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Patients' Cultural Rights in the Clinical Context

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Abstract

This paper is located within two important theoretical discussions in human rights, namely: (i) the view that human rights are indivisible and that, as a consequence, one cannot separate human rights related to health, for example, from those related to politics, civil rights or culture; and (ii) that, within this theoretical position, cultural rights have a privileged position as rights with a transversal or cross-cutting character: in other words they are implicated in many if not most situations where human rights are involved. In this paper, these two theoretical positions are explored through the example of cases where cultural rights operate within the clinical setting, one in relation to the treatment of patients with HIV/AIDs and the other in relation to the language rights of patients in a multi-lingual environment in Africa. In both cases, the relationship between human rights and development is an important context of the discussion and one in which it will be placed.

Keywords

Right to Health, Cultural Rights, Transversal Human Rights, Sustainable Development

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Introduction

First, it is of interest that none of the talking points provided for the session in which this paper was delivered referred to the role of cultural rights, a fact that matches the general neglect of this set of rights by Governments and most HR theorists[1]. For example, when fulfilling their reporting obligations under the International Convention on Economic, Social and Cultural Rights (ICESCR, 1966), States Parties rarely make reference to cultural questions. Certainly, these represent a challenging set of rights, both theoretically with regard to issues such as relativism and collective rights and also practically, in view of the fear of many governments that they may encourage secessionist ambitions of cultural minorities.[2] With regard to the right to health which represents the other main human (social) right under examination here, it is useful here to remind ourselves of what elements constitute this right.[3] These can be divided into the following general categories:

1. Equal access to the available prevention, treatment and healthcare services;

2. Specific issues such as right to privacy, right to information and consent issues.

As a general strategic approach, this paper is located within two important theoretical discussions in human rights, namely: (i) the view that human rights are indivisible and that, as a consequence, one cannot separate human

1. Janusz Symonides, 'Cultural Rights,' in Janusz Symonides (ed) *Human Rights, Concept and Standards* (UNESCO 2000).

2. Janet Blake, *Exploring Cultural Rights and Cultural Diversity, With a Compendium of Relevant Human Rights and Other Instruments* (UK: Institute of Art and Law), 2014.

3. Article 12 reads: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

rights related to health, for example, from those related to politics, civil rights or culture; and (ii) that, within this theoretical position, cultural rights have a privileged position as rights with a transversal or cross-cutting character[1]: in other words they are implicated in many if not most situations where human rights are involved. In this paper, these two theoretical positions are explored through the example of cases where cultural rights operate within the clinical setting, one in relation to the treatment of patients with HIV/AIDs and the other in relation to the language rights of patients in a multi-lingual environment in Africa.

The Indivisibility of Human Rights

Several international texts have strongly promoted the indivisibility and equality of all the human rights found in the 1948 Universal Declaration of Human Rights (UDHR) and the 1966 Covenants.[2] One of the most important (and oft-quoted) of these statements is found in paragraph 5 of the Vienna Declaration (1993)[3] and this is often regarded as the classic expression of the equal importance and status of all human rights.

All Human rights are universal, indivisible and inter-dependent and inter-related. The global community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis.

The Proclamation of Tehran (1968) is another of the key contextual documents in which this paper is situated. Despite the date of its adoption, the following points remain surprisingly relevant today:

1. The crucial importance of economic, social and cultural rights to the full realization of all human rights and fundamental freedoms;

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1. Patrice Meyer-Bisch, 'Le droit à l'interdépendance et au développement des libertés' in Johanne Bouchard, Stefania Gandolfi and Patrice Meyer-Bisch *Les droit de l'homme : une grammaire du développement* (Harmattan, 2013).

2. International Covenant on Civil and Political Rights (UN: Geneva, 16 December 1966), online: <http://www.ohchr.org/english/law/ccpr.htm>; International Covenant on Economic, Social and Cultural Rights (UN: Geneva, 16 December 1966), online: <http://www.ohchr.org/english/law/cescr.htm>.

3. World Conference on Human Rights, 'Vienna Declaration of the World Conference on Human Rights' (25 June 1993) at para. 3, online: <http://www.ohchr.org/english/law/vienna.htm>.

