

Annotated Bibliography: Human rights and Health Equity

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This bibliography pulls together recent articles that speak to the relationship between human rights and health, particularly focused on health equity, poverty and community agency. The bibliography was prepared for the EQUINET Health Rights theme and the articles described in the bibliography have informed much of the conceptual approaches developed in EQUINET to harnessing rights approaches to build health equity. The bibliography overlaps to some extent with other bibliographies held by EQUINET on health equity themes. It should prove useful for researchers exploring issues of human rights in relation to equity. The intention is to keep this bibliography updated in future, to support EQUINET's activities in this area.

1. ARTICLES

Akhter M, Northridge M. (2002). Ethics in Public Health (Editor's Choice). AMJ Public Health 92: Issue 7 p1056

This editorial runs a commentary of the articles that have been published that particular month in the AMJ Public Health, all of which relate to ethics in Public Health. The articles refer to various crucial topics such as how to ensure that all populations including vulnerable groups benefit from recent advances in medical technology, how to ensure that research involving human subjects causes no harm and the challenges of global inequity in health and how these can be addressed.

Angel M. (2000) Patients' bill of rights and other futile gestures. N Engl J Med. 342:1663-1664

This is an editorial that looks at Health Care Reforms that have been at the top of the political agenda in America fuelled by the inflation in health care costs, increase in the number of Americans without health care insurance and the abuses of managed care. These have given rise to a number of patients' rights bills in an effort to restore to patients and their doctors control over medical decisions rather than being controlled by health plans and employers. The author agrees on the aims of these patients rights bills but goes on to discuss why he thinks these patient rights bills will not achieve what they intent to achieve because employers might stop offering health care benefits. This would result in the increase in the number of uninsured and underinsured people. She suggests a number of possible solutions to this problem.

Beaglehole R, Bonita R. (2000) Reinvigorating public health. Lancet 356:787-8.

The authors suggest that reinvigoration of public health will require an increase in commitment from the public-health workforce to a broader view of public health and to values of equity and ecological sustainability. They further argue that public-health practice needs to focus on overall improvement in population health through the reduction of the readily preventable burden of

disease—both communicable and non-communicable—especially among disadvantaged groups. The main way to achieve this goal is by reducing social and economic deprivation. Public-health scientists and practitioners can contribute to this goal by clarifying the links between social and economic factors and health status, and by identifying cost-effective approaches to overall health improvement. The authors also highlight the need for strong political and professional leadership and emphasising the role of equity and human rights for the reinvigoration of public health.

Baum F. (2001) Health, equity, justice and globalisation: Some lessons from the People's Health Assembly. J Epidemiology and Community Health 55:613-617.

This is a commentary describing some of the deliberations at a gathering of public health activists, the People's Health Assembly held in Savar, Bangladesh from the 5-9 December 2000. The participants examined the health impacts of globalisation, particularly the impact of global trade regimes and also considered what could be done to change its character and impact. At the end of the meeting the delegates unanimously adopted the People's Charter for Health, which outlines the global health crisis, details six principles and then sets out a call to action. Most of the content for this Charter is derived from the 'Health For All by the year 2000' document but in addition, it calls for radical change in global trading patterns and relationships and clearly points to the practices of multinational companies as a threat to health. Debate at the assembly suggested three main reasons for the maintenance of global inequities and these are further elaborated on in the article. The overall aim and goal of the assembly is to establish a world where health for all is a reality rather than a receding dream. The author offers three areas in which action is needed to reverse global inequities. The author suggests that opportunities (individual and through professional associations) should be taken to lobby governments about the need to tackle inequities and improve national and global public health governance. The author suggests the presentation of the complete differences in health status between rich and poor countries as both a human rights and public health mockery.

Benatar SR. (2002) Reflections and recommendations on research ethics in developing countries. Soc Sci Med 54(7): 1131-41

The author starts by highlighting the disparities in health care, health expenditure and health status geographically with the poorest countries bearing a disproportionately large burden of disease mainly from preventable diseases. A critical reassessment of the traditional ethical practices of informed consent is done highlighting the shortcomings of these approaches and some other often overlooked questions pertaining to the information, power and resource asymmetry between the research subject and the researchers. A wider role is proposed for research ethics committees, one that includes an educational component taking into consideration the rights of the participants. It is proposed that new ways of thinking are needed about the role of research ethics in promoting moral progress in the research endeavour and improving global health.

