Our first problem was where to start. Our next problem was where to stop.

To many readers of this magazine, the breadth of our topic “Health as a Human Right” is already apparent. It spans preventive medicine to emergency response. It is everything from an old man’s right to be respected when he reveals his depression to a family doctor in small town Canada, to access to clean drinking water and security of person following an earthquake in Indonesia. It is an individual’s right to reach his or her full potential; it is the health of nations as a tool of liberation. Maybe we waste our breath going on about a connection so obvious.

But consider that the curricula of medical schools are dominated by lessons on pathophysiology. Consider how much more time is spent teaching medical students pharmacology as compared to ethics or sociology or history or anthropology – the disciplines that equip a young impressionable medical student with the tools to see the political context of his or her actions. We medical students could graduate into practice regarding ourselves as little more than highly-paid mechanics who fix what’s broken, then go home to hide in our lovely, entitled lives. Clearly, given the trust placed in us by patients, and the resources society invests in our education, we are honour-bound to adopt a wider construction of the notion of healing.

The articles in this issue of MSI will make this argument again and again. Gaffney’s discussion of colonial medicine, Hassani’s examination of unethical drug trials, Ajibola’s overview of legal mechanisms by which health is and is not upheld as a human right in Africa, and Jacob’s primer on the right to health during emergency response, each provide a look at the social and historical context of health as a human right.

From context we move to action. Rohde tells us of his own work against slavery in Africa. McDonald relates her experience providing abortions to women in Denmark and contrasts it with the situation in her home country of Canada. Dunne shows us two images from her time on a summer placement in Tanzania.

And from work abroad, we turn to work at home, which, to our delight and surprise, formed the bulk of what our authors wanted to talk about. Gilbert tells us about a project to provide health care to vulnerable populations in London; in a similar vein, Zaky writes about issues surrounding the denial of free universal HIV/AIDS treatment in the UK. As a counterpoint to McDonald, Buenaventura gives a graphic illustration of forced female sterility in the Philippines. Ernani writes of her growing awareness of violence against health care workers in Brazil. Tylee invites us to help improve human rights abroad by examining our own purchasing behaviour at home. Finally, Pink and Tittala give us glimpses of awareness-raising through medical education at their home universities in Canada and Finland, respectively.

Entire libraries could, & have, been filled with discussions of health as a human right, so you will undoubtedly find holes in our coverage here. We leave it to you to continue the discussion.

In solidarity,

The Editorial Team of MSI 14
From Mopti, Mali, if you go down to the river’s edge and climb onto an old wooden pirogue, you can ride the River Niger north for three days. Timeless villages stick to the river’s edge. Children stare and wave and play. Commercial boats might pass you in the night. Trade in salt, ivory and slaves has passed along this route for thousands of years. Young men sit on the sides of the boats and throw watermelon rinds over the edge and watch them float away. At night, kerosene and candlelight remind you that African waterways are a paradox, malarial breeding grounds and a chance to stare at an unpolluted desert sky, a time to think and fall asleep floating northwards…

When you get to the ancient river port of Niafunke, head northeast. The bumpy road. Seventeen people piled into the back of a converted Toyota truck with a camper shell. Grandmothers sitting at roadside, colorful head wraps made of desert cloth. Camels blocking the road. All of this will remind you that you are in West Africa. Head toward the center of town. Get off at the circle and enter the timeless beaten walls of Timbuktu. At night, only candlelight shines on the sandy paths; shoes are unnecessary. Round loaves of bread are baked daily in mud ovens, which provide a meeting place at the intersections of each dark alleyway. Children wander these paths where the sand has begun to take over, where the doorways appear to be melting, where you have to step down almost two feet to enter the house of the lineage of healers. Children sing songs, old stories of camel caravans returning with tons of salt from the flats a thousand miles to the north. You can fall asleep knowing many merchants – camel traders, men and women with broad stories – have slept where you are sleeping…

In the morning, a merchant, robed and wrapped. His family lineage represents a thousand year-old history of the Moors from the north trading with the Arabs from the East and coastal tropical Africa from the south. A meeting in the desert. The merchant will undoubtedly invite you to tea, walk you through the markets of women selling onions, tea, spice. He will walk you past the mosques, 800 years old and in need of patching as the mud melts away, a slow erosion each year…

And after you have touched the walls of the narrowest of paths a after you have visited the timeless homes of the first European traders and the Malian chiefs, the kind merchant will take you to his home. Three floors, built of mud. Dark stairways without windows, rooms to store the camels and their small rations. And while sitting on the floor drinking tea, you will watch young African men working in the hot desert sun. One wears old jeans, a Mickey Mouse t-shirt, brown and torn, a sweat-stained head wrap. He mixes concrete, making blocks. Another man softens mud. Another carries the materials to the top of the stairs to begin building the fourth floor.

These young men are slaves, stolen from their homes in the desert, working for nothing. This is the desert reality of human rights.

Awareness, followed by action: this is our job as international medical students. The right to not be enslaved is as fundamental a human right as the right to live without polio, malaria, or schistosomiasis. The trafficking of human beings must be stopped. We are a crucial part of that struggle, that future.

Jesse Rohde
is Disasters and Emergencies Coordinator for IFMSA-USA, and is the Americas Regional Assistant to IFMSA’s Standing Committee On human Rights and Peace.
During the past 16 months, major disasters have happened throughout Asia, Africa, and America. Hundreds of thousands of people have died and millions have had their lives changed. In this difficult time, sometimes the right to health might be neglected. This is understandable since disaster devastates medical facilities as well as creating many victims, and chaotic situations where people tend to put their own safety and comfort above everything. However, this is an obligation for humanitarian agencies and people who are not impacted by the disaster to help and to protect the health rights of vulnerable people.

Citra (23 years) is a medical student who was impacted by Tsunami. She used to live in a tent, where living conditions were inadequate. Citra joined the 500 other IDP (internally displaced people) in the fields, using minimal water and sanitation facilities. However, inadequate temporary latrines, an unclean environment, and overcrowded camp, had to be accepted. However, being a medical student, she aware of the importance of cleanliness and a healthy lifestyle. “Living in this tent is so stressful, I have to wake up early in the morning to line up to shower, and it is very dirty. So many people are using the latrine that they don’t have time to clean it”.

While some settlements are overwhelmed with donated goods and facilities are overwhelmed, in other places IDPs did not receive any help/assistance. This imbalance was caused by poor coordination amongst humanitarian organizations.

These stories are examples of disorganization in the initial phases of an emergency, which leads to the right to health being neglected. We cannot lose sight of what we should have learned from recent disasters. Serious reflecting on these lessons can protect the right to health of a vulnerable person during a disaster.

