

Abstract

South Africa's transition to democracy illustrates both obstacles and opportunities for advancing the right to health. The broad definition of human rights in the context of the anti-apartheid struggle, while instrumental for overthrowing an unjust regime, laid the seeds for divergent emphases on how rights should be mainstreamed in post-apartheid public policy. This is evident in the current framing of public health policies as merely issues of service delivery. This retreat from embracing the place of socio-economic rights in public health policies is exacerbated by the neo-liberal policy context and lack of governance experience in translating policy into practice. The training of health professionals must by necessity include the skills to advocate for the rights of the vulnerable and ensure the agency of communities in the redress of socio-economic rights violations.

Le passage à la démocratie en Afrique du Sud montre à la fois les obstacles et les opportunités que rencontre l'avancement du droit à la santé. La définition au sens large des droits de la personne dans le contexte de la lutte contre l'apartheid, tout en ayant joué un grand rôle dans le renversement d'un régime injuste, a été à l'origine de conceptions opposées sur la manière d'intégrer ces droits dans les politiques d'après l'apartheid. On le voit bien à présent dans la formulation des politiques de santé publique qu'on présente uniquement sous l'angle de la prestation de services. Ce recul par rapport à l'intégration des droits socio-économiques dans les politiques de santé publique est exacerbé par le contexte politique néo-libéral et le manque d'expérience en matière de gouvernance pour mettre cette politique en pratique. La formation des professionnels de la santé doit obligatoirement inclure les aptitudes à défendre les droits des personnes vulnérables et assurer un mandat aux collectivités dans les recours exercés en cas d'infractions socio-économiques.

La transición de África del Sur a la democracia ilustra tanto obstáculos como oportunidades para el avance del derecho a la salud. Aunque fue clave para derrocar a un régimen injusto en el contexto de la lucha contra el apartheid, la definición general de los derechos humanos sentó las bases para varios énfasis divergentes sobre la forma en que los derechos se deben incorporar a la política pública post-apartheid. Esto se evidencia actualmente en la formulación de políticas de salud pública como meramente cuestiones de entrega de servicios. Este paso hacia atrás en el reconocimiento del lugar que deben ocupar los derechos socioeconómicos en las políticas de salud pública se intensifica con el contexto de la política neoliberal y la falta de experiencia de los que gobiernan en llevar las políticas a la práctica. Por necesidad, la capacitación de los profesionales de salud debe incluir las habilidades para abogar por los derechos de los vulnerables y asegurar la participación de comunidades en la reparación de violaciones de los derechos socioeconómicos.

HEALTH AND HUMAN RIGHTS: What Can Ten Years of Democracy in South Africa Tell Us?

Leslie London

Despite significant health gains in post-apartheid South Africa, particularly related to the expansion of coverage by basic services and a Bill of Rights hailed worldwide as among the most progressive in the world, the realization of health as a right in South Africa remains elusive.^{1,2} For example, a recent review suggested that between 1996 and 2002, infant mortality in South Africa had risen from 45.4 to 59.0 per 1,000, while life expectancy had declined in the same period from 57 years to 52.5 years.³ Most strikingly, the South African government's reluctance to provide anti-retroviral treatment for people living with HIV, and the presidential flirtation with dissident science in the face of the most explosive HIV epidemic in the world, is a reminder that even in societies with high levels of formal commitment to human rights principles, translating human rights rhetoric into delivery on the right to health is a complex and fraught process.⁴⁻⁶

Leslie London, MB, ChB, MD, MMed (Public Health), is Associate Professor at the School of Public Health and Family Medicine at the University of Cape Town. Please address correspondence to Leslie London, Health and Human Rights Division, School of Public Health and Family Medicine, University of Cape Town Health Sciences Faculty, Anzio Rd., Observatory, Cape Town 7925, South Africa or to ll@cornack.uct.ac.za.