2. The fulfilment of all rights as a prerequisite for sound and effective economic and social development policies (at national and international levels).[1]

The Transversal character of cultural rights

Cultural rights are essential to the full realisation of almost all human rights, including the rights to health which has a number of cultural dimensions to it. Claims to cultural rights lie at the heart of the dignity of each human being and, hence, the heart of all human rights and all over the world. Yvonne Donders noted in 2007 that:

Cultural rights are consequently more than those rights that explicitly refer to culture, but include all human rights that protect or promote components of the cultural identity of individuals and communities as part of their dignity.[2]

As such, we can see the essential importance of respecting these rights to fully achieving the right to health since health care services ought to consider the dignity of patients in a variety of ways. In addition to this, the discussion of this paper also takes place within the wider context of the role human rights play in achieving development, especially human and social development of which health is a central plank.

Development, Indivisibility of Rights and Culture

This 'human-centred' view of development is of extreme relevance to the guarantee of social rights (such as the right to health care) since it concerns

1. "12. The widening gap between the economically developed and developing countries impedes the realization of human rights in the international community. The failure of the Development Decade to reach its modest objectives makes it all the more imperative for every nation, according to its capacities, to make the maximum possible effort to close this gap; 13. Since human rights and fundamental freedoms are indivisible, the full realization of civil and political rights without the enjoyment of economic, social and cultural rights is impossible. The achievement of lasting progress in the implementation of human rights is dependent upon sound and effective national and international policies of economic and social development …"

2. Yvonne Donders (2007) 'The Legal Framework of the Right to Take Part in Cultural Life' in Yvonne Donders and Vladimir Volodin (eds) *Human Rights in Education, Science and Culture – Legal developments and Challenges* (UNESCO Publishing 2007) at p.236.

not only the minimal right of 'subsistence'[1] but it also places an emphasis on human capacities or capabilities.[2] It requires that attention be given to people's ability to be active participants in and contributors to society.

One of the conditions that will determine the success of development programmes is the acknowledgement of local cultural specificities and, with regard to the provision of healthcare services, local norms and cultural habits are fundamental to how these should be provided. For example, we cannot discuss health without analysing its sociological and religious aspects. The case of a German colleague at Shahid Beheshti University who is a consultant gynaecologist/obstetrician by training, but teaches in the German Literature Department in our university is a telling one. When I asked her why she no longer practises her medical specialism (she used to see students and staff once a week at the university health centre) she responded that the local cultural factors in dealing with obstetric and gynaecological cases were too difficult for her to deal with.

Languages are also a cultural factor of enormous importance since development programmes can be impeded or even fail if no translation into the local language is available. In addition, culturally inappropriate symbolism or terminology can also be a major obstacle to the success of development projects, especially in the field of sexually-transmitted diseases and infections. Both of these points will be illustrated below.

In order to illustrate more clearly the indivisibility of human rights with regard to both development and healthcare provision, it is helpful, here, to take the example of one of the Millennium Development Goals (MDGs), namely MDG 6: Combat HIV/AIDS, Malaria and Other Diseases. In view of the cross-cutting character of HIV/AIDS as a human rights issue which implicates not only economic and social rights but also cultural, civil and even political ones too. Through an analysis of this, we can provide a means of clarifying the interrelated character of all human rights. In order to do this,

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1. As the social rights of the ICESCR are sometimes understood. See: Brian Orend (2002) *Human Rights: Concept and Context* (Broadview Press, Ontario) at p.139.

2. See, for example, John M. Alexander 'Capabilities, human rights and moral pluralism,' (2005) 9(1) *International Journal of Human Rights* 451-469; and Appadurai, Arjun (2004) 'The Capacity to Aspire: Culture and the Terms of Recognition' in Vijayendra Rao and Michael Walton (eds.) *Culture and Public Action* (The World Bank and Stanford University Press).

I set out briefly below the rights in both the International Covenant on Civil and Political Rights (ICCPR, 1966) and the ICESCR (1966) that are implicated in combating HIV/AIDS (and other communicable diseases).

First, if we look at the rights guaranteed in the ICCPR (1966)[1] there are several rights relevant to this question, in particular the rights to:

- Non-discrimination and equality;
- Privacy;
- Freedom of information;
- Family life;
- Life itself.