Everyone has the right to life, with dignity and respect for their human rights. The right to health is recognized in a number of international legal instruments. This embraces not only the right to equal access to health care, but also to the underlying determinants of health, all of which involve the fulfillment of other human rights, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy environmental conditions, access to health-related education and information, non-discrimination, and human dignity and the affirmation of individual self worth.

Health care is a critical determinant for survival in the initial stages of disaster. Disaster almost always has significant impacts on public health and the well being of affected populations. The impact on public health may be described as direct (eg. injury, psychological trauma) or indirect (infectious diseases, malnutrition, complication of chronic diseases). Indirect impacts are usually related to factors such as inadequate quantities and quality of water, breakdowns in sanitation, interruption in food supplies, disruption of health services, overcrowding and population displacement.

During an emergency response, when mortality rates are frequently elevated or could soon become so, first priority humani-
tarian interventions must focus on urgent survival needs, including basic medical care. The goal of response is to prevent and reduce excess mortality and morbidity and to promote a return to normalcy. Once survival needs have been met, and mortality rates have declined to near baseline levels, a more comprehensive range of health services should be developed. Throughout the initial phase of the response, a health system approach to design, implementation, monitoring and evaluation of services will contribute to ensuring that the most important needs are met.

Priority health interventions vary according to the type of disaster and its impact. Basing the design of these interventions on public health principles will ensure that the greatest health benefit is provided to the greatest number of people. Priority public health interventions include adequate supplies of safe water, sanitation, food and shelter, infectious diseases control, basic clinical care and diseases surveillance. Expanded clinical services, including trauma care are given higher priority following disasters that are associated with a large number of injuries. Access should be based on the principle of equity, ensuring equal access according to need without any discrimination that could lead to the exclusion of specific groups.

The right to health can be assured only if the population is protected. The professionals responsible for the health care system must be well trained and committed to universal ethical principles and professional standard. Once this is in place, the system in which they work must be designed to meet minimum standards of need. In order to support this, the state must be disposed to establish and secure these conditions of safety and stability. In times of armed conflict, civilian, hospital and medical facilities should in no circumstances be the object of attack, and health and medical staff have the right to be respected. Essential to this perspective on human rights are issues of dignity and equity, and the obligations of states and non-state actors in fulfilling the individual’s right to health.

Dima Mayasari

lives in Banda Aceh, Indonesia, and is now a fifth-year medical student of Syiah Kuala University. She worked with the United Nations and humanitarian agencies following the Tsunami of 2004, and did emergency response for the Nias earthquake in 2005.

The highly profitable journey of a new medication from laboratory bench to bedside, and then to the pharmacy shelf is often long and troublesome. Traditionally, drugs are first tested on animals, then, in a series of phases that may take several years, on human subjects. Ethics of human trials have always been the source of much controversy. Such trials are regulated and governed by watchdogs in developed countries; however, the story is somewhat different in developing countries.

In recent years, pharmaceutical corporations and their patrons in the biomedical profession and the public sector have faced several obstacles in recruiting human subjects, as well as having their proposals passed by ethical review boards (Kottow, 2002). Rising competitive pressure on companies to develop and market drugs faster, has shifted their focus from the countries of the North to those of the South. This shift of focus is one of the most and least examined manifestations of the neo-liberal globalizing movement. The ability of researchers to conduct unethical drug trials in developing countries is symptomatic of a deeper calamity – the deep and dividing inequality between the countries of the North and the South. Furthermore, as the director of marketing for Johnson & Johnson stated, foreign patients with little exposure to medicines “offer a blank slate for experimentation” as their medical deprivation makes for a scientifically sound study (Flaherty et al., 2000:A01) This, in turn, speeds new drugs to the marketplace of the developed world.

Take, for example, the case of AZT trials in Thailand. A commendable journalistic effort by the
Washington Post exposed the breach of moral codes in the work of several investigators conducting AIDS studies in this country (Flaherty & Struck 2000:A01). Sponsored by the US Army, the experiments aimed to determine the natural course of vertical transmission of HIV from seropositive mothers to infants through “monitoring”. This approach did not call for the provision of the effective antiretroviral drug AZT to any of the participants. The trial was approved by the National Institute of Health (NIH) before the widespread availability of AZT. Researchers from Harvard University who felt that it would be unethical not to provide participants with AZT were conducting a similar trial simultaneously. Note that AZT had proven effective in reducing the incidence of vertical transmission of HIV in the US and France, and had been pronounced the standard treatment in the North prior to the Thai studies. Army researchers refused to allot some of their grant funding (a modest $1 million) to purchase AZT (cost of $15000). Unwilling to cooperate with the Harvard team (the Army believed cooperating would have implied “surrendering the site”), army investigators decided to wait for the Thai government to provide the medication. The Army argued AZT was not deemed standard therapy in Thailand without the Thai government’s approval. Needless to say, the provision of AZT would have clouded the scientific validity of the study, as it would have interfered with the “natural” transmission of HIV! 37 babies born to the HIV positive mothers, who could have been spared in the duration of study, contracted the virus. The Thai government approved AZT several months prior to the conclusion of the above study; however, the provision of AZT was stalled through bureaucratic means, lest the scientific purity of the research be “corrupted” by the medication (Bosely, 2000). In response to criticism from several ethics review boards, the team leader expressed his disappointment with the boards, as “their deliberations seem often devoid of the larger view of advancing medical science for public good as opposed to the individual” (Flaherty & Struck, 2000: A01).

It appears that on the path to scientific glory, the prosperous North contributes genius and hypotheses, while the South provides vast numbers of patients. The health of the South is deemed secondary to the advancement of science. With this reality in mind, I ask the reader to compare the case discussed above with the infamous Tuskegee experiment below. Have we truly progressed?

The Tuskegee experiments were conducted by the US government on black farm workers in the US from 1932 to 1972 (Francis, 2001:32). Investigators wanted to monitor the natural course of a syphilis infection without the provision of treatment. Although Penicillin, still the most effective therapy for syphilis, became available in 1943, the investigators did not provide the drug to their patients, and actively dissuaded them from pursuing the treatment option for 30 years (Francis, 2001: 33). This was done so that the treatment would not cloud the scientific validity of the study of “Untreated Syphilis in the Negro Male”. The Tuskegee experiments were stopped due to public outrage after front-page reports in the New York Times exposed this inherently racist and dehumanizing practice of medicine. In 1997, President Clinton offered formal apologies to the survivors of these experiments and called the studies “a blight on our record” (Francis, 2001:35).

Striking parallels between Tuskegee and the Thai study are disturbingly clear. The unequal distribution of power in the doctor-patient interaction is facilitated by the lower socioeconomic status of participants of color, scientific egotism, and a medical orthodoxy with a racist past. This past is perpetuated in the present. Tuskegee may never be repeated in the USA, yet this blight on North’s record continues. Tuskegee has been exported to the South.