Bloom BR. (1999) The Wrong Rights: We Need Rights To Prevention, Not Just Payments, Newsweek 10/11/1999

Bloom notes that half of the two million deaths that occur in the United States each year are preventable. He singles out tobacco use, unhealthy diet and inactivity, alcohol, infectious diseases, firearms, and accidents as the leading preventable causes of death. The cost of prevention would be only a few cents out of each dollar spent on health care. He comes up with a bill of rights that is made up of 6 components namely: the right to information, mother and infant care, teenage counselling, childhood immunisation, health screening and the right to a healthy environment. Bloom argues that investing a small percentage of the trillion dollars currently spend on medical care into enforcement of these rights would save billions of dollars in medical costs and result in a dramatic improvement in the well-being of the society.

Braverman P Tarimo E. (2002). Social inequalities in health within countries: not only an issue for affluent nations. Soc Sci Med 54:1621 - 1635

The article starts by giving a background on the widening health inequalities within low, middle and high-income countries. Within these countries there is gross inequality by ethnic or racial group and also for rural versus urban dwellers. The concept of equity in health is explored. The authors argue that pursuing equity in health can be understood to mean striving to reduce avoidable disparities in physical and psychological well-being—and in the determinants of that well-being—that are systematically observed between groups of people with different levels of underlying social privilege, i.e., wealth, power, or prestige. They also argue that many countries are finding it difficult to implement and sustain equity-promoting policies in sectors with major influences on health in the face of powerful global economic, social, and political trends. The conclusion explores the role of international agencies, which can undermine or strengthen national efforts to achieve greater equity.

Braverman P, Gruskin S. (2003b). Poverty, equity, human rights and health. Bull World Health Organ 81(7): 539-45

The interrelationship between poverty, equity and human rights has been insufficiently examined. The article explores the concepts of poverty, equity and human rights in relation to health and to each other. The link between poverty and health is bi-directional with material deprivation resulting in poor health and conversely, poor health resulting in poverty. Equity in health is concerned with eliminating health disparities that are systematically associated with social disadvantage and marginalisation. Five ways are suggested in which health institutions can deal with the problem of health within a framework encompassing equity and human rights. The authors suggest that using a human rights framework to consider both poverty and equity can provide unique, valuable and concrete guidance for actions of national and international health and development organisations.

Bryant JH, Khan KS, Hyder AA (1997). Ethics, equity and renewal of the WHO's health-for-all strategy. World Health Forum 18: 107 – 115; discussion 116-60

This is a discussion of the new health for all strategy advocated for by WHO. The authors argue that with the change in the understanding of medical ethics and disease patterns, the new health-for-all strategy must give prominence to the consideration of equity, utility, equality, and human rights. In order to attain justice, the equilibrium between equity and equality should be maintained. The principles of primary health care contained in the WHO's Alma-Ata Declaration also need to be strengthened to place proper emphasis on the need for information systems, decision-making mechanisms, and support systems. The most important activities the WHO is applying to its effort to renew its "health for all" strategy are 1) clarifying the concepts; 2) strengthening links to related fields; 3) working in partnership with countries, regions, and organizations; and 4) promoting the dissemination of information and ideas. The WHO's renewed strategy must bring clarity, practicality, and effectiveness to global health activities while fostering an understanding of the moral and human rights issues that contribute to human well-being.

Burris S. (2002). Introduction: Merging law, human rights, and social epidemiology. *Journal of Law, Medicine and Ethics* 30:498-509

Previous research has shown the nature of the relationship between social conditions and health. The author suggests that the law also operates in complex ways to structure the functioning of a population and ultimately impacting on the health of the population. The author of this article gives a brief overview of the link between human rights and health as identified by Mann et al. An assessment is done on the link between health, human rights and the law. The author assesses the effects of laws and legal practice on health and the circumstances under which "law reform and human rights advocacy are effective political strategies for health".

Buthelezi G, Barron P, Makhanya N, Edwards-Miller J. (1997). Measuring the move towards equity. From the site of service delivery. Results for the nine provinces. Health Systems Trust, Durban

This research was done across the nine province of South Africa. The overall aim of the research was to evaluate the quality of service provision rendered at the primary level in South Africa, and to describe any major differences between provinces and between rural and urban / peri-urban parts of the country. A total of 160 clinics, 3 from every region of each province in South Africa were visited. 71 were rural, 39 peri-urban and 50 urban. A questionnaire was used to collect information. The key indicators that were recorded were: infrastructure, workload, support, equipment, drug availability, emergency referral, management of sexually transmitted infections, tuberculosis services, integration of services and antenatal care. The results indicate general deprivation in the rural clinics. The authors hope that this rapid appraisal will provide useful information for improving the quality of primary health services. Furthermore, it is planned that this study will be repeated, so as to monitor the improvements, and thereby measure South Africa's move towards equity in primary health service provision thereby realising people's right to the highest attainable standard of living.

