

Caring for human rights Challenges and opportunities for nurses and midwives

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Abbreviations

In this report the following abbreviations are used:

AI	Amnesty International
AIDS	Acquired Immunodeficiency Syndrome
ANA	American Nurses Association
BMA	British Medical Association
CEDAW	Convention for the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CPT	European Committee for the Prevention of Torture
CRC	Convention of the Rights of the Child
DENOSA	Democratic Nursing Organization of South Africa
DOTS	Directly observed treatment (short course)
ECHR	European Convention on Human Rights and Fundamental Freedoms
FGM	Female genital mutilation
FGC	Female genital cutting
FIGO	International Federation of Gynaecology and Obstetrics
HIV	Human immunodeficiency virus
HRC	Human Rights Committee
HRW	Human Rights Watch
ICC	International Criminal Court
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICM	International Confederation of Midwives
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross
IDF	Israeli Defence Forces
ILO	International Labour Organization
ISONG	International Society of Nurses in Genetics
MDRI	Mental Disability Rights International
NHS	United Kingdom National Health Service
NORAD	Norwegian Agency for Development Cooperation
PEP	Post-exposure prophylaxis
PSI	Public Services International
RCN	Royal College of Nursing
SARS	Severe Acute Respiratory Syndrome
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCAT	United Nations Committee against Torture
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization
WMA	World Medical Association
ZNA	Zambia Nurses Association

Caring for human rights

Challenges and opportunities for nurses and midwives

Nurses deal with human rights issues daily, in all aspects of their professional role. Nurses may be pressured to apply their knowledge and skills in ways that are detrimental to patients and others. There is a need for increased vigilance, and a requirement to be well informed, about how new technology and experimentation can violate human rights. Furthermore nurses are increasingly facing complex human rights issues, arising from conflict situations within jurisdictions, political upheaval and wars. The application of human rights protection should emphasise vulnerable groups such as women, children, elderly, refugees and stigmatised groups.¹

This paper discusses the role of human rights in the work of women and men involved in nursing – as nurses, as midwives or as others involved in the care of the sick and needy.² The goal of this review is to examine a wide range of links between nursing and midwifery practice and human rights and offer some recommendations about how to deal with the many human rights challenges nurses and midwives face. The paper is written for anyone connected with the health professions, particularly nursing and midwifery. It emphasizes the importance of a human rights-based approach to nursing and the relevance of human rights to professional practice in a wide variety of settings. The paper could serve as a review of issues, as a teaching resource and as a guide to literature.

1. Introduction

Nurses and midwives share with other health professions a commitment to the well being of patients and to a professional practice based on codes of ethics. However, they increasingly face impediments and challenges to fulfilling this role. These challenges range from those in daily practice where the increasing complexity of health care raises significant ethical issues

¹ International Council of Nurses (ICN). *Nurses and Human Rights*, Geneva, 1998. Available at: <http://www.icn.ch/pshumrights.htm>. Accessed 9 May 2006.

² In this paper the term “nurse” will refer to a person “who has completed a nursing education programme and is qualified and authorised in her [or his] country to practise as a nurse” (ICN Constitution, Article 6). Where the term is used in a different sense this will be indicated. “Midwife” is used in the sense contained in the definition elaborated by the International Confederation of Midwives (ICM) and the International Federation of Gynaecology and Obstetrics (FIGO), stressing both education and registration and an orientation towards supervision, care and advice to women during pregnancy and childbirth and care of the mother and child after the birth. See: <http://www.internationalmidwives.org/Statements/Definition%20of%20the%20Midwife.htm>. This paper updates and expands an earlier paper on the same themes published by Amnesty International (AI) in 1997. See *Nurses and Human Rights*. London, AI Index: ACT 75/000/1997, and also a more recent short statement on this subject: ‘Amnesty International urges a stronger human rights role for nurses and midwives.’ London, AI Index: ACT 75/002/2005.

through to nursing in areas of natural disaster and poverty and in regions of conflict and tension, where there are persistent risks of nursing staff and their patients being victimized – as a result of their witnessing abuses or treating individuals regarded by the authorities as opponents or subversives, or being regarded as subversive themselves. They can suffer harm as a result of “being in the wrong place at the wrong time”. Nurses also risk being pressured to collaborate or collude in abuses occurring in their presence or with their knowledge.