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Ten years into a fledgling democracy, reflection on the South African experience of attempts to marry a health system's transformation to a human rights agenda may help to advance understanding of the obstacles and opportunities for advancing the right to health more generally.⁷ By understanding the historical context in which rights struggles related to health struggles, and shaped activists' perspectives both before and during transformation in South Africa, the conceptual links between health and human rights may be sharpened.⁸ Important lessons may also emerge for how human rights advocacy can impact on operationalization of the right to health in other countries in transition. Although there is an international movement to mainstream the right to health, which is illustrated, for example, by the appointment of a United Nations Special Rapporteur on the Right to Health and in the World Health Organization's (WHO) health and human rights series, empirical evidence for the realization of the right to health in health systems undergoing transition is scant.⁹⁻¹¹

This article will therefore sketch a brief history of health activists' engagement in the anti-apartheid movement within South Africa and the basis for the health sector's involvement in human rights concerns. Thereafter, it traces the mainstreaming of human rights during South Africa's transition, as well as government and civil society responses including the role of health training institutions. Lastly, the article concludes by reflecting on what elements are potentially instructive for advancing the engagement of the health sector with the human rights movement, particularly as countries move from unjust and repressive political systems to democracy.

Health and the Anti-Apartheid Movement

As an illustration of Jonathan Mann's triadic relationship, apartheid South Africa was one of the clearest examples of the simultaneous ways in which human rights abuses impact on health, health care impacts on human rights, and how human rights and health struggles are consonant paths to human well-being.¹² Firstly, apartheid laws created the homelands system as the cornerstone of "sepa-

rate development," depriving black South Africans of citizenship and confining them to underdeveloped and impoverished homelands generating a legacy of death and disease due to undernutrition, tuberculosis, and infantile gastroenteritis, illustrating starkly the impact of human rights violations on health.¹³ Secondly, the systematic insertion of race ideology in the planning and delivery of health services resulted in vast numbers of black South Africans receiving health care that was grossly inferior or absent, depriving a whole population of its right of access to health care, to dignity, and to equality—an illustration of health care impacting on human rights.¹⁴ In the reaction, mobilization of struggles for health and for freedom were merged into one seamless movement, both ultimately seeking a society based on respect for human dignity and individual and social well-being.¹⁵

Thus, civil society formations within South Africa actively drew on the support of health workers across a range of issues, including children's rights, opposition to domestic violence, access to social services, and promotion of community empowerment through health worker projects.^{16,17} Even the seemingly mundane task of securing worker's compensation for occupational injury became a highly politicized activity, attracting the attention of the security police on occasions, as the burgeoning trade union movement increasingly mobilized workers in the anti-apartheid struggle.^{18,19} Consequently, the health sector was one of many that were aligned in the democratic movement in South Africa, and health professionals were both direct and indirect participants in struggles for better housing and opposition to racist, segregatory policies as well as draconian security legislation.²⁰

Notably, those health organizations campaigning for civil and political rights (for example, against detention without trial) were also the same groups simultaneously devising policies for primary health care in post-apartheid South Africa, lobbying for a national health service, and joining with civic organizations campaigning for better housing.²¹⁻²⁴ In their work, activist health organizations understood instinctively the links between civil and political

rights, on the one hand, and social and economic rights on the other, and how both had to be addressed to effect an adequate transition in South Africa.²⁵

A seminal event in South Africa's health and human rights history was the death of Steve Biko, a political activist detained by security forces in 1978, who died from injuries sustained during torture under interrogation, in circumstances where the medical doctors responsible for his care subjugated their clinical judgment to that of the security police.²⁶ The import of his death was not only in the gross violations of human rights that occurred with his torture, but in the clear evidence of complicity on the part of the medical doctors who treated him while in detention. The following exchange from the inquest into Biko's death provides the evidence:

Sydney Kentridge: In terms of the Hippocratic Oath, are not the interests of your patients paramount?
(Lawyer for the Biko family)

Ivor Lang: Yes.
(Doctor responsible for Biko's medical care in detention)

Sydney Kentridge: But in this instance they were subordinated to the interests of the security police?

Ivor Lang: Yes.²⁷

The attempts at a cover-up by the Medical Association and the Medical Council in South Africa provoked popular outrage against their failure to uphold professional and ethical obligations.²⁸ Health professionals who saw themselves as apolitical were so deeply offended by the injustice of Biko's death that they were willing to sign petitions, write letters, march and hold placards, and, most importantly, join organizations to work for change, thereby spurring the growth of a human rights movement in health in South Africa.²⁹ In that sense, a single violation of civil and political rights (among many such violations under apartheid) prompted the development of organizations to address a full range of human rights related to health—civil and political as well as socio-economic.