Braveman P Gruskin S. (2003a) Defining equity and health. J Epidemiol Community Health 57:254 - 258

This is a conceptual discussion whose objective is to propose a definition of health equity to guide operationalisation and measurement, and to discuss the practical importance of clarity in defining this concept. Equity in health can be—and has widely been—defined as the absence of socially unjust or unfair health disparities but the authors suggest a new definition that entails the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different positions in a social hierarchy. The often-confusing differentiation of equality from equity is discussed. The authors suggest that while equity and equality are distinct, the concept of equality is indispensable in operationalising and measuring health equity.

Cherry M. (1999) South Africa reveals plans to make AIDS a notifiable disease. Nature 399:288

In 1999, South Africa's then Minister of Health, Nkosazana Dlamini Zuma, proposed that AIDS should be made a notifiable disease in the country, a move intended to help reduce the spread of the HIV epidemic. She announced the proposals at a joint meeting with the health ministers from Namibia and Zimbabwe and further commented that governments cannot afford to be dictated to by human rights or AIDS activists regarding the issue of HIV/AIDS. She said it was high time AIDS started being treated as a public health issue like TB and not with secrecy. This suggestion has however, ignited discussion about the rights of people living with HIV/AIDS.

Chowdhury Z, Rowson M. (2000). The People's Health Assembly: Revitalising the promise of 'Health for all.' Br Med J 321:1361 - 1362

The Alma Ata declaration signed in 1978 by 134 health ministers from around the world, set a deadline for the year 2000 for achieving health for all. The strategy to achieve the goal would be the implementation of primary health care, with its emphasis on community participation, and tackling the underlying causes of diseases, such as poverty, illiteracy, and poor sanitation. The People's Health Assembly convened to discuss the failure to achieve "Health for All," and plan what to do next.

Dollar D. (2001). Is globalisation good for your health? Bulletin of the World Health Organisation 79:827-833

The author notes that there has been increasing globalisation in the past decade. This is also associated with an increase in international travel. The relationship between globalisation and income in poor countries is discussed with particular emphasis on the role of globalisation in poverty reduction. The author discusses the adverse health effects of globalisation but argues that these problems are present in countries that are weak or strong globalisers and therefore cannot be attributed to globalisation. The author argues that globalisation can increase the incomes of poor people leading to improvements in health.

Farmer P. (1999). Pathologies of power: Rethinking health and human rights. Am J Public Health 89: 1486-1496

The author suggests that focusing on the purely legal view of human rights will obscure the dynamics of human rights violations. Analysis from other disciplines has revealed that human rights violations are a result of what the author calls "pathologies of power." This implies that social inequalities based on race or ethnicity, gender, religious creed, and social class are the motive force behind most human rights violations. The author argues that violence against individuals is usually embedded in entrenched "structural violence". The author suggests a rethinking and a new approach on the subject of health and human rights, in order to be able to live up to the challenge of promoting the highest possible level of health for all

Farmer P (2001). The major infectious diseases in the world- to treat or not to treat? N Engl J Med. 345:208-10

This is an editorial in which the author notes that the majority of the patients with multi-drug resistant TB throughout the world are not receiving effective therapy. The often-cited reason is the limitation in resources. The author discusses the fact that these patients suffer because they are unfortunate enough to live in impoverished countries with the universal assumption that multi-drug resistant TB is treatable in some settings and not in others. The author discusses the excuses that are often raised for not bringing life-saving drugs to resource poor settings such as lack of sustainability and the lack of appropriate technology. The author also highlights the need to increase access to all people with all medical advances.

Fassin D, Schneider H. (2003). The politics of AIDS in South Africa: Beyond the controversies. Br Med J 326(7387): 495-7

South Africa has an estimated five million people infected with HIV, which is the highest number of infected people in the world. The author discusses the three social factors that seem to place South Africa at a higher risk of HIV. The three factors that the author elaborates on are: social inequalities in income and employment status; mobility and lastly; sexual violence whether by known or unknown perpetrators, in commercial or conjugal sex. The complexity of the South African situation in relation to these three factors is discussed.

Frerichs RR. (1995) HIV winners and losers. Epidemiology 6(3): 329-31

The author describes man and scientists' relentless efforts to curb the HIV/AIDS pandemic as well as the various challenges that are met on the way related to the biological characteristics of the virus such as mutations, as well as adverse human behaviours such as avoidance of voluntary counselling and testing, resulting in the rapid spread of the virus in ignorance. The author argues that for humans to become winners in the race for survival there is need to do more to empower people to protect themselves from HIV by various means such as the development of a vaccine, the development of female microbicides and the regular use of condoms. The author also advocates for widespread testing and the change of people's attitude toward HIV positive people.

