

Human Rights: A professional responsibility and an institutional obligation

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The series of articles in this edition of SAJOT illustrates powerfully the claim developed by the late Jonathan Mann and colleagues that Human Rights and Public Health provide parallel and complementary approaches to maximising human being¹. Even though the 1978 Declaration of Alma Ata on Primary Health Care framed health explicitly as a right, it has taken some 20 years from the adoption of the Alma Ata Declaration for the health community globally to acknowledge the importance of the links between health and human rights. The papers in this special edition provide evidence of the different ways in which human rights and health practice are integrally related. More particularly, they reflect the growing realisation amongst those concerned with the development of professionalism, skills and knowledge in the health disciplines, that the practice of healing and health care must be more than just a technical exercise, but should include acknowledgement of the social roles of professionals, particularly at the intersection of ethics, human rights and development.

A striking feature of all the articles^{2,3,4,5,6,7} is the extent to which vulnerability is key to considerations of human rights in professional practice. Such vulnerabilities are typically multiple, for example in relation to people who are both disabled and homeless² or unemployed³ or who are children with special needs⁴. Because human rights approaches imply the prioritisation of the needs of those who are most at risk⁵, multiple vulnerabilities are critically important to health programming and to adjudication of whose needs should be prioritised in the context of resource constraints. As alluded to in the articles, advocacy to secure rights should therefore emphasise the critical obligations of the state in prioritising those who suffer multiple axes of vulnerability. Indeed, it is the particular strength of invoking human rights claims to provide a direct line of accountability for the state to deliver on its constitutional obligations on health.

A further aspect to emerge from the discussions is the indivisibility of human rights, across the spectrum from civil and political rights to socioeconomic entitlements. This is illustrated, for example, in the inter-connectedness of the rights to dignity of people with psychiatric disabilities with their rights to work³ and the right of children to access mobility devices being necessary for protecting their dignity and access to health care⁴. Realisation of rights is thus important not only in and of themselves, but as being instrumental to the realisation of other rights.

However, more importantly, as identified by a number of the articles, rights on paper mean little unless there are mechanisms in place to enable rights-holders to realise their rights. Agency on the part of those most vulnerable to human rights violations⁹ is therefore critical to effective redress of discrimination against disabled people and, as a vehicle to assist them to participate and engage in realising their rights, community-based rehabilitation workers have emerged as powerful voices to assist disabled persons to exercise agency. Without agency on the part of the most vulnerable in society, human rights approaches, in their enthusiasm to alleviate suffering, may risk reinforcing dependency on handouts.

Yet, the strength of rights in holding government accountable has also been criticised for leaving untouched, or at least struggling to engage with, the world of inter-personal relationships. In other words, some critics have held that human rights work well for the legal accountability, but do not change behaviour or influence the values held by people which shape their interactions with other human beings. However, most striking in the papers in this

collection, are examples where a rights focus has, for example, worked powerfully to prompt reflection on personal beliefs and attitudes² or to prompt novel methods of participatory data collection⁷; responses that are far more nuanced and rich than reliance on legal standards to redress inequalities.

What does this mean for professional practice? Overwhelmingly, the authors of these articles point to the importance of moving beyond a medical and individualised deficit approach towards a more socially engaged practice, which prioritises equity and social justice. This, too, has implications for the training of students at under- and post-graduate levels, since teachers of these students will need to be in a position to make rights real for their trainees. To this end, the Health Professions Council of South Africa has recently adopted a resolution to make the teaching of ethics, human rights and health law a compulsory requirement for graduate competencies across the health professions¹⁰ and the attention to human rights in the curriculum has recently been a focus of a national conference to identify core competencies in human rights for health professionals¹¹.

SAJOT's adoption of a regular human rights feature is therefore both timely and an important signal that the Occupational Therapy profession is taking very seriously the Truth and Reconciliation Commission's recommendations that human rights should form an integral part of health professional training. It also reflects an important level of institutional commitment to mainstreaming human rights as a professional obligation. One hopes that the example of the Occupational Therapy profession will prompt other disciplines to follow suit in helping to ensure that graduates in all the health professions make human rights a core aspect of their professional practice.

References

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