Moreover, the identification with a human rights agenda emerged intuitively among South African health activists long before formal recognition of the health and human rights movement internationally or before WHO had moved beyond its Alma-Ata statements on primary health care to begin to mainstream human rights in health.^{30,31} Rather than framing the discourse within the paradigm of international human rights law, activists used human rights in an aspirational fashion, largely as an all-encompassing statement of resistance, as part of a process that Marais describes as one where “struggles of civil society organs were seen in purely instrumental terms ... incorporated into the external assault against the apartheid state” and so offered a broad banner under which to mobilize many concerns for social justice.³²

This lack of specificity in defining what constituted human rights, and how it should be incorporated in popular action, while entirely appropriate in broadening mobilization for political resistance at a given historical point in time, contained significant implications for the ways human rights (and health) were (or were not) to be operationalized as transformation unfolded in post-apartheid South Africa in later years.

Mainstreaming Human Rights Post-Apartheid

As apartheid’s demise gradually loomed towards the end of the 1980s, the health sector witnessed the incremental dismantling of apartheid in health care. Hospitals gradually desegregated, black medical students were allowed to study at “white” medical schools, black doctors’ pay equalized, and they could stay in the same accommodations as their white colleagues.³³ Conditions in prisons improved, restrictions on visits to political detainees began to be relaxed, and routine use of torture of political opponents of apartheid ceased. With hindsight, it emerged that many of the petty apartheid practices (for example, racially segregated hospital wards) were based not directly on law or regulations but on administrative practices or memoranda issued by medical bureaucrats, whose enthusiasm to replicate their political masters’ apartheid vision outweighed their sense of professional ethical values.³⁴

Moreover, the focus of human rights violations shifted during the early 1990s away from the state to violations perpetrated by a sinister third force, in the form of mass killings on commuter trains, rampaging vigilantes in rural homesteads, and supposed black-on-black violence.³⁵ Although these developments were shown by the work of South Africa's Truth and Reconciliation Commission (TRC) to have been largely orchestrated by apartheid agents to disrupt the transition, these shifts in the political context for rights violations were perhaps the first warning that simplistic notions of human rights were insufficient to characterize how to advance human rights outside the apartheid context.³⁶ Rather than viewing human rights as being primarily about protecting individuals from an overbearing state, rights approaches needed to be more nuanced in serving the process of transformation.

Nonetheless, what emerged in 1994 was a remarkable shift—a transition from an undemocratic, racist state to a political system with universal suffrage and formal democracy that avoided a race war. This shift included a Constitution with a highly inclusive and comprehensive Bill of Rights. It also established a range of institutions to protect democracy, the rule of law, and respect for human rights in the form of the South African Human Rights Commission (SAHRC), the Gender Commission, and the Public Protector. Further, legislation provided for the Truth and Reconciliation Commission, whose work in the late 1990s was to make explicit the nature, extent, and circumstances under which gross human rights violations had taken place under apartheid. In short, alongside an incredible political journey, South Africa was witness to an evolving infrastructure and commitment to building a human rights culture across all sectors of society.

Civil Society, Human Rights, and Transformation in South Africa

Because of the strong tradition of rights activism in civil society groups within the anti-apartheid movement, there was a strong base for engagement of the health sector in human rights as South Africa entered its post-apartheid transition. This was particularly evident in the area of re-

productive rights, where gender activists were able to mobilize organized labor, nongovernmental organizations (NGOs), and government, using a discourse that linked individual rights to service provision around key reproductive health goals.³⁷ The TRC's investigation in 1997 of the health sector in South Africa provided an important additional impetus to the mainstreaming of a human rights focus in the health sector.³⁸ What was viewed previously as the domain of radicals gained sudden credibility.³⁹ For example, the extent to which human rights were a professional responsibility became a debate of substance for educational institutions and for professional organizations within their own structures and constitutions.^{40,41} From being peripheral to policy formation and the exercise of state power, health activists were called to enter government and professional organizations—the same decision-making bodies that they had worked to discredit just five years earlier.