Geffen N. (2001). Applying human rights to the HIV/AIDS crisis. Human Rights Dialogue Spring/Summer 2001:13-14

A description is given of how in the United States and Europe, people with HIV/AIDS are living longer, healthier lives primarily because of the availability of antiretroviral treatment. This is contrasted to the developing world, where there is a high death rate due to the absence of life saving drugs. The author describes how they are using a human rights framework as the fundamental basis of advocacy for social justice on the issue of obtaining the drugs necessary to sustain life targeting both the domestic and the international levels. An example of the legal battle that took place in South Africa to force the government and pharmaceutical companies to recognize and adhere to basic rights, such as the right to health care, that are enshrined in the South African constitution is discussed.

Gilson L, Mills A. (1995). Health sector reforms in Sub Saharan Africa: lessons of the last 10 years. Health Policy Apr-Jun 1995; 32(1-3):215-43

The authors explain that health sector reform has occurred in many Sub Saharan African countries and various forces such as the international policy environment initiated this. The authors review two of the strategies that have been implemented by governments and these are the reforming of the financing strategies and the change of public sector organisation and procedures. To assess the impact and the experiences associated with these reforms the authors used two criteria of efficiency and equity. They finally present lessons learnt from the reform experience.

Haywood M, Allman D. (200) Confronting AIDS: Human rights, law and social transformation. Health and Human Rights 5: 1 149-179.

The authors try to explain and describe the main features of the campaign for human rights during the HIV/AIDS epidemic. They emphasize the importance of using human rights approaches in an effort to fight HIV/AIDS. They argue that in many countries HIV infection is being fuelled by poverty and inequality. They describe in detail the role of a human rights approach to combating HIV/AIDS and the evolution of this paradigm with time.

Jacobson PD, Wasserman J. (2001). Missing in action: The public health voice in policy debates. (Editorial). Journal of Public Health Management and Practice 7(3): ix-x.

The authors explain from their experience how they have noticed that opinions, advice and knowledge from public health professionals seem to be absent, ineffective or insignificant in state level policy making debates. They discuss why this is so and suggest ways to correct this.

Jacobson PD, Soliman S. Co-opting the health and human rights movement. Journal of Law, Medicine and Ethics 30:705-715

Authors note that public health efforts to improve the community's health may violate human rights. The authors use the United States perspective of individual civil rights and discuss how public health impacts on these. The authors also examine the implications of using human rights and law to advance public health using various examples such as tobacco control and

gun control. They explore the question of where the balance has to be drawn between individual rights and community rights.

Kanaaneh H, McKay F, Sims E. (1995). A human rights approach for access to clean drinking water. Health and Human Rights 1(2): 190-204

In this case study the author describes how in northern and central Israel are about 70 villages that are not recognized by the state of Israel and at least half of these villages are not connected to the national drinking water networks and lack sufficient quality and quantity of water. There are many outbreaks of diseases associated with contaminated water supply that have occurred, as well as substantial environmental distress. It was an outbreak of hepatitis A that led to the cooperation of a public health physician, a nurse, an environmental engineer, and a human rights lawyer to successfully take a case to the International Water Tribunal to get access to safe drinking water for these communities. "This case study provides a model for cooperation between proponents and practitioners of health and human rights."

Kruger N. (1994). Epidemiology and the web of causation: Has anyone seen the spider? Soc Sci Med 39:887-902.

Currently accepted terms in modern epidemiology are 'multiple causation' and the 'web of causation.' The author argues that the term 'web' remains widely accepted but poorly elaborated, reflecting in part the contemporary stress on epidemiologic methods over epidemiologic theories of disease causation. In this discussion the author discusses the origins, features, and problems of the 'web'. She poses the question of the whereabouts of the putative 'spider,' and examines several contemporary approaches to epidemiologic theory, including those that stress biological evolution and adaptation and those that emphasize the social production of disease. "To better integrate biologic and social understandings of current and changing population patterns of health and disease, the essay proposes an ecosocial framework for developing epidemiologic theory. Features of this alternative approach are discussed, a preliminary image is offered, and debate is encouraged".

Kruger N, Birn AR. (1998). A vision of social justice as the foundation of public health: commemorating 150 years of the spirit of 1848. Am J Publ Health 88:1603-1606.

The author describes how in 1948 popular uprisings and movements around the world were advocating for social justice and political and economic democracy. In the same year the 1848 Public Health Act was passed in Great Britain. This act authorized a newly created General Board of Health to establish local boards to deal with water supply, sewerage, and control of offensive trades, as well as to institute surveys and investigations of sanitary conditions in particular districts. The author argues that social justice is the foundation of public health and that public health is a public matter. Societal patterns of disease and death can give rise to debates and possible research hypotheses and also help uncover ideologies and policies that contribute to or even expand social inequalities in health.