In the ICESCR (1966)[2], we can find several relevant rights related to:

- Non-discrimination and equality;
- Freedom to work;
- Social security;
- Special protection for mothers and children;
- Access to basic health care/services;
- Education;
- Enjoyment of the benefit of scientific advances.

What is most striking when one conducts such an analysis is not only that are there a number of civil and political rights that one can associate with the prevention and treatment of HIV/AIDS, illustrating the indivisibility of human rights, but also the range of economic, social and cultural rights beyond simply the right to health that are implicated.

The Importance of Cultural Rights in Health Care - Two Illustrative Cases

In this section, I hope to develop and illustrate the more conceptual approach that I have set out above through two illustrative cases, namely:

1. How we can address cultural diversity within the healthcare system;
2. Language rights in health care provision.

Before I do so, however, it is useful to remind ourselves of the rights that are of relevance to this discussion and these specific cases, all of which are found in the 1966 ICCPR and ICESCR.

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1. International Covenant on Civil and Political Rights (UN: Geneva, 16 December 1976), online: <http://www.ohchr.org/english/law/ccpr.htm>.

2. International Covenant on Economic, Social and Cultural Rights (UN: Geneva, 16 December 1966), online: <http://www.ohchr.org/english/law/cescr.htm>.

Article 27 (ICCPR)[1] ascribes the right to persons belonging to linguistic minorities to use their own language, including in their dealings with public and administrative services. Importantly, this article moves beyond a simple guarantee of non-discrimination towards the more positive notion of preserving and linguistic, religious or ethnic identity. As noted by Thornberry, the use of mother tongue languages of minorities is increasingly encouraged in the court system (where interpretation should be provided if not), administrative system and health care.[2]

Article 15 (ICESCR) is primarily concerned with the right to participate in cultural life which is not directly a health-related right, except as far as this right may actually be dangerous or damaging to health, good health is necessary precondition to be able to do so etc. However, we should remember sub-paragraph (b) of paragraph (1) which asserts the right "[t]o enjoy the benefits of scientific progress and its applications". Among these benefits, it is clear that advances in medical science and technology are some of the most important of these for ordinary people.[3] Article 2 of both the ICCPR and ICESCR[4] calls upon Parties to guarantee all the rights included in those two Covenants; "without discrimination of any kind as to race, colour, sex, language… or other status". Hence, members of ethnic minorities and speakers of minority languages should have full enjoyment of any of the rights in these Covenants. These include such rights as:

- The right to work (Arts. 6-8, ICESCR);
- The right to social security (Art.9, ICESCR);

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1. Art.27 of the ICCPR reads: "In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language."

2. Patrick Thornberry (1991) *International Law and the Rights of Minorities* (Oxford: Clarendon Press) p.197.

3. This provision would, for example, place under question the pricing of essential treatments for AIDS or cancer beyond the means of the healthcare services of poorer countries.

4. "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

- The right to family life (Art.10, ICESCR);
- The right to health (Art.12, ICESCR);
- The right to education (Art. 13, ICESCR);
- The right to participate in cultural life (Art.15, ICESCR);
- The right to a fair trial (Art.14, ICCPR);
- The right to freedom of expression (Art.19(2), ICCPR);
- Right to take part in public affairs and have access to public service in his country (Art. 25, ICCPR).

1. Cultural Diversity in Health Care and Protecting Individual Rights

The conundrum as to how and when to draw a line between those cultural practices acceptable to human rights (and their related cultural diversity) and those that are deemed to be in contravention of these standards is not only found in relation to cultural diversity and heritage. It can also be seen in other areas, in particular with regard to health care since many such cultural practices involve inflicting some form of bodily harm.[1]

If we seek to take a more positive view of the role culture can play in healthcare provision, a diversity based approach (DBA) can be recommended. This is one that uses culturally sensitive practices in health and social care services and, hence, respects the diversity in and among different cultural groups. It also recognises the fact that non-egalitarian and racist power relationships can harm people's health. In their article on the DBA in healthcare, Chau, Yu and Tran explore the experience of Chinese people living in the UK in order to demonstrate how a better understanding of the diversity of ethnic minority groups could strengthen cultural sensitivity in the delivery of health services.[2]

Their research notes the important point, however, that an approach that may be positive for the group as a whole may not sufficiently respect the rights of individual members; in other words, not all approaches to culturally sensitive practices are sensitive to the diversity of members of the same ethnic minority group. This question is addressed with regard to a child's right to health as guaranteed under Article 24 of the United Nations

1. Female genital mutilation is the obvious case, although there are many other candidates, including tribal scarring and even male circumcision.