The term “transformation” became an important defining paradigm for a range of self-reflective activities post-1994. A number of institutions undertook processes of self-examination, sometimes willingly, sometimes reluctantly, and with variable degrees of success.⁴² The Medical Council, the body charged with statutory responsibilities to maintain ethical standards in the profession, underwent an interim council phase and restructured itself to ensure greater representivity of black professionals, and it established an advisory committee on human rights, ethics, and professional practice.⁴³ The Medical Association underwent tortuous years of merging with its former opponents, rewriting its Constitution, and ensuring that its leadership reflected the diversity of membership of the profession.⁴⁴ It weathered devastating leadership conflicts, but it also established a Committee on Human Rights, Ethics, and the Law.⁴⁵ Similar developments occurred in the nursing and other health professions.⁴⁶

As ministers at the national and provincial levels and public servants in the health ministry, former opponents of apartheid now had responsibility for alternative policies and programs advocated during the anti-apartheid struggle. This period saw the realization of a number of pro-poor policies

in health and social services; for example, the extension of free care to pregnant women and to children.⁴⁷ Coupled with the extensive human rights machinery developed after 1994, expectations emerged of partnerships between civil society and the new government in the development and implementation of health policies.⁴⁸ The post-apartheid decade, therefore, represented a period of intensely participatory policy formation, in which human rights were seen as key to transformation in the new South Africa. Huge opportunities were opened for human rights discourse to enter public policy and for health professionals engaged in human rights work to push for policies that prioritized equity and protection of vulnerable groups. This was particularly evident in the work of the Reproductive Rights Alliance that used explicit rights language to coordinate lobbying and constitutional court action in support of new abortion legislation.⁴⁹ Access to services for termination of pregnancy, protection of Persons Living with HIV seeking employment, and community service for medical graduates to improve human resources in underserved rural areas are all examples of areas that saw post-1994 health legislation with an explicit rights agenda.⁵⁰⁻⁵² This mirrored developments outside the health sector such as legislation to promote land redistribution, to allow access to information, and to protect whistleblowers.⁵³

What Are the Dimensions of Human Rights and Health in the “New” South Africa?

Ten years into South Africa’s democracy, however, it is now possible to reflect more critically on how the health and human rights nexus has evolved. While there have been significant changes in the legal and policy environment, also evident is the unfolding of a number of contradictions in the evolving relationship of health to human rights. These are tensions emerging post-1994 that were submerged by the “homogenizing sweep” of the anti-apartheid struggle.⁵⁴

Firstly, the human rights machinery created post-apartheid, which seeks to redress past inequality and allow formerly disadvantaged groups access to justice, has also provided opportunity for the rich and powerful to misuse

their power. For example, the tobacco industry challenged the South African Department of Health's regulations controlling smoking in public places by using transparency legislation to demand access to the research data on which the Department's proposed regulations were based.⁵⁵ The fact that a powerful lobby group from industry could use machinery designed to protect victims of abuses to promote its own interests, illustrates how human rights institutions are of necessity contested terrains. In promoting such institutions, mechanisms must ensure disproportionate access for those intended to benefit mostly from its protections—the vulnerable and marginalized.

The work of the SAHRC post-1994, notwithstanding important limitations, reflects an attempt to reach constituencies most in need.⁵⁶ For example, its poverty hearings in 1998 and its investigations into conditions of farm workers reflect efforts to ensure that rights mechanisms are used primarily to address groups most disadvantaged under apartheid and at risk for discrimination in the present transition.⁵⁷ The SAHRC also routinely audits the performance of government departments, requiring them to report progress towards the realization of socio-economic rights, including access to health care. These are important checks and balances institutionalized in post-1994 South African society, around which will hinge the success or failure of the South African transition.

Furthermore, how rights are broadly understood in South Africa at present is a product of a number of forces. Firstly, activists with little experience of government were thrown suddenly into positions where they had to begin to not only develop but also implement policy. Faced with the resistance of an established bureaucracy, idealism and ideology proved insufficient to drive the changes to institutional culture needed to translate new policies into action. Secondly, current rights approaches reflect a diversity of meanings inherited from the lack of specificity given to human rights in the anti-apartheid struggle, where accommodation of the widest spectrum of views was key to mass mobilization for the political overthrow of the apartheid regime. In government policy, human rights are increas-

ingly, although not uniformly, being accepted in relation to classic civil and political rights, and as providing protection from discrimination, and less and less in relation to socio-economic rights.⁵⁸ For example, measures to protect individuals from discrimination, are framed very explicitly as rights issues in a constitutional framework, whereas provision of housing, access to health care, and land reform programs are increasingly framed as matters of “delivery” of social services, important for redress of inequality (and for reelection at coming elections) but divorced from a constitutional obligation of the state in terms of the Bill of Rights.