Leon DA, Walt G, Gilson L.(2001) recent advances: International perspectives on health inequalities and policy. Brit Med J 322:591-594

In this article the authors give an overview of the current debates around inequity, inequalities, poverty, and health, drawing together current international understandings of the problem. They highlight issues that reflect the complexity of the scientific, conceptual, and policy issues inherent in addressing the issues of poverty, inequality, and health. They suggest that to be effective, action must be rooted in better understanding of the full scope of current knowledge.

Loewenson R. (2001). Globalisation and occupational health: a perspective from Southern Africa. Bulletin of the World Health Organisation 79: 863-868

The author describes globalisation and its impact on employment trends and including employment for women. There is further discussion on the new occupational hazards that are associated with globalisation particularly linked to the expansion of electronic, chemical and biotechnology industries. There is examination of the response of public health and health policy to these new challenges.

Lomas J. (1998). Social capital and health: Implications for public health and epidemilogy. Soc Sci Med 47:1181-1188

The author discusses the fact that societal organisation, interaction and association are probably the most important determinants of health. Therefore importance must be placed on the role of our social systems in shaping health. The author highlights the importance for researchers to look beyond the individual and also “their communities, their networks, their workplaces, their families and even the trajectories of their life”. The discussion also looks at how modifying disintegrating social structures impacts on health.

London L. (2002a). Human rights and public health: Dichotomies or synergies in developing countries? Examining the case of HIV/AIDS in South Africa. Journal of Law, Medicine and Ethics 30:677-691

The author uses case studies of various policy responses to HIV/AIDS in South Africa to try to answer the question of whether human rights can be used as a tool for equity and to explore the link between human rights and health. The author also applies a framework for analysing the response to the various HIV/AIDS issues and indicates that there is a synergy between health and human rights

London L. (2002b). Ethical oversight of public health research: can rules and IRBs make a difference in the developing countries? Am J Public Health 92:1079-84

The author suggests that ethical review of public health research must find ways to recognize the agency of vulnerable individuals, groups, and communities in the review process if it is to address effectively the ethical dilemmas currently evident in collaborative international research. The author suggests a different approach to the traditional ethical perception of vulnerability, which is based on the inability or incapacity to make independent

decisions and yet ignores the researcher-subject relationship and community agency. The author also discusses the concept of vulnerability of governments in developing countries due to the process of globalisation and the implications for public health research.

Mac Farlane S, Racelis M, Muli-Musiime F. (2000). Public health in developing countries. Lancet 356 (2000): 841-846

The authors discuss the effects of poverty in excluding people from the benefits of health-care systems and restricting them from participating in decisions that affect their health. They note that in many countries the incidence of poverty has declined, but the absolute numbers of poor people have increased and disparities in their share of resources are becoming greater. They suggest that there is need for enabling people to play a more active role in matters relating to their health and for this to happen, there needs to be worldwide intersectoral commitment that enables people to organise freely around their interests and to support their health initiatives.

Marchand S, Wickler D, Landesmann B. (1998). Class, health and justice. Millbank Quarterly 76:449-468.

The authors highlight that although the link between social class and health status has been fully documented, the precise nature of the injustice has not been made clear. Four alternative views are presented, corresponding to four goals: "(1) maximizing the sum total of health; (2) equalizing the health status of higher and lower social classes; (3) maximizing the health status of the lowest social class; and (4) maximizing the health status of the sickest individuals in society." The nature of the injustice is further obscured by several theoretical and empirical questions, like the degree and significance of personal responsibility for illness and the relation of the degree of economic inequality to sum total of health.

McIntyre D, Gilsion L. (2002). Putting equity in health back onto the social policy agenda: experience from South Africa. Soc Sci Med. 2002; 54:1637-56

There has been a recent revival of interest in health equity, including consideration of the notions of vertical equity and procedural justice. The authors explore the possible application of these notions within the context of South Africa, regarded as one of the most unequal societies in the world, with its unique history of apartheid. The authors give a description of the effects of the apartheid policies, which promoted differential access to economic and social resources. They analyse the inequities in health in South Africa and the challenges met in trying to achieve the equity goal.

Mc Kinlay JB, Marceau LD. (2000). To boldly go...Am J Publ Health 90(1):25-33

The authors of this paper analyse the state of public health in the United States. They argue that every era has its own distinct health challenges, and those confronting the US today are unlike those plaguing public health a century ago. "Global environmental threats, the disruption of vital ecosystems, planetary overload, persistent and widening social injustice and health inequalities, and lack of access to effective health care will be among our

major challenges in the future". They argue that the perspectives and methods that were developed and that served so well during the infectious and chronic disease eras have limited effectiveness in the face of these newly emerging challenges to public health.