This paper reviews some of the risks of human rights violations faced by nurses and midwives or seen by them during their work. It also examines their role in the provision of care to people whose rights have been violated; argues for a continuing and stronger role by the nursing profession in the defence of patients under threat, the rights of women and girls, the protection of nurses and nursing associations at risk. The paper calls for the promotion of ethics and human rights standards and suggests that there is a need for a constant monitoring by professional associations and human rights groups of pressures on nurses to engage in unethical behaviour.

Amnesty International believes that nurses and midwives have much to contribute to the protection and promotion of human rights through ethical professional practice, through the rejection of participation in abuses of human rights and through playing a whistle-blowing role when they do witness grave abuses occurring which are not being addressed.

Amnesty International recommends, among other things, that:

- Nursing associations and individual nurses should increase their efforts to protect and promote human rights
- Professionalism and professional ethics should be strengthened and promoted among national nursing associations and their members
- Security for nurses and midwives within the health services and in areas of human rights abuse should be strengthened
- Professional and human rights training should be made more regularly available throughout a nurse’s or midwife’s career.

Amnesty International and the health care professions

Amnesty International is an international human rights organization with nearly two million members in more than 180 countries or territories. Amnesty International’s mission is to undertake research and action focused on preventing and ending grave abuses of the rights to physical and mental integrity, freedom of conscience and expression, and freedom from discrimination, within the context of its work to promote all human rights³.

The Amnesty International Health Professional Network was established more than 30 years ago and comprises individuals, groups and networks of doctors, nurses, mental health specialists and other health professionals in more than 30 countries. The Network works for

³ Amnesty International’s mission statement is available on-line at: <http://web.amnesty.org/pages/aboutai-statute-eng#top>

the goals of AI through the application of professional knowledge, contacts, letter-writing and lobbying skills.

For many years Amnesty International has called for a strong role by the nursing profession in protecting patients' rights, and advocating on behalf of nurses at risk.⁴ Furthermore, it has recommended active monitoring by nursing bodies and human rights groups to protect the rights of nurses pressured into unethical behaviour.

AI has continued to note compelling evidence of the harmful and chronically damaging effects of human rights violations on individuals and communities, some of which relate to medical and nursing practice. These include the direct impact on health of torture, ill treatment and lawful and unlawful punishments. They also include the consequences of gender-based violence and harmful traditional practices, the impact of poverty and the failure of states to meet their obligations to protect the human rights of individuals and populations. In these areas, nurses and midwives can play a role in keeping the interests of patients foremost and working to defend their human rights. In so doing they affirm the ethics of the health professions.

1.1 Historical perspectives on nurses and human rights

It is not possible in this short section to address adequately the historical relationship between nursing and human rights and ethics since the nineteenth century. This section is intended to draw on some specific examples to illuminate wider human rights principles and problems. The history of nursing is described elsewhere and is the subject of specialist academic study.⁵

Nursing famously was seen as a humanitarian force during the nineteenth century when the caring role of nurses was grafted on to the privations and suffering of military conflict. Florence Nightingale and, belatedly, Mary Seacole came to define the healing role of the nurse through their well-publicised work during the Crimean War.⁶ Clara Barton, a prominent nursing figure during the American Civil War, also contributed much to the development of nursing and founded the US Red Cross.⁷ The subsequent development of nursing reflected many of the principles elaborated during this period and later in the nineteenth century and early twentieth century. However, this wholly benevolent view of nurses' capacities was later to change as a result of abuses of nursing's humanitarian role.

It was the behaviour of doctors in Germany between 1933 and 1945 that drove much of the post-1945 discussion on medical and research ethics and contributed to the creation of a World Medical Association (WMA) with medical ethics as a principal focus.