This is most clearly illustrated in the record of the South African government on HIV, where the government’s record on anti-discrimination has been almost faultless. It has passed very strong labor legislation protecting Persons Living with HIV from discrimination, developed anti-discriminatory school admissions policies, and tackled the health insurance industry for excluding HIV-related illnesses.⁵⁹⁻⁶¹ Yet it has been deeply reluctant to concede the provision of anti-retroviral (ARV) treatment, in fact opposing civil society claims to the right of access to health care, as contained in its own Constitution.

This reluctance to provide ARVs, first in relation to pregnant women and then for all people living with HIV, has been framed in terms of cost and equity considerations. In contrast, it has been a civil society grouping, the Treatment Access Campaign (TAC), that has shifted the debate firmly to one of fundamental human rights and utilized the human rights machinery established by the same government to force its hand on the ARV issue.^{62,63} Indeed, the National AIDS plan of the South African government includes a reference to human rights but confines its concerns to broad issues of discrimination, rather than reflecting on any state obligation to fulfill socio-economic rights.⁶⁴

At the same time as there is a narrowing of a rights approach in government, a widening of rights approaches is apparent in civil society with strong alliances developing, for example, between TAC and the Trade Union Movement in a campaign for a basic income grant as a poverty alleviation mechanism, illustrating the continuum of health

across a range of socio-economic rights.⁶⁵ This also reflects the slow recovery of civil society from the blighting experienced in the immediate post-1994 transition when NGOs were decimated by the redirecting of foreign funding away from civil society groups to the new democratic state.⁶⁶ Many commentators see this rebirth of civil society as key to securing the democratic gains of the 1994 transition, both in terms of formal political participation and also in accessing basic socio-economic entitlements increasingly resisted by government.⁶⁷

Importantly, accessing socio-economic rights through the courts alone remains of limited value as a strategy to realize the right to health.⁶⁸ For example, a High Court ruling that prevented the eviction of a group of informal settlement residents near Cape Town in 2000, while hailed as a major victory for socio-economic rights jurisprudence, was not accompanied by any degree of popular mobilization.⁶⁹ As a result, the responsible authorities have not been forced to take appropriate remedial action, and the community remains living in inadequate housing conditions to date. This illustrates the importance of popular action as a necessary complement to legal strategies to achieve realization of socio-economic rights.⁷⁰

Why should this be the case—that a government whose liberation struggle against apartheid inspired human rights movements internationally has seemingly reneged on its human rights commitments? Contributory factors may well be the idiosyncratic role played by President Mbeki's flirtation with dissident AIDS science, the nature of centralized political control and patronage in an evolving democracy, or the contested lack of ministerial leadership, political independence, and integrity.⁷¹⁻⁷³ There are, however, also important reasons that can be traced back to how the notion of human rights was incorporated in the liberation struggle in South Africa.

Faced with apartheid, it was both easy and politically necessary to overlook the implications of the link between civil and political rights to socio-economic rights because the same illegitimate government was violating both types of rights on a massive scale. Today, however, the govern-

ment consists of precisely those former anti-apartheid activists, and liberation movement politicians, who have now to deliver on all human rights. This change has been accompanied by a downplaying of the link between socio-economic rights and civil and political rights, such that access to health care is increasingly reframed away from a rights paradigm. For example, in her address on World AIDS Day in December 2003, the Minister of Health repeatedly cited the importance of service delivery in addressing HIV/AIDS, and did not acknowledge the right of access to health care.⁷⁴ Similarly, in her court arguments against the TAC's legal action to force a programme for the prevention of mother-to-child transmission of HIV, the Minister's argument was that matters of policy implementation were the prerogative of the executive rather than the courts, notwithstanding the fact that the matter pertained to a socio-economic right of access to health care. Notably, the Constitutional Court disagreed that the Executive was beyond judicial review, although it did confirm a reluctance to make such interventions routine.^{75,76}