Clinical research is necessary if biomedicine is to continue providing new treatments. Neoliberalism seems equally entrenched, with multinational giants generating and reaping much of the world’s economic prosperity. These two intersect in the case of drug trials. Doctors and patients also lobby for life-saving medication.
Drug companies have a vested interest in creating new, profitable medications. Globalization, underpinned by market ethics, often harms the worst off. However, a global ethics agreement has the potential to redress the balance and promote greater equity. Such an ethic must be underpinned by the principle of distributive justice on a global scale and be in the framework of fundamental human rights: the right to live with dignity, respect and health.

Behzad Hassani
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Project: London – why London?

Médecins du Monde (MdM) is an international charity known for its efforts in providing assistance to vulnerable populations and for its testimonial against social injustices. On hearing about their intentions to set up a project in London, one of my first thoughts was why a charity, known for their work in developing countries, would focus their efforts in the UK? Surely, such a scheme was not required when we have the National Health Service (NHS): a well-structured healthcare system and one which, more importantly, provides healthcare free of charge for those who live here?

As a medical student mainly attached to hospitals in West London, I now realise that I have had limited exposure to the challenges faced by a subset of people in more socially deprived areas of London who are experiencing difficulty in accessing free NHS healthcare. These “vulnerable groups” include refugees and asylum seekers, the homeless and women working in prostitution.

Rationale behind the project

The constitution of the World Health Organisation (WHO) states, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, social and economic condition”. In many countries these ideals cannot be upheld due to fundamental problems in infrastructure secondary to economic, social or political crises. This does not apply in the UK, where the NHS states that it was founded on the requirements of being “universal in its reach, high quality and available on the basis of clinical need (without regard for the patient’s ability to pay)”. It was on this premise that the organisers of MdM’s Project:London, set out to discover why certain groups in London are currently unable to access the healthcare that they are entitled to.

Their subsequent research resulted in the creation of Project:London – an independent free service that aims to provide the information and support necessary to integrate the vulnerable person into the mainstream health services.
Facilities for basic healthcare, administered by a registered General Practitioner (GP) or nurse, are provided in the interim between presenting to the service and accessing existing health services. A key additional component of Project:London is the advocacy work done by the project volunteers, who represent the service users and, if necessary, defend their right to free healthcare.

The clinics

At the moment, MdM is working with three partnership organisations in London: Praxis (working with displaced people and new residents); Providence Row (working with homeless people); and U-turn (working with women in prostitution). So far, only the first phase has been launched, with Praxis, and sessions are currently running on Monday and Wednesday afternoons.

The volunteer teams that form the basis of the Project:London comprise GPs, nurses and “support workers”. As a medical student, I applied to be a support worker and attended a weekend of training before starting work at the clinics. Volunteering for a session involves travelling to the clinic premises (a converted church) provided by Praxis in Bethnal Green, East London. Once there, you help to set up the room for the clinic and then wait for service users to turn up.

When a service user arrives, the support worker helps them to fill out a questionnaire. This allows us to record key pieces of information about the service users, for example, their ethnic origin and immigration status, which can then be used to help us identify the needs of the service user and, also, to lobby for change to healthcare services. After filling out the questionnaire, the service user is taken to an adjoining room for their medical consultation with a doctor or a nurse.

It was quiet at the clinic when I arrived for my first session. The session supervisor gave me a folder of patient case notes and asked me to follow up some service users who had been to the clinic previously. My first phone-call was to “Ahmed”, who had been refused registration at his local GP practice. Although he spoke some English, he had had some difficulty communicating with the receptionist and had been turned away, possibly, when they realised he was an asylum seeker. It was unclear exactly what had happened, so we phoned the GP’s reception to find out whether they would register him. An agreement was reached that if he used his brother’s address to register, the GP would see him. “Ahmed” went back to the same GP surgery and successfully registered.

Whilst I was on the phone, “Leon” had arrived at the clinic, asking to see a doctor. He was a quiet young man from Cote d’Ivoire, who had fled to the UK after he had witnessed the murder of his son by a group of soldiers. He had left his wife and other family behind. It was clear that “Leon” would not only require registration with a GP, but also referral to organisations that would provide him with the support that he needed.

“Hassan” was a middle-aged man from Turkey, whose chemotherapy treatment for bowel cancer had been terminated when the hospital cancer services decided that they did not consider him a UK resident. They also presented him with a hostile letter and large bill for the treatment that he had already received. He came to us in despair. After consultation with a human rights lawyer, we found that his situation might not be so bleak, since a “reciprocal health-care” agreement existed between the UK and Turkey. It was thought that “Hassan” might be able to continue his chemotherapy on the basis on this.

How to get involved

Opportunities for medical students include:
- Fund-raising
- Volunteering to raise awareness about Project: London
- Volunteering for a session as a support worker

To find out more about this and how to get involved in MdM’s Project:London, please contact:

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Rose Gilbert
is a 5th year medical student at Imperial College London, UK. She joined Medecins du Monde Project: London in October 2005.
In July 2005, I had the opportunity to do a four-week elective with IFMSA in Obstetrics and Gynecology in Copenhagen County Hospital, located just outside of Copenhagen, Denmark. I am also a member of a North American group called Medical Students for Choice. We believe in a woman’s right to choose, and be guaranteed, an abortion if she so wishes. We also believe in the right to choose other reproductive options, from adoption to in vitro fertilization. We are here to ensure that she has the choice.

Overview of Abortion in Denmark

Abortion is accessible to Danish women on the same grounds it is accessible to Canadian women: to save the life of the woman, to preserve her physical/mental health or her economic/social well-being, to terminate a pregnancy that results from rape or incest, to terminate a pregnancy involving an impaired fetus, or involves fetal impairment. Abortion for any reason in the first 12 weeks of pregnancy has been legal in Denmark since 1973. Special circumstance abortions have, however, been available since 1956; for example, if a woman had more than four children, or if she was more than 38 years of age. One large difference between Canada and Denmark is that in Denmark, after 12 weeks gestation, an abortion must be approved by a committee of three people, including an obstetrician/gynecologist, a psychiatrist, and a director from the hospital where the abortion is to be performed. If a woman’s pregnancy poses a risk to her life, or if it adversely affects her physical or mental health, she is able to get an abortion at any gestational age, without committee approval. Otherwise, if the woman requests an abortion after 12 weeks, the committee assesses whether or not she may receive an abortion. They make this decision based on several factors: Does the pregnancy, childbirth, or childcare pose a risk to her health based existing or potential physical or mental illnesses? Is her health at risk of deteriorating as a consequence of the pregnancy due to the conditions in which she is living? Was the pregnancy a result of a criminal act? Is the fetus at risk of congenital and hereditary abnormalities? Has the fetus been injured or experienced disease?