Meyer IH, Schwartz S. (2000). Social issues as public health: promise and peril. *Am J Public Health* 90:1189-91

In this critique the authors address traditional public health research with epidemiology as its dominant field. They highlight the fact that traditional public health does not address public health activism that advocates social change with health being one of the outcomes of interest. Using an example of homelessness as an example of the potential unintended consequences of examining social problems through a health prism. They suggest a broader view to the currently narrow perspective of public health and that the capacity of public health research should be developed to address social problems.

Mooney G, Jan S, Wiseman V. (2002). Staking a claim for claims: a case study of resource allocation in Australian Aboriginal health care. *Social Science and Medicine* 54: 1657-1667

The vast differences in health between indigenous and non-indigenous Australians are noted. The authors discuss the definition and notion of equity. They go on to discuss and assess the financial resource allocation within the system. They hope that "ultimately, achieving this greater clarity and explicitness will also potentially enable resource-allocation decisions, both within and beyond the context of Aboriginal health, to be made more in line with broader policy objectives."

Navarro V. (1999). Health and equity in the world in the era of 'Globalisation'. *Int J Health Services* 29:215-216

The author critically discusses some of the major arguments given for the growth of inequalities in health in the world today. He also questions the "technocratic," "humanistic," or "apolitical" discourse used by most international agencies in their analysis of the growing inequalities, a discourse that obscures the actual causes of this growth: the power relations among and within countries.

Ngwena C. (2000). The recognition of access to health care as a human right in South Africa: Is it enough? *Health and Human Rights* 5(1): 26-44

A right of access to health care services is among the economic and social rights guaranteed by the Constitution of South Africa. Given the jurisprudential novelty of such a right and its dependence on economic resources, however, its realization is likely to be difficult to secure. The article discusses the scope and limitations of the right of access to health care in South Africa. Though the country's courts have yet to develop clear principles for interpreting a right of access to health care services, the more significant obstacles to the full enjoyment of this right are the country's pervasive poverty, gross income disparities, and extremely high burden of disease.

Ray S. (1992). Women and AIDS Support Network: mutual support to change community norms. AIDS Health Promot Exch. 1992(3): 4-6

The author gives a description of the Women and AIDS Support Network (WASN), which was formed, by a group of women in Zimbabwe in June 1989 to improve women's self-esteem and confidence and to bring about changes in attitudes and reactions toward AIDS-related problems. The group is made up of both HIV-positive and HIV-negative women.

Whelan D. (1998) Human Rights approaches to an Expanded Response to address women's vulnerability to HIV/AIDS. Health and Human Rights 3(1): 20-36

The author notes that it is now widely accepted that there are societal determinants of women's vulnerability to HIV/AIDS and these need to be addressed. In this discussion the author analyses the key research on gender and vulnerability including five key policy and program responses. These are:

- Access to HIV-related information, education and skills
- Access to economic resources
- Appropriate services and technologies
- Access to social support

The author uses the contents of the four human rights treaties (ICCPR, ICESCR, CEDAW, CRC) as benchmarks and analyses how each of the five key policy areas results in the promotion or protection of the rights indicated in the four instruments. The author recommends the use of the human rights approach to reduce women's vulnerability to HIV/AIDS.

2. WEBSITES

Anonymous. (2003). Patient responsibilities and rights. South Devon Healthcare NHS Trust. Accessed at <http://www.sdhct.nhs.uk/info/patientinfo.htm> on 15 January 2005

On this web page, the aim is to make people get the most out of the National Health Service in the United Kingdom and this is to be possible if they do know their rights and responsibilities. 10 rights are listed and these include the right to be treated with respect and courtesy among others. Seven responsibilities are also listed and include reasonable behaviour from patients and their relatives and friends and also the responsibility to consider participating in research.

Rights:

- * To be treated with respect and courtesy. To have privacy, confidentiality and dignity respected.
- * Receive clear understandable information about your treatment and care. Ask questions if you are unsure.
- * Know the name of the person treating you and their professional capacity.
- * To be kept informed on waiting times, delays and cancellations.
- * If you desire you can be accompanied by a friend or relative during

consultation or examination.

* You have the right to refuse treatment - the consequences of refusing treatment will be made clear to you.

* To be informed of hospital regulations.

* Provide feedback which will help us improve the quality of care we offer in the future.

* To know what is being written about you at the time it is being written.

* To have access to your health records.

Responsibilities

* We appreciate reasonable behaviour from patients, relatives and friends.

* To provide full information about past or present illness and other health matters which will aid treatment.

* To confirm that you understand the treatment being provided and course of action.