Various factors may drive this contradiction. At a psychological level, people who fought for freedom, who saw themselves as champions of human rights, cannot reconcile the idea that they might now be obstacles to the realization of socio-economic rights—hence, the reframing away from a rights paradigm of issues of access to health care. One might even describe this as reflecting a kind of cognitive dissonance on the part of many health professionals in government. Coupled with political contestation around styles of leadership within the ANC that saw the largely exile-driven “authoritarian approach” come to dominance over the “more open and responsive style” of the internal liberation movement, there appears to have been little room for critical self-reflection on ruling party practices.⁷⁷

Secondly, the influence of global neoliberal economic policy has taken hold profoundly in the South African body politic, such that underlying economic assumptions behind the supposed lack of resources for ARV provision are not questioned or even made explicit.^{78,79} Moreover, none of the Bretton Woods institutions' policy advice to recipient countries makes

more than token acknowledgement of human rights obligations, and certainly not in relation to socio-economic rights, preferring to link any mention of human rights to questions of “good governance.” South Africa’s post-apartheid economic policy has been so conservative as to be considered an indigenous structural adjustment program, yet without any indebtedness to the World Bank or the International Monetary Fund.⁸⁰

While most evident around HIV, such contradictions in how human rights shape public policy in South Africa are emerging elsewhere—for example, in issues of land reform and food security.⁸¹ This means that health professionals in civil society engaged in integrating human rights in health have to continue to make the links between civil and political rights and socio-economic rights in general, and health in particular. Having a democratically elected government is no guarantee that the full spectrum of rights will be respected, protected, or fulfilled. Moreover, changes within the organization of the health professions remain contested and incomplete. For example, some seven years after his role was first highlighted by the TRC, both the Medical Association and the Health Professions Council have yet to conclude any disciplinary steps against Dr. Wouter Basson, the cardiologist who oversaw the apartheid military’s program on chemical and biological warfare.⁸² It is therefore not only government that represents a site of ongoing contestation but also the institutions of the health professions whose organizational cultures lag behind the policy aspirations of new leadership seeking to profile new values such as a commitment to human rights.

Health Professionals As Advocates for Human Rights?

How does one operationalize policy commitments to a human rights approach to health within professional practice, particularly at the interface between health professionals and their patients and communities? One of the important developments in the South African health sector has been the adoption of a Patients’ Rights Charter by the Department of Health in 1999.⁸³ Despite its title, the Charter is less about rights than about delivery (see Table 1).

The Charter is located in the Department's Quality Assurance division and is essential as a tool to ratchet upward quality of health care, rather than being institutionalized in a specific rights framework.

Most health care providers interviewed in studies on the Charter view it as yet another burden placed on already overworked, underpaid, low-morale personnel, and exhibit little enthusiasm for its implementation.⁸⁴ From their point of view, patients are rude and unappreciative of the difficult circumstances under which many health workers labor. Patients, in their turn, are frequently unaware of the Charter and see the long queues and rudeness from health care providers as yet one more burden.

Human rights in this context become reduced to oppositional entitlements in a fruitless antagonism between the disempowered rights-holder and the disempowered rights-gatekeeper. Some of the most successful translations of pa-

| Patients Have the Right To: | Patients Have Responsibilities To: |
|---|---|
| <ul style="list-style-type: none"> • Knowledge about medical insurance • Choice of health services • A named health care provider • Confidentiality and privacy • Informed consent • Refuse treatment • Second opinion • Continuity of care • Complain of poor quality care • Healthy and safe environment • Participate in decision-making • Access to health care | <ul style="list-style-type: none"> • Take care of own health • Care for, protect the environment • Respect the rights of others • Utilize services properly, not abuse them • Know what service is offered • Provide accurate information • Advise health care providers about end-of-life decisions • Comply with treatment • Ask about costs, arrange payment • Take care of health records |

Table 1. *The South African Patient's Rights Charter**

*The South African Patient's Rights Charter, Department of Health, Ministry of Health, South Africa.