Will the child be affected by a serious physical or mental disorder? Is the woman able to give proper care to the child?

Although these seem to be rational issues as to whether or not a woman can receive an abortion after 12 weeks, this process takes away her choice and places it in the hands of committee members. There is no guarantee these committee members are pro-choice; if they are, they may be able to justify an abortion when a woman requests it, no matter what the circumstances. But if they are not, a woman may have to finish her pregnancy against her own choosing. I was surprised by all of this, as I believed Denmark would have rules very similar to Canada. In Canada, although there are no laws governing abortion, it is the woman’s right and her choice alone to have one, for any reason. The gestational age up to which one may be
performed is generally 20 weeks, although it can be later under certain circumstance. The people of Denmark, from my experience, are generally of the attitude “live and let live,” but this 12-week law does not embrace the concept of allowing a woman to live her life as she chooses. I asked one of the Danish obstetricians about this law, and she replied by saying the majority of women who don’t know they are pregnant by the time 12 weeks comes around generally have mental disorders or poor social circumstances. Although this may be true in some cases, I believe this is a gross overgeneralization. There should not be a time limit, within reason, placed on the decision to have an abortion. It is a difficult decision that most women never want to be in the position to have to make. Denmark does offer abortions beyond 12 weeks, so why are they reserved for special circumstances?

I attended an abortion clinic in the hospital several times during my elective, and noticed it operated similarly to what I have seen in Canada, including care such as pre- and post-procedure counseling. The obstetrician performing the procedure did not agree with abortions, except under exceptional circumstances. She did, however, provide superb patient care - with compassion - and appeared not to let her personal feelings interfere with her professional duties. It was inspiring. As she put it, “Although I don’t agree with what these women are doing, it is not my choice. I am not terminating her pregnancy. She is.” There are doctors in both Canada and the United States who can still learn from this attitude. This experience showed me that although we may not be able to change opinions, we should set principles of professional duty that must be upheld.

An abortion allows a woman to choose whether or not he wants to be pregnant. This provides her with a sense of personal security and the ability to control her own future. Every person deserves that right.

Christina McDonald is entering her third year of medical school at The Schulich School of Medicine & Dentistry, University of Western Ontario, located in London, Ontario, Canada. She is originally from Halifax, Nova Scotia, Canada. She says, “I am not a writer, but I wrote this article because I believe in a woman’s right to choose an abortion if she so wishes.”

The dusty war-torn lands of southern Sudan and Sri Lanka, the lush and tropical coffee plantations in Mexico, the Doctors without Borders feeding camp in northern Nigeria, aid programs in sub-Saharan Africa, aboriginal communities in the Canadian north, neurosurgery in Jamaica and in Bolivia. All these stories were brought together recently under one roof at Dalhousie Medical School’s 6th annual global health conference.

During a spring weekend in the midst of studying, assignments, exams and other typical activities in the life of a medical student, an eclectic group of speakers convened to share their experiences in global health, specifically in global inequities such as education, access to healthcare, income potential, and aid programs.

Jacob Deng, founder of the Halifax organization, Wadeng, Wings of Hope, kicked off the weekend conference with a documentary film that captured his first trip home to his native country of Sudan in the almost twenty years since he fled Sudan as an 8-year-old refugee. The film was an emotional one, complete with reunions with two of his sisters. Jacob also spoke of his current fundraising project, the Brick by Brick Campaign, whose goal is to raise money to build schools and sustainable education programs in southern Sudan.

Eleanor Fitzpatrick, a paediatric emergency nurse at the IWK Health Centre, recently returned from a feeding camp in Northern Nigeria
as a volunteer for Médecins Sans Frontières (Doctors without Borders). She shared stories and photos of the feeding program the team set up in an abandoned warehouse for severely malnourished children. She also fielded many questions about the possibility of volunteering with MSF.

The founder of the first Fair Trade coffee roaster in Canada, Jeff Moore, spoke of his experiences starting his company, Just Us Coffee Roasters in Wolfville, Nova Scotia. He educated the audience about the positive and far-reaching implications of fair trade. His talk was particularly pertinent to the layperson who wants the chance to make a difference in the health of people in developing countries every time he or she shops at a grocery store.

A local neurosurgeon and winner of the 2005 Dr. John Savage Memorial Award in International Health, Dr. Renn Holness, gave a talk about his tireless efforts providing surgical equipment and access to health care to nations in the Caribbean.

Dr. Stan Kutcher, Dean of International Health at Dalhousie University, moderated a panel discussion with Jeff Moore, Jacob Deng, Alexis MacDonald (Director of Programs for the Stephen Lewis Foundation), and Lindsay Moore (a registered nurse and Red Cross International delegate who has worked in Sri Lanka and in Northern Canada). Lindsay Moore spoke of the challenges working in remote areas of Sri Lanka disrupted by civil war, as well as the challenges faced while working with aboriginal communities in the Canadian north.

The conference culminated on Saturday evening with a flavour-filled dinner created by members of the global health initiative. The keynote speaker, Dr. Ivar Mendez, Professor and Head of the Division of Neurosurgery at Dalhousie University, recounted his health care experiences in his native country of Bolivia. The evening was topped off by various multi-cultural musical performances, including the Halifax African Dancers and the Halifax Salseros.

This diverse group of speakers provided a keen group of medical students and interested community members with insight into the inequities that exist in health care and in social justice around the world. Their stories and experiences illuminated issues surrounding global health that medical students may not otherwise have learnt through the Dalhousie curriculum.

Deborah Pink is a medical student at Dalhousie University in Halifax, Nova Scotia, Canada. She is Dalhousie’s International Health Liaison and she helped to organize this year’s Global Health Initiative conference entitled: Global Inequities.
This photo was taken at a home for street children in Tanzania, Africa. Children come to live at the home after being orphaned or abandoned, or after they have run away from home to escape abuse. Stories like these boys’ are far too common. WHO currently estimates that there are over 2 million orphans in Tanzania.

The photo is called ‘The new generation’ because despite their hardships, these children remain hopeful about the future. Tanzanian people I met are remarkable in their willingness to help one another. The boys in this photo wanted to learn to use the stethoscope so they could continue to work after the Canadian medical team had gone home. When I look into their eyes, I can see the joy of childhood still shines from inside of them; they believe they can grow up and become doctors to mend their sick communities. These children are the future of Tanzania.