* To follow treatment plans recommended. The patient is responsible for the consequences of refusing treatment or not following professional advice.

* Be considerate to other patients by assisting in the control of noise, smoking and by restricting the number of visitors.

* Notify the appropriate member of staff if you cannot make an appointment - alternative arrangements can be made, benefiting others.

* Consider participating in education, training and research.

The following is a table of some of the Patient Rights Charters in various countries.

Country	Name	Website
France	Charted u Patient Hospitalise	http://www.cherstein.fr/charte/chartepatient.html
United Kingdom	The Patient's Charter for England	http://www.pfc.org.uk/medical/pchrt-e1.htm
Spain	Charter of Rights and Duties of Patients	
Malaysia	Patient's Charter	http://prn.usm.my/edl/patient.html
South Africa	Patients Rights Charter	http://www.hst.org.za/doh/rights_chart.htm
Portugal	Patients' Rights Charter	http://www.dgsaude.pt/carta.htm
Honk Kong	Patients Charter	http://www.ha.org.hk/charter/pceng.htm
Europe	Active Citizenship Network: European Charter of Patents Rights	http://www.activecitizenship.net/projects/europ_chart.htm
Italy	Active Citizenship Network: Italian Charter of Patents Rights	http://www.activecitizenship.net/health/italian_charter.pdf
Germany	Patientenrechtscharta	http://www.bach.de/patientencharta.shtml
Cyprus	Cyprus Patients Rights' Charter	http://www.activecitizenship.net/documenti/Cyprus Charter Patients' Rights.doc

CWGH (2002a). Community health and community participation in health: The Community Working Group on Health. Accessed at <http://www.tarsc.org/prog2.html> on 18 January 2005

The Community Working Group on Health (CWGH) was formed in 1998. The aim was to tackle health issues of common concern. There are about twenty-five organisations in the CWGH. In 2001, the CWGH carried forward its programme of national and district activities to strengthen community health, the primary health care system and the participation of communities in all aspects of health systems, including health planning. CWGH co-operated with government, church, private, non-government and traditional health providers to strengthen the inclusion of community priorities and roles in the health system. The CWGH plans to strengthen its links with other civic networks nationally and regionally, to ensure that health rights are known and recognized and given the priority they deserve

3. CHAPTER IN BOOKS

Chen LC, Berlinguer G. (2001). Health equity in a globalising world. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuyia, M. Wirth, eds., Challenging Inequalities in Health: From Ethics to Action. Oxford University Press, New York:12-23.

The authors highlight the fact that globalisation involves the multidimensional integration of the world economy, politics, culture and human affairs. This integration is changing world health dynamics posing new challenges to the health sector. They review the health dimensions of globalisation such as emerging infections, environmental threats and socio-behavioural pathologies.

Diderichsen F, Evans T, Whitehead M. (2001). The social basis of disparities in health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuyia, M. Wirth, eds., Challenging Inequalities in Health: From Ethics to Action. Oxford University Press, New York:12-23.

The authors discuss the worrying reality of health disparities between and within countries. The authors then draw on a framework that was developed by Diderichsen and Hallquist that delineates the four main mechanisms that play a role in generating health inequity. These mechanisms are social stratification, differential exposure, differential susceptibility and differential consequences. They then describe each of these mechanisms on turn. Finally, given the above mechanisms they suggest a number of entry points for policy interventions or options for redressing the health inequities.

Du Guerney J, Sjoberg E. (1999). Interrelationship between gender relations and the HIV/AIDS epidemic: Some possible considerations for policies and programs. In J.M. Mann, S. Gruskin, M.A. Grodin, G.J. Annas, eds., Health and Human Rights: A Reader. Routledge, New York: 202-215.

The authors note that over 90% of new HIV infections in adults are as a result of heterosexual transmission. The chapter gives a detailed description of how gender relations play an important role in the spread of HIV. They suggest

that in order to combat the epidemic effectively gender analysis should be incorporated in the prevention efforts. This will give a more comprehensive picture of the magnitude epidemic as well as potentially effective strategies.

Evans T, Whitehead M, Diderichsen F, Bhuyia A, Wirth M. (2001). Introduction. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuyia, M. Wirth, eds., Challenging Inequalities in Health: From Ethics to Action. Oxford University Press, New York:12-23.

This is the introductory chapter of the book: Challenging Inequalities in Health: From Ethics to Action. The authors note that in the last 50 years of the 20th century many countries have experienced gains in health status. The authors suggest that these statistics and indicators need to be disaggregated so that the true figures and statistics for the various groups are revealed as in some cases there might actually be a decline in the health status of these groups and this reduction is not indicated in the aggregated statistics. Equity in health is defined and the authors give a commentary of the subsequent chapters in the book that deal with the following themes: how inequity in health is measured, the global patterns of health inequities, poverty and marginalisation, gender, education, social context and social policies.