tient rights approaches in health care have emerged not when a Charter has been imposed from above, but when local communities, organized in the form of health committees, and local clinic staff have engaged in discussion about what are reasonable and feasible standards for meeting a right of access to health care in a context of local resource scarcity.⁸⁵ Where staff and users' representatives have been able to work together to set jointly agreed-upon standards, the process has been mutually empowering, enabling health professionals to see the value of human rights approaches to health with benefits to the communities they serve. While such examples are isolated, they provide important lessons. Even in the current repressive environment in Zimbabwe, such health care provider-user interactions around patient rights have helped defend significant rights to health and access to health care.⁸⁶

In this context, health training institutions have a key role to play in equipping graduates with the skills and orientation to make human rights standards part of their practice—whether as advocates for the vulnerable or simply as clinicians and researchers who recognize where and how obligations to respect, protect, and fulfill human rights intersect with their practice.⁸⁷ Despite the advent of formal democracy in South Africa, the problem of dual loyalties continues to confront health professionals and poses hard ethical choices about prioritizing the rights of patients and communities over state policies.⁸⁸ A case in point is a medical superintendent of a rural hospital who, in 2001, was dismissed for assisting a local NGO supplying anti-retroviral medication to rape survivors at a time when national health policy and statements from the President suggested ARVs were toxic and against policy. His choice to align his professional practice with rape survivors' right of access to health care resulted in some cost to his own career.⁸⁹

Despite the constraints inherent in the nature of professionalism—that is, the authority granted to professionals compromises the potential willingness to step beyond boundaries—training can shift students' perceptions of advocacy towards seeing this as a regular part of a doctor's or nurse's job. Critical in this process is the institutional environment, role models, and the agency of students them-

selves. The Rural Support Network is a project run by mainly black health science students in South Africa, aimed at encouraging health professionals to return to rural areas to serve the needs of neglected populations. It recruits school leavers in rural areas for studies in the health disciplines in the belief that students from rural areas are more likely to return to rural practice.⁹⁰ It has been effective in mobilizing students towards an advocacy agenda based on promoting access to health care for disadvantaged rural communities and has been actively driven by students as agents of change.⁹¹ The role of teachers and training institutions should be to facilitate such initiatives in building a culture of rights advocacy among graduates.

Lastly, agency is also about users of services and communities. If advocacy for human rights is to be placed at the core of professional training, communities must be active in that process. Many of the most effective learning experiences for students are placements in communities for project work, where they engage with and work alongside community health workers, civic organizations, and community groups on health projects, learning in ways that classrooms cannot teach. The integrity and equality of these community partnerships can demonstrate the potential of a human rights agenda for student advocacy. Much as human rights activists working with torture survivors have learned that empowerment is key to enabling individuals to overcome the consequences of torture, medical and public health students engaging in advocacy must recognize the importance of empowering victims of violations of socio-economic rights, both individuals and communities, to be active agents in the redress of these violations. Without such a framework, training institutions for health professionals risk reducing the health and human rights content of their curriculum to theoretical and acontextual teaching, which is unlikely to shift professional practice, or to equip graduates with the necessary skills and insights to challenge policy-makers to fulfill the full spectrum of human rights in regard to health.

Conclusion

South Africa's political transition has inspired many around the world in the struggle for justice. However,

without careful analysis of the contradictions that emerge in operationalizing a human rights approach in health, we run the risk of over-simplifying and mythologizing a struggle that is not yet ended. How does a struggle against injustice ensure that socio-economic entitlements for the poor and marginalized are not consigned to second priority when that same political leadership takes the reins of government? Some important lessons to emerge in the South African context are the importance of identifying how human rights can become a casualty of the typical transition phenomenon of the gap between policy and practice and of global economic forces that allow neoliberal policy choice to erode liberatory values and commitments. Moreover, the South African post-apartheid transition has shown the need to constantly challenge the institutional culture of the organizations of government and of the health professions, as well as the importance of operationalizing the link between civil and political rights, on the one hand, and socio-economic rights, on the other, not only by political decision-makers but also by active elements of civil society. As part of civil society, institutions that train health professionals have a key role to play to ensure that graduates are equipped to turn the obligation to respect, protect, and fulfill the complete spectrum of human rights into an everyday part of their practice.

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