This photo was taken at Upendo Home in Tanzania. It is a home for people infected with leprosy and their families. ‘Upendo’ means ‘love’ in Swahili. The 2005 MedOutreach team from the University of Western Ontario traveled to Arusha, Tanzania, to provide medical and dental aid. In between medical projects, the team also lent a hand with odd tasks. A new building was being completed at the leprosy home and the team was happy to help with the painting.

is entering her third year of medical school at the Schulich School of Medicine & Dentistry, University of Western Ontario located in London, Canada, where she is the International Health Liaison. is inspired by the people of Tanzania and remains committed to raising awareness and helping other Canadian medical students get involved with medical projects in Africa.
The Philippines is a developing country. It is a place where there exists great disparity between the rich and the poor. As you trail the more progressive places in Manila such as Makati and Ortigas, you will find luxurious houses with large gardens complete with swimming pools, extravagant automobiles, and assemblies of household helpers and drivers. However, just across from these gated subdivisions, one is unlikely to miss a sprawling neighbourhood of “squatters,” which provide a stark contrast to the polished mansions of the rich.

Poverty is a reality many Filipinos face. Many have to survive on an income of P100.00/day (a meager US$2.00/day). This is not even enough to cover the basic necessities of the family such as food, clothing and shelter. It is in this context that many have come to debate how to alleviate the poverty that affects the majority of Filipinos.

As a medical student in a government teaching hospital, I am a witness to these heated government policy debates. Many with a dim glimpse of reality correlate poverty with “overpopulation.” With this unexamined dogma, some would go to any extent to curb the population even if it entails curtailing the basic human right of the patient’s autonomy.

It is common practice for doctors and health workers to prescribe artificial contraceptives right and left in the Philippines. With the massive number of patients coming in, a short explanation of side effects and consequences could hardly pass for “patient education.” A proper explanation of the use of natural family planning, which is tedious to teach, is likely to be neglected.

In another government birthing hospital where my sister trained as a clerk, she witnessed doctors coercing their patients to subject themselves to tubal ligation. She narrates the conversation that usually takes place between a doctor and patient:

“Nay, pang ilan na ‘yan?”
Mother, how many children do you have?
“Pangatlo na po doc.”
It is my third, doctor.
“Talian na natin?”
Let’s perform ligation?
“Ha? Baka masakit po yun…”
Huh? It might be painful…
“Hay, naku misis! Mabilis lang po yun. Bakit kaya mo ba ba buhayin ang mga anak mo kung manganak ka ulit? Hindi kayo makakaalis dito nang hindi kita tinatalian!”

My goodness, Misis! It’s just a quick procedure. Why? Can you still raise your family if you give birth to another one? You can’t leave without getting a ligation!

If you know the Filipino character/temperament – especially that of the poor – you would know that instead of inquiring further about the procedure or asserting their right as a patient, they would quietly submit to whatever procedure their doctor prescribes even if it means sacrificing their beliefs and principles. In the birthing hospital I mentioned above, hundreds of tubal ligations are performed every week. Many are performed without consent, and through coercion.

The debates continue... Is it really overpopulation that drags the Philippines down to extreme poverty? Or is it the other way around——our human resources, which provide services all over the world including Spain, Italy, Japan, and the United Kingdom, as the only saving grace that keeps the Philippine economy afloat through the OFW’s (Overseas Filipino Worker) dollar remittances? Are we poor because we are too many or because of other factors such as faulty government policies, corrupt public officials, and an ignorant population? Should we then simply subscribe to band-aid solutions such as massive application of sterilization? And worst of all, should we overstep the freedom of others especially that of the poor and the weak just so we can uphold our personal opinions about the problem?

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The UK is facing a sexual health crisis and is said to have the worst sexual health in Western Europe. [1] Between 1999 and 2002, the incidence of HIV rose by 20% annually, and about a third of HIV-positive people were unaware of their serum-status. For too long, HIV has been associated with asylum seekers, which has fuelled public fear and prejudice about immigration.

In April 2004, the department of health passed regulations to withdraw all free secondary health care (except in cases deemed immediately necessary or life threatening) to failed asylum seekers. While treatment of certain infectious diseases still remains free, HIV/AIDS care is not. [2] This policy was introduced in response to media calls for more stringent measures to protect public purse and public health. The media allege that most HIV positive asylum seekers are either “health tourists” or economic migrants abusing the UK’s free NHS; they ask why we should be using our scarce resources to treat them. However, no hard evidence exists that “health tourism” occurs. In fact, a survey done in 2003 showed more than three quarters of people learned of their HIV status more than 9 months after entry to the UK, and over half were not diagnosed until they became unwell. [1] The reality is that failed asylum seekers are desperate, needy and require psychological help. [4]

Asylum Seekers comprise some of the UK’s most vulnerable immigrants; ten thousand are currently in the UK. [2] Many are fleeing their countries due to fear of persecution based on race, political opinion, religion, nationality or membership of a particular social group. To some degree, they all face the following problems: lack of a support network, immigration difficulties, unemployment, malnutrition, lack of appropriate housing, psychological issues, and health care issues. Failed asylum seekers are often labelled “bogus”, yet this is not the case. Statistically, of 25,155 asylum decisions in 2005-6, 81% were refused. Most appealed, and of 28,025 appeals received, only 20% succeeded, leaving 22,420 failed asylum seekers. [9] While an asylum seeker’s claim may have failed, they should still have access to healthcare. Doctors are taught to make the care of the patient their first priority. Doctors are not “immigration officers”, however they are being forced to decide whether or not to treat a patient, not on medical grounds, but on whether the patient has the right papers or illness. [5]

Denying anti-HIV treatment to failed asylum seekers has no sound economic, public health, or moral justifications. In fact it could raise the number of new cases in the UK by failing to treat highly infectious cases [3]

John Hutton, Minister of Health, commented, “We must remember that the NHS is a national institution and not an international one…. the NHS is first and foremost for the benefit of residents of this country.” [3] However, one could say that the UK has an ethical obligation to treat those who are within the UK geographical confines. Could this not incorporating asylum seekers too? If the use of NHS resources to treat asylum seekers would compromise the care of UK residents, this would be reason to restrict care, but current immigration patterns and control do not suggest that there would be a large burden on the NHS. In fact, HIV treatment could save the NHS money and cut the number of new HIV cases by 60%. [6] According to government figures, fewer than 900 people with HIV entered the country between 2003 and 2004. At an average cost
of £7,000 per year, the report points out that providing them with antiretroviral treatment is far more cost effective than treating repeated opportunistic infections. If early detection and treatment of the virus prevented just one case of transmission, it would save the NHS between £500,000 and £1,000,000. [7] Undiagnosed people (31% being the UK estimate) [8] will continue, unknowingly, to transmit HIV to others causing major public health repercussions.