2. Ruby C.M. Chau, Sam W.K. Yu and Cam T.L. Tran (2011) 'The diversity based approach to culturally sensitive practices,' (2011) 54(1) *International Social Work* 21-33.

Convention on the Rights of the Child (1989) by Tobin in his examination of the drafting of this article.[1] Article 24 reads:

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services… .

3. *States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children*. (Emphasis added)

As he notes, in seeking to formulate an article that addressed the health-related rights of children, the drafters came up against "the constant and at times seemingly irresolvable dilemma that characterises international human rights law - the need to accommodate and respect cultural differences and at the same time protect the internationally recognised rights of individuals".[2]

This, in turn, raises the question as to which traditional practices should be outlawed by Article 24. A Report prepared by the Economic and Social Council of the UN (ECOSOC) in 1986 attempted to respond to this and listed the following practices as unacceptable: "female circumcision, other forms of mutilation (facial scarification), forced feeding of women, early marriage, the various taboos or nutritional practices which prevent women from controlling their own fertility, nutritional taboos and traditional birth practices."[3] In applying Article 24, the Committee on the Rights of the Child (CRC) has included in a list of those practices which raise concern the following: virginity testing, food taboos, consanguineous marriages, extraction of milk teeth, selective abortions, traditional medical practices and traditional practitioners.[4]

As is always the case when addressing the challenges of respecting diversity of cultural traditions within a human rights framework, some

1. John Tobin (2009) 'The International Obligation to Abolish Traditional Practices Harmful to Children's Health: What Does It Mean and Require of States?' (2009) 9(3) *Human Rights Law Review* 373-396.

2. *Ibid* at p.374.

3. Report of the Working Group on Traditional Practices affecting the Health of Women and Children (E/CN.4.1986/42.

4. See: Tobin *op.cit.* n.19 at p.381 for further details.

difficult questions arise, such as: Who should make such a determination? Does this betray a 'western' prejudice against non-western practices? Certainly, the origins and continued practice of most of the aforementioned cultural traditions lies almost exclusively within non-Western cultures. As Tobin notes, this would appear to demonstrate a "tendency to condemn non-Western cultural practices and condone or overlook the deeply embedded traditional practices within Western cultures that may also be harmful to the health of children".[1] He cites as a counter-example to this the treatment by the CRC Committee of corporal punishment, a practice deeply embedded in many Western countries, as one that confirms this concern since the level of condemnation for this has been much less.

Of course, the decision as to what amounts to a "harmful" cultural tradition will inevitably be influenced by cultural values and other subjective considerations, such as the construction of gender. Hence, to focus too heavily on the bio-medical impact of any traditional practice without giving sufficient importance to the cultural and social context in which that practice takes place would be inadequate. This does not mean that States must adopt an entirely relativist notion in identifying the harm to a child's health, but it does carry significant consequences in terms of (a) the extent to which harmful traditional practices can be identified within a particular community and (b) the choice of measures to ensure abolition of their harmful effects.

As a general approach towards such challenges, then, we can recommend a multifaceted approach that is designed through dialogue with the communities that tolerate harmful practices (including female genital mutilation). This should be aimed at achieving the effective elimination of such harmful practices. Such a participatory policy approach is not only more likely to be effective and socially sustainable, it is also necessary if we wish to avoid imposing external values.

2. Using local languages and culturally-appropriate messages in health care

It is an obvious point that language is a central feature of many if not most clinical activities: For people to enjoy good health, they need to have access to health services such as medical tests, drugs, health education etc.