Freedman LP. (1999a). Censorship and manipulation of family planning information: An issue of human rights and women's health. In J.M. Mann, S. Gruskin, M.A. Grodin, G.J. Annas, eds., Health and Human Rights: A Reader. Routledge, New York: 145-179.

This Human Rights Report points out how States often censor, manipulate or control information regarding reproductive health. The author describes the essential features of sexual and reproductive health rights. The article gives an analysis of Reproductive Health Policies from various countries. The role of contraception and abortion as well as how information can be manipulated either to deny or to impose these services is explored. The author concludes the report by noting that women should be allowed to make decisions regarding reproduction based on accurate, full and appropriate information.

Freedman LP. (1999b) Reflections on emerging frameworks on health and human rights. In J.M. Mann, S. Gruskin, M.A. Grodin, G.J. Annas, eds., Health and Human Rights: A Reader. Routledge, New York: 227-252.

The author describes how both public health and human rights are potentially powerful tools that can either advance human well-being or at times can result in the maintenance of the status quo or the reinforcement of existing hierarchies. The author suggests that in order to advance human well-being, there is a need to rebuild the understanding of health, human rights and human well-being.

Gilson L, McIntyre D. (2001). South Africa: Addressing the Legacy of Apartheid. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuyia, M. Wirth, eds., Challenging Inequalities in Health: From Ethics to Action. Oxford University Press, New York:12-23.

The authors review the inequity in health and the poverty that existed in South Africa during the apartheid era. They then provide an overview of inherited

health inequities and an exploration of the influence of socio-economic factors over this pattern. They analyse the potential impact of the government's macroeconomic framework called: Growth, Employment and Redistribution (GEAR) strategy. They address the questions of how GEAR might affect household health and health inequity.

Gostin L, Mann JM. (1999). Towards the development of a Human rights impact assessment for the formulation and evaluation of public health policies. In J.M. Mann, S. Gruskin, M.A. Grodin, G.J. Annas, eds., Health and Human Rights: A Reader. Routledge, New York: 54-71.

The authors explain how public health policies can result in the violation of human rights if they are not well thought-out within a human rights framework. The authors propose a seven-step impact assessment tool that helps in the evaluation of the effects of public health policies on Human Rights. The aim is to achieve the optimum balance between public health outcomes and at the same time avoiding the violations of human rights.

Gruskin S, Tarantola D. (2002). Health and Human Rights. Chapter 4.1, In J Last ed. Oxford Textbook of Public Health. Oxford University Press, New York:311-335.

This chapter describes how health and human rights were fields that were developing in parallel and were thought to be distinctly separate and sometimes even antagonistic until a few years ago. The HIV/AIDS pandemic put these two in the limelight and demonstrated the synergism between them. The United Nations has shown its commitment to the development of the field by paying more attention to it and increasing the resources that are required for the implementation of health and human rights in its various departments. The authors explain in detail the international and the regional human rights instruments that are relevant to health and the monitoring mechanisms in place.

Peter F, Evans. (2001). The ethical dimensions of health equity. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuyia, M. Wirth, eds., Challenging Inequalities in Health: From Ethics to Action. Oxford University Press, New York: 24-33.

The authors start by discussing the concept of health and state that health is "not simply a biological norm but the product of complex social and biological valuations". They discuss the distinction between health equity and health inequalities. They suggest that the fundamental question for assessing health equity is how to decide which social inequalities in health are unfair and hence constitute inequities.

4. HUMAN RIGHTS INSTRUMENTS

The International Covenant On Economic, Social And Cultural Rights (ICESCR)

Adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) of 16 December 1966. UN Commissioner

for Human Rights, Geneva. Available at
http://www.unhcr.ch/html/menu3/b/a_cescr.htm
The ICESCR entered into force on the 3rd of January 1976

International Covenant On Civil And Political Rights (ICCPR)

Adopted and opened for signature, ratification and accession by the General Assembly resolution 2200A (XXI) of 16 December 1966. UN Commissioner for Human Rights, Geneva. Available at
http://www.unhcr.ch/html/menu3/b/a_ccpr.htm
The ICCPR entered into force on the 23 March 1976

International Convention On The Elimination Of All Forms Of Race Discrimination (ICERD)

Available at: <http://www.iwtc.org/ICERD.html> The ICERD entered into force on 4 January 1969.

Convention On The Elimination Of All Forms Of Discrimination Against Women (CEDAW)

Available at: <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>. Adopted in 1979 by the UN General Assembly and entered into force on 3 September 1981.