Although the government’s strong political response to migrants’ use of NHS facilities, alongside the persecution of migrant men for sexual HIV transmission, may seem to indicate to the public that they are acting strongly to protect the nation’s sexual health, in reality these measures are doing little to help. If the government wants to help the public, then it needs to prioritize sexual health more and provide better funds to modernize the sexual health service. Also, sexual health education needs to be emphasized and focus directed to the public’s understanding of the disease. Furthermore, the public need to be aware that the rising rate of HIV is due less to deliberate transmission by immigrants, and far more to the erosion of funding for HIV prevention schemes. “Is it ever right to deny lifesaving treatment to someone simply because their status in the country has yet to be decided?”[2]

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Human rights are immutable and inalienable; they are recognized in law to protect and enhance human dignity. Specific human rights, such as the right to life, as well as freedom of thought, expression and religion are enshrined in the Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948. One of these rights is crucial to the attainment of the other fundamental rights and freedoms, and is a critical determinant of the standard of living in any economy, namely the right to the “highest attainable standard of physical and mental health, without discrimination of any kind.” In current human rights terminology, countries that have reasonably attended to civil and political rights and are now considering health, social and economic rights are described as “second generation” countries. Countries that are still grappling with basic political and civil rights are first generation. Unfortunately, most African countries belong to the latter group.

Health & Development in Africa

The question of health being a right is yet to be appreciated by many. Health standards in Africa as a whole are deplorable. Infectious diseases, especially Malaria and HIV/AIDS, as well as regional conflicts, continue to decimate the African population, maiming millions and rendering them incapable of fending for themselves, deepening poverty in the process. Sexual violence furthers this negative course, and both fighting troops and peacekeepers have been implicated in parts of Africa undergoing large-scale wars. The ratio of available health service providers to patients is very low. Health care facilities are grossly insufficient.

It is worthy of note, however, that improvements are being made gradually in many
parts of Africa. Wars are coming to an end, and peace accords are being signed. Nations at peace are seeking development, and are slowly but surely moving in the direction of its attainment. The African Union is playing an increasingly important role in this regard.

Dr. Ibrahim Samba, WHO African Regional Director, called on African governments to "accept the basic diagnostic point that good health is an integral part of development". Tackling health problems should be part of the economic development equation, which could help African countries achieve sustainable development. Health has been shown over time to be both a cause and effect of development. A healthy population would be strong enough for intensive productive efforts to be undertaken and sustained.

Are African legal instruments adequate to protect health as a human right?

Article 16 of the African Charter on Human and People’s Rights declares "every human shall have the right to enjoy the best attainable state of physical and mental health". It further suggests that states party to the charter “shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick”. These measures include steps by governments to prevent violation by the state, its agencies, or private citizens, of peoples’ right to health; they also offer means for redress. The state is also expected to provide sufficient resources to meet the public health needs of the people. Section 17 (subsection 3) of the Constitution of the Federal Republic of Nigeria requires the state to direct its policy towards the provision of medical facilities adequate for all citizens. However this section of the constitution is ‘non-justiciable’, that is, it cannot be upheld by the law courts.

Today, African countries are gradually taking action towards the entrenchment of the health rights of the people in their law books. The National Assembly of Nigeria is presently working on a Child Rights Bill. Similar efforts are being made in South Africa. Work in this direction should be intensified. However, laws are only words and must be followed by deeds for targets to be met. Adequate action should be taken today in order to protect the rights of people with special needs, of the girl-child, or people living with HIV/AIDS, and of women who fall victim to trafficking. Only in this way can progress be made toward the high ideal of health for all in Africa and the world. Laws must be enforced. A gradual evolution of the legal framework is definitely preferable to a high jump to western standards that may be difficult to sustain.

Recognizing that Africa must be responsible for herself, before asking for external technical or financial support, President Thabo Mbeki of South Africa made a passionate appeal “that we (Africans) should first of all make a determination that we shall be our own liberators from poverty and underdevelopment.”

A motion for progress

As medical students, we must be involved in the present debate on health and human rights. Work can start via an IFMSA Project on Human Rights Education & Promotion. Through it, we could propagate the message of health as a human right across our nations, and at the level of our medical schools and teaching hospitals. Medical students must be willing to propagate the message, working with other health professionals, to the world.

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According to René Cassin, “Human rights are what no one can take away from you”. In a less philosophical manner of thinking, one can understand them as claims that we are justified in making, which depend on no promises or guarantees by another party.¹ An instrument created by the United Nations to recognize and to enforce human rights is the Universal Declaration of Human Rights. Article 3 states that “everyone has the right to life, liberty and security of person”. Obviously, health professionals, as human beings, also have the right to be secure at all times, including while they’re at work.

There is a clear connection between health care workers’ right to security and what is known as “biosafety”. In the past, this term meant the “safe handling, transfer and use of living organisms modified through biotechnology”.² However, nowadays biosafety can be understood as “the collection of actions directed to the prevention, minimization, or elimination of risks that are inherent to the activities of research, production, teaching, technological development, and paying of services, regarding the health of man and animal, preservation of the environment, and the quality of the results.” (Teixeira and Valle)

I was led into further contemplation on biosafety topics last week, because during my professional practice lessons, I was confronted with a completely new and scary situation for any medical student, but especially to a Brazilian one, who is not used to violent attacks in this country: we were prohibited from going to the streets to visit the families we take care of, because a wave of violence against security forces and civilians was taking place over the entire state of São Paulo!

For safety reasons, we went to our health center, but we were told to stay there and discuss some health topics. The nurse that accompanies and guides our work said that it was too dangerous to walk in the area, especially because we didn’t know who might somehow be connected to the attackers, and when and where the next attack would take place.

All of this confusion began when São Paulo’s current government decided to isolate the leaders of a criminal faction called Primeiro Comando da Capital – PCC (First Command of the Capital). One of their most important (and dangerous) leaders, Marcos Williams Herba Camacho, known as Marcola, was transferred to Brazil’s safest prison on May 13th, 2006.

In retaliation to the government’s decision, the prisoners from more than 73 prisons organized 251 attacks, including the burning of 91 buses, besides attacks to the civil and military police, from May 12th to the 16th. While politicians discussed the best way to bring an end to the attacks, 128 were killed, and 59 were wounded.³

All of this brought a question to our minds during our professional “practice” lesson: was the fact that we, students, stayed inside the health center during the attacks, a biosafety measure?

Using the above-mentioned definition, we can affirm that, by eliminating the risk of being attacked in a street during our service, this was indeed a biosafety measure. This led me into further thinking about my home visits and this new concept of biosafety, which goes beyond being careful in labs and proper handling of all kinds of genetic material.