1. *Ibid* at p.382. See also: Sonia Harris-Short (2002) 'Listening to 'the other'? The Convention on the Rights of the Child' (2002) 2 *Melbourne J. International Law* 304-352 who argues that agreement on 'culturally legitimate' universal standards should be possible, despite culturally relativist positions.

and health services are provided through some linguistic media.[1] This being the case, there is a need to take a serious consideration of how the language factor impacts on the delivery of health services in multilingual countries such as Botswana where up to 80% of the active adult population have contracted HIV.[2] The importance of language in clinical services is succinctly put in the following observation by Cameron and Williams:[3]

Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences.

The ideal situation - both clinically and from a human rights perspective - is clearly to have clinical encounters conducted in a language understood by both the clinician and the patient. This, however, is not always the case in many clinical contexts, including those in sub-Saharan Africa.[4] For example, a patient may come across a local doctor with whom s/he does not share a common language or even an expatriate doctor[5] who does not speak a local language. The patient, if they are lucky, will know sufficient English to be able to communicate through that medium (up to a point) with the local or expatriate doctor. However, some expatriate health services personnel may

1. For a general discussion of language-related rights, see: T. Skutnabb Kangas and R. Phillipson (eds.) (1995) *Linguistic Human Rights: Overcoming Linguistic Discrimination* (Mouton de Gruyter, Berlin).

2. For this discussion of language use and health care, I draw on the excellent work on language, health and human rights of Professor Gregory Kamwendo a linguist at the University of Botswana. See: G.H. Kamwendo (2004) *Language Policy in health Services: A Socio-linguistic Study of a Malawian Referral Hospital* (Institute for Asian and African Studies, Helsinki).

3. R. Cameron and J. Williams (1997) 'Sentence to tent cents: a case of relevance and communicative success in non-native–native speaker interactions in medical settings,' 18 (4) *Applied Linguistics* (1997) 416-445 at p.419. Cited in Kamwendo *op.cit.*n.16.

4. Kamwendo *op.cit.* n.25.

5. Usually working for an international NGO such as Doctors without Borders.

not even be able to communicate effectively through English, such as in the case of Taiwanese medical personnel working in Malawi. To make matters worse, interpretation is not always provided by competent people[1] and so the quality of the language service may not be satisfactory, resulting in a far from satisfactory clinical outcome.

To underline the prominent place played by language not only in clinical encounters but, more importantly, in protecting a patient's right to health, is the startling case of a fifty-six-year old Turkish woman who was refused a heart transplant by a clinic in Hanover (Germany). The decision to refuse her the transplant was language based. Since she did not speak German the hospital feared that the "patient might not understand the doctor's orders, might take the wrong medicine and might not be able to get help if there were complications".[2] Here, the decision taken was that, whenever there was no bridging language between a patient and his/her doctor(s), no operation should be carried out. This decision amounts to having an institutional language policy that, as we have seen, breaches the patient's human right to receive health care on an equal basis with other qualifying patients without any language-based discrimination.[3]

3. Culturally appropriate HIV prevention message

Cultural rights can also be implicated in prevention of illness and preventing the transmission of a disease such as HIV/AIDS. These include conveying a culturally-appropriate message as well as through a widespread local language. As an example of this, Kamwendo cites HIV/AIDS prevention message placed on advertising billboards in Botswana that read: "People say small houses strengthen relationships. But having small houses spreads HIV".[4]

How can "small houses" spread AIDS? In order to understand this, it is necessary to know that, in the context of Botswana; a 'small house' is a man's extramarital affair and signifies a woman who is lower in status than

1. Sometimes medical staff or patients may interpret for other patients, or relatives may also interpret for patients.

2. B.Spolsky (2004) *Language Policy* (Cambridge University Press) at p.1.

3. As guaranteed by Art.2 of the ICESCR with regard to the right to health.

4. G.H. Kamwendo (2008) "But having small houses spreads HIV": problems of language and communication in health services in sub-Saharan Africa,' paper presented to UNESCO/UNU conference on *Globalization and Languages: Building on Our Rich Heritage*, Tokyo 27-28 August 2008.

the legitimate or senior wife. Of course, the term 'small house' is likely to be misinterpreted by anyone who is not familiar with the local context. However, even if the recipients of this message do all understand the reference made in the message English is, unfortunately, not the best medium for communicating with the local audience since most people in only Botswana know and speak Setswana, the national language. Clearly, that would be the best medium for disseminating HIV/AIDS messages in Botswana and reaching both the widest audience and the constituency most in need of hearing it.[1]

Here, then, we see an example of a well-meaning but misguided attempt to get across the HIV/AIDS prevention message through using culturally-appropriate content that will not be as effective as it needs to be since it is delivered in an inappropriate language. In a country such as Botswana where up to 80% of the active adult population have contracted HIV, this is a serious issue with obvious human rights implications.

