient attention to the quality of services provided. This fails to meet national and global guidelines. Further research is needed to determine the generalizability of these findings, and what would be necessary to translate existing guidelines into programmatic action and provider practice in Brazil and the rest of the world.

2:30 – 2:50PM  Competing Miseries in a Failed Health System – Nadejda Marques

Scarcity in health care is a constant source of tension but in a country with significant resources such as Angola, competing miseries and suffering for the lack of basic and primary care are unnecessary. In this presentation I argue that the failure of authorities to provide more adequate health care constitutes a clear violation of human rights. Analysis of data collected in nineteen HIV testing and counseling units including in five maternities in four provinces in Angola demonstrate that most health units did not have drinking water or sanitary conditions to receive patients. They lacked basic equipment for testing and data collection, basic medical supplies, educational and preventive materials, and communication and transportation infrastructure. In addition to the generalized shortage of doctors, health care providers have no specific training on HIV/AIDS and in at least two health units did not speak the national language. I argue that in many ways the human rights movement has promoted the issue of HIV/AIDS and that in Angola, advocating for the rights of persons living with HIV/AIDS might be a way to advocate for improving a health system that is failing its population.

Panel Session 5  How Doctors and Lawyers Work Together

3:20 – 3:40PM  Forensic Evaluation of Torture Survivors: Legal and Medical Considerations – Dr. Ami Laws

Abstract: This lecture will review international human rights law as it applies to torture, give an overview of torture practices around the world, then focus more specifically on police torture in Punjab, India from the 1990's to the present.
Abstract: Recent comparative studies suggest that Colombia has the highest per capita rate of right to health litigation among low-income and middle-income countries. The puzzle that I address in my paper is the following: if during the late 1980s and early 1990s comparable middle-income countries—e.g. Brazil, Costa Rica, and South Africa, among others—introduced into their constitutions similar institutional arrangements for the protection of socioeconomic rights (such as powerful Constitutional Courts and effective judicial mechanisms) what explains Colombia’s unparalleled escalation of right-to-health litigiousness with harmful financial and equity consequences? I argue that unlike other comparable cases, Colombia witnessed during the past twenty years (1991-2011) an overlap of two consequential processes: on the one hand, the introduction of a health care overhaul based on the regulated competition of private health providers and insurers; on the other, the implementation of judicial institutions that led to the enforceability by judges of the right to health as a justiciable basic right to demand concrete healthcare services such as pharmaceuticals. In my paper I will contend that the harmful escalation of right-to-health litigation is one of the unexpected consequences of the overlap between healthcare reform and the enforceability of the right to health.