One of the families I have to visit has a member who is an alcoholic. On my first visit, he was absent, and on the second one, he was sober, but didn’t seem to want to talk. Nevertheless, I was told by the community agent that when he’s sober, he can talk for hours, and will be nice and polite. However, if he’s drunk, then he’ll shout at people and call them bad names... Even if the person is a nurse, a doctor or a health student. So I was advised not to enter the house when he’s drunk and to postpone the visit to his family to a later date, when he would not be present, or when he would be sober. Once again, Teixeira and Valle’s definition of biosafety is applicable.

Extending this modern biosafety concept even further, I thought of another family I visit. Their home is located in an area of slums, which used to be a drug selling point. So, again, I was advised by the community agent not to enter the place without asking the head of the family first, and making sure that no one’s selling drugs or...
doing anything illicit. I was advised that for a long time there have been no drugs in the area, but that I should be careful anyway.

In essence, through the examples of the criminal faction attacks in São Paulo and the domiciliary visits I do, it has become clear that the protection of health professionals is not restricted to laboratories, hospitals, and health centers, but it is already extended to every part of the healthcare system, including domiciliary visits. Even more, safety measures are not only about avoidance of being physically injured, but also about taking the necessary actions to avoid being morally, socially, and/or psychologically damaged.

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Colonial Medicine: A Tainted Legacy

Was the institution of colonial medicine as beneficial and humanitarian as is commonly supposed? Was it one of the ‘undeniable benefits’ of imperialism? For early European colonizers, the hazards of disease were an accepted aspect of any untamed, tropical wilderness. They believed that only through their superior knowledge and methods was it possible to bring these areas under control. Western medicine represented progress towards a more civilized social order. It was portrayed to natives as immensely valuable, well worth the price of relinquishing their independence. Historians, also, have come close to endorsing this opinion. Most recent writers, however, have taken a more critical view, highlighting the disastrous consequences of European influences and seeing colonial medicine itself as a major health hazard for indigenous groups. Principally responsible for the many shortcomings of colonial medicine was the contempt and disrespect that the rulers had for the ruled.

Nowhere were these feelings more robust than in the European colonization of Africa. For colonizers, the African man personified suffering and degeneracy, and his homeland was a cesspool of fever and affliction. His black body was associated with degradation, pollution, and disease. Furthermore, when nineteenth century scientists structured human phylogeny, they placed the African at the least advanced level of Homo sapiens. As comparative anatomy progressed, the reduction of the world’s societies to organic bases gained authority and verified popular conceptions of the Dark Continent with its black bodies and dim minds. For example, the Dutch scholar Petrus Camper formulated a scale, called the facial angle, which correlated the shape of the human skull with mental capacity. Not surprisingly, his ludicrous study ranked Africans slightly above apes in terms of intellectual ability. What is more, his pronouncements were widely publicized beyond the scientific community and accepted by an interested public. Europeans became convinced that Africans and other primitive peoples were an unsophisticated subspecies that would benefit from advanced colonial medicine.

Unfortunately, colonial medicine, like other imperial creations, was often instituted through cruel, unsympathetic methods, as illustrated by an epidemic of plague in colonial India. On September 23, 1896, Bombay declared that bubonic plague had broken out in the city, prompting massive state intervention. The draconian methods employed were the most drastic that had ever been used to quash an epidemic. Steps were taken to disinfect the city and isolate individuals suspected of infection. Bombay was drenched in a solution of carbonic acid and seawater in efforts to eliminate the responsible pathogen. The panic-driven search parties often made false diagnoses, which resulted in healthy individuals...
being quarantined, and plague stricken people left free. Understandably, there was widespread hostility to the plague measures. Indians evaded and resisted search parties, subtracting from any positive effects that the programs may have otherwise had. In retrospect, it is clear that the invasiveness and severity of the eradication techniques were largely responsible for their ineffectiveness.

Callous medical practices were also responsible for the initial failure of efforts to control the spread of leprosy in Africa in the 19th and 20th centuries. At the time, most European doctors concluded that leprosy was infectious and incurable. Therefore, isolation was the only acceptable public health policy. As was the case in India, rulers were prepared to impose their methods at any human cost. Police marched into homes, identified suspected lepers, and hauled them off to hastily erected leprosaria. Conditions were deplorable within these institutions as evidenced by the structure in Emjanyana whose superintendent reported ten years later that no drug he used had any effect. Naturally, friends and relatives of lepers resisted the brutal interventions, and helped lepers to escape from the dreadful prisons.

The prevalence of leprosy declined in Africa during the 1920s. Modern opinion attributes this not to compulsory segregation, but rather to the adoption of more humane methods. As the hydnocarpus and sulfone drugs became available, authorities began to rely on the hope of a cure rather than compulsion, and cast aside their ruthless measures. This optimism transformed morale as patients stopped hiding from health authorities and began volunteering for treatment. "Treatment at last became primarily a medical rather than a charitable enterprise." Lepers flocked to hospitals as the certainty of death faded. Colonizers quickly recognized the benefits of compassionate care over forceful intervention.

Indeed, history displays many instances of colonial authorities correcting faults in their intervention strategies and seeing striking results. Consider the fight against smallpox in 19th and 20th century India. As one of India’s most virulent epidemic diseases, smallpox was widely represented in religious belief and ritual. For example, the goddess Sitala was responsible for bringing and preventing the disease, depending on whether she was angry or content. Additionally, the prophylactic practice of inoculation/variolation was sanctioned by religion and commonly performed by India’s leading religious specialists.

Variolation boasted remarkable effectiveness and efficacy. Innoculators utilized advanced delivery systems: a tribe of lower class Brahmins called Tikadars performed annual, systematic variolation trips. The variolators were so skilled that they could adjust their dosing to deliver a requested number of pustules to patients. Also, although inoculated patients were technically contagious, variolators only used matter from previously inoculated people with mild presentations. Moreover, while vaccination required a special bifurcated needle, dried vaccine, and glycerol to suspend the vaccine in, variolation required no materials other than a simple blade; variolation was cheap and readily available. Indeed, the discoverer of the smallpox vaccine, Edward Jenner himself, was a trained variolator who was inoculated at the age of eight.

Despite the virtues of variolation, British colonizers refused to integrate vaccination into indigenous methods and forced secular vaccination upon the people. As expected, they were met with strong resistance. Although methods became more humane during the WHO’s eradication campaign starting in 1967, Indians continued to resist vaccination because of its secularity. The WHO accomplished little headway in India until the 1970s when they began to acknowledge the indigenous belief system. They trained inoculators as vaccinators so that they
could immunize trusting patients while paying homage to Sitala. In doing so, the WHO de-coupled vaccination from its cultural and political entanglements and began to achieve significant results that culminated in the eradication of smallpox in 1978.