This example points to another complicating factor when seeking to educate a local population about HIV/AIDS. Although the use of indigenous languages in HIV/AIDS education makes sense in terms of reaching a wider audience, there is a serious lack of culturally appropriate and acceptable terminologies in those languages that the billboard cited above sought to address. This is due in large part to the close association of HIV/AIDS transmission with sexual relations, which is a taboo subject in many African (as with other) societies.[2] Therefore, HIV/AIDS education programmes need to seek ways of overcoming these cultural and linguistic hurdles and it is necessary in every country to consider carefully the terminologies that are currently in use in HIV/AIDS education in order to determine their effectiveness and social acceptability.[3] This is no easy task in a multilingual and multicultural society where ensuring equality of access to the HIV/AIDS education message may prove complicated for the reasons set out above.

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1. Kamwendo *Op.Cit.* n.32.

2. Kamwendo *Op.Cit.* n.32.

3. An interesting parallel can be found with delivering school-based education (as the right to education). Although education through the medium of a local language is, of course, a major step towards responding to the requirements of Art.27 of the ICCPR, having culturally appropriate content is also important (as is made clear in Art.3 of the CRC).

Squaring the circle - the rights to health and development

Coming back to the indivisibility of human rights and the significance of this for reaching the goals of development, we can refer to the aforementioned case of Botswana. The country is a democracy with reasonably good guarantee of civil and political rights (including a relatively freed press) but also has the world's highest incidence of AIDS. As Michael Ignatieff has noted:

All the gains in civil and political rights that have been made there will be wiped out by the catastrophic losses in economic and social rights. At this level of incidence of AIDS, the virus destroys the infrastructure of a society. It cuts into the defences that make civil and political rights possible.[1]

In another example, according to a 2002 report one in six adults in South Africa had contracted HIV and 1,000 people were dying per day of AIDS-related conditions.[2] Despite being one of the wealthiest countries in the region, the South African Government was held by the Constitutional Court on Appeal (in the *Treatment Action Campaign v. Ministry of Health* case, 2002[3]) to have failed in its duty to provide equitable access to health care over its restriction of the use of an anti-retroviral drug Nevirapine (used to prevent mother-to-child HIV transmission) in public health services even though it received the drug free of charge. This Court judgment was based in part on the South African government's international obligations under the 1966 ICESCR.

Clearly, such failures to prevent and treat HIV/AIDS effectively denies many members of a given society, such as in Botswana or South Africa, the ability to function and live full lives along with the related set of human rights.[4] As Shue has noted,[5] "No-one can fully… enjoy any right that is supposedly protected by society if he or she lacks the essentials for a

1. Michael Ignatieff (2001) quoted in *The Economist* in a Special Report on *Human Rights* 18 August 2001 at p.20.

2 Report cited in the *Treatment Action Campaign v. Ministry of Health* case, Constitutional Court of South Africa, Case CCT 8/02, 5 July 2002.

3. *Ibid*.

4. The World Medical Association regards the right to health as one of the fundamental human rights, without which enjoyment of other human rights is often not possible.

5. H. Shue (1996) *Basic* Rights, second edition (Princeton University Press) at p.24.

reasonably healthy and active life…" In addition, the importance of good health for sustainable development is highlighted in a special way by the fact that three out of the eight MDGs (2000-2015) directly addressed health issues. A clear message from this is that there can be no sustainable development when a significant number of people in a society do not enjoy good health. This is especially true of AIDS since the professionally active age group is disproportionately affected by the virus. It is only healthy people that can contribute significantly and meaningfully to national development. Hence, not only are individual human rights severely damaged by serious (and preventable or treatable ill-health) but even the solidarity right to development can be harmed in extreme cases.

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