Through these historical examples, this essay ascribes much of colonial medicine’s failure to implementation strategies that violated the right to health of indigenous populations. Fundamentally, colonial medicine was predicated upon the underlying belief that indigenous people were inferior and ill-informed, and would benefit immensely from Western bioscience. Indigenous beliefs about health and disease were viewed through a reductionist lens and misconstrued as ignorant and archaic. Even today, across sociocultural boundaries, medical belief systems always demonstrate contradictory understandings. The legacy of colonial medicine begs us, as students of biomedicine, to recognize that our medical belief system is but one of many in the world. To be successful practitioners, we must refuse to allow our ethnocentric views to violate our patients’ right to health. For aspiring physicians, medical pluralism, not biomedical monopoly, should be the ultimate goal.

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8. Ibid. p. 49.
make the case that unethical business practices exacerbate human rights violations. Working at home to minimize our participation in such practices may be one of the most effective ways in which we can promote human rights. Don’t get me wrong, other elements in the fight to promote human rights, such as political action and providing aid to poor communities, are very much needed. However, corporate behavior has such a huge impact on economics, and consequently politics, that it’s easy to see how the socioeconomic systems that permit human rights violations are facilitated by unethical corporate behavior.

Pragmatically, what does this mean for us as concerned citizens? How can we encourage local and international companies to abandon practices that aren’t ethical and are linked to human rights violations?

It seems like we should first and foremost exercise our right to vote in support of politicians who are willing to introduce effective corporate social responsibility laws. However, in countries where such legislation could facilitate significant change, unethical corporate activities don’t often affect the majority of the people voting. Furthermore, many corporations may move their operations out of countries that enforce corporate social responsibility laws, so there is often a concern about possible economic consequences associated with the application of such laws. As a result of these facts, governments are often not particularly interested in socially responsible legislation for corporations. While voting ethically and other forms of political pressure can sometimes produce positive legislative changes, trying to implement change on the issue of human rights exclusively through political channels is not likely be effective.

So where does this leave us? What form of pressure will companies respond to on the issue of social responsibility? I think the answer lies in our control over our financial resources. Each of us controls, or hopefully will at some point control, a small part of two critical elements in a free market economy: consumer income and investment capital. There are a lot of challenges associated with effectively using this control. However, if we can focus this power collectively, we may be able to use it synergistically with political pressure to facilitate changes in corporate behavior for the better.

Being aware of where the money we spend goes is extremely difficult these days. With so many companies participating in the production and delivery of consumer goods, it’s fairly hard to figure out if an unethical company is benefiting when something is purchased. Nevertheless, there are some things that we can do as consumers to reduce our involvement in unethical activities. The simplest strategies are to reduce our consumption of goods and services as much as we can and to buy second hand goods wherever possible. Another good method is buying goods and services from local small businesses, which are often less willing and less able to participate in unethical commercial activities. There are also some larger companies that are known to have relatively progressive labor policies, and patronizing these companies is a way to influence the free market economy for the better. This is most effective when purchasing expensive goods and services, since it maximizes the market share held by more ethical companies. Unfortunately, it often takes significant investigations to determine whether a company’s reputation in this area is deserved or is simply a consequence of a PR campaign. However, information on many companies’ track records in terms of social responsibility is often easily found on the internet [3].

Controlling investment capital is another tool that I think we must use to promote corporate social responsibility. Often in defending ethically questionable practices companies will state that their responsibilities are to making profits for their shareholders, not to satisfying an ethics committee. If potential shareholders refuse to commit capital to companies engaged in unethical activities, then companies will be compelled to change their policies. This goes beyond choosing “ethical funds” from an investment firm’s portfolio. Often the term “ethical” is used as loosely as possible in this context and these portfolios are frequently nothing more than a PR shtick. Truly ethical investing may require privately investigating established portfolios or investigating individual companies for investment, as several groups of concerned citizens have done recently [3, 4]. Ethical investing is a very difficult challenge, but if we can all rise to it, it has the potential to create significant changes in corporate behavior.

With the level of interconnectivity in the business world today, participating in activities that are linked to human rights violations appears to be
a symptom of living in the first world. None of the above measures are going to eliminate our participation completely. But if we can create a significant market for ethically produced goods and services and ethical investment opportunities, and couple that with targeted political action, we might find that we can get companies moving in the right direction. If we pick our battles, and make sure that we fight some of them, we may see meaningful change in our lifetimes. And if anyone finds an ethically pure place to buy coffee somewhere along the way, I’d be interested in hearing about it.

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Human Rights in Medical Education: an example from the Finnish Global Health Course

Human rights issues are crucial for health professionals to understand, and should be covered in their education. Frequently, health professionals are the first ones to meet victims of human rights violations: domestic violence, torture and discrimination, to name a few. It happens everywhere. In Finland – considered a “cradle of equity” – Amnesty International has criticised the national government over the prevalence of vio-

ence against women in the country; thus, health professionals need to recognize the signs and symptoms. On the other hand, it is not exceptional that health care professionals are guilty of human rights violations themselves. They may not always be even aware of the harm they cause in clinical practice, research or policymaking. Health care students should be given tools that help them respect, promote and protect human rights. Efforts to this end are underway in Finland.

The Finnish Diploma Course on Global Health is the product of an international network of public health oriented organisations in Chile, Finland, the Philippines, Nigeria and Tanzania. The course is organised every second year for recently graduated physicians, as well as for medical, veterinary and dentistry students. This year marked the fourth time the diploma course was held. The theoretical part of the course was held in May in Tampere, Finland, and the main organisers were the Faculty of Medicine in the University of Tampere and the Finnish Medical Society, Duodecim. It was financed mainly by the Finnish Ministry for Foreign Affairs. Altogether about 40 students, of whom half were Finnish and half came from the partner countries, got to participate in the course.

This year, at the request of the course organisers, the Finnish Medical Students’ International Committee (FiMISC) and Amnesty International Med Group organised a human rights theme night for the course participants. After introducing some of the activities Amnesty and FiMISC are involved in, then answering participants’ questions, interactive human rights exercises were performed. The participants became familiar with the main human rights conventions, and
actively discussed human rights
issues related to health, cultural
differences and globalisation, as
well as human rights education in
health care. An “agree”-
“disagree” exercise was espe-
cially interesting, as people from
very different cultures and educa-
tional backgrounds expressed
their opinions. For example,
questions of human rights quickly
turned into questions of animal
rights when veterinary students
discussed the right of diabetes
patients to insulin treatment.

Health care personnel are in a
key position to recognise violence
and many other human rights
violations, and to make the
causes and consequences
known. With the political power
granted by their expertise and
authority, they have an unavoid-
able social responsibility to act
on these issues. To be effective
advocates for human rights, they
should receive adequate educa-
tion and be aware of their re-
ponsibility.

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