⁴ Amnesty International. *Nurses and Human Rights*. AI Index: ACT 75/002/1997. Available at: <http://web.amnesty.org/library/index/engact750021997>

⁵ See, for example, the UK Centre for the History of Nursing and Midwifery, <http://www.ukchnm.org/>; Barbara Bates Center for the Study of the History of Nursing, <http://www.nursing.upenn.edu/history/>.

⁶ Both wrote of their experiences. See: Nightingale F. *Notes on Nursing: What it is and What it is Not*. Lippincott Williams and Wilkins: Philadelphia, 1992 [first published 1860]. Seacole M. *Wonderful Adventures of Mrs Seacole in Many Lands*. Harmondsworth: Penguin, 2005 [first published 1857]. Further information on Florence Nightingale is available via the Florence Nightingale Museum web-site: <http://www.florence-nightingale.co.uk/>

⁷ Oates SB. *Woman of Valor : Clara Barton and the Civil War*. New York: Free Press, 1994.

Mary Seacole, whose "wonderful adventures" were first published in 1857. © Jamaica National Library

Mary Seacole, whose "wonderful adventures" were first published in 1857. © Jamaica National Library

It also gave rise to the adoption of the Nuremberg Code⁸ and to the priority given to research ethics given by the WMA. While the collusion of German doctors in the Nazi "euthanasia" and genocide programs has been analysed in considerable detail⁹, the behaviour of nurses during the Third Reich has received considerably less attention, though there are nevertheless a number of important studies illuminating the role of nurses during the Nazi period, 1933-1945.¹⁰ Examination of the role of nurses in the mass murder of psychiatric patients and "incurable" or "malformed" children under the Nazis throws light onto the processes whereby nurses can be persuaded to participate in unethical and lethal behaviour.

According to one scholar, it is clear that "the architects of the 'euthanasia' programme did not set out to terrorize nurses [into] carry[ing] out measures that contradicted their most fundamental professional and moral imperatives."¹¹ Rather, they intended

...to dampen their sense of alarm, immobilize them through feelings of helplessness, and exploit their desire for emotional equilibrium. Confrontation and crisis were to be avoided; and in those instances where self-conscious awareness of complicity in murder emerged, it was contained with the aid of bureaucratic and discursive pressures, in the realm of the private.¹²

Nurses involved in euthanasia were sometimes unable to account for their behaviour: "The only explanation I can give is that I didn't have enough time to think about it at that time because the nurses were put under a lot of stress"; "I didn't do it readily because I really

⁸ See Annas GJ, Grodin MA (eds). *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation*. Oxford University Press, 1995.

⁹ See, for example, Lifton RJ. *The Nazi Doctors: Medical Killing and the Psychology of Genocide*. New York: Basic Books; Proctor R. *Racial Hygiene: Medicine under the Nazis*. Cambridge: Harvard University Press, 1988;

¹⁰ Articles and books in English include: Benedict S. Killing while caring: the nurses of Hadamar. *Issues in Mental Health Nursing* 2003;24:59-79 Benedict S. The nadir of nursing: nurse-perpetrators of the Ravensbruck concentration camp. *Nursing History Review* 2003;11:129-46; Hoskins SA. Nurses and national socialism – a moral dilemma: one historical example of a route to euthanasia. *Nursing Ethics* 2005; 12(1):79-91; McFarland-Icke B. *Nurses in Nazi Germany: Moral Choice in History*. Princeton: Princeton University Press, 1999; Steppe H. Nursing in the Third Reich. *History of Nursing Society Journal* 1991;3:21-37.

¹¹ McFarland-Icke (see note above), p.257.

¹² McFarland-Icke. p.257.

detested it. I repeat, I didn't do it readily. In fact, I can't say why I didn't refuse".¹³

Others accounted for their behaviour in terms of discipline: "I saw ... the act of giving medicine, even in order to kill mentally handicapped persons, as an obligation I wasn't allowed to refuse. In case of refusal, I always imagined my dismissal from the job of nurse and civil servant, which is why I didn't refuse"; "Among the nurses there was strict discipline and every subordinate nurse was obliged to strictly execute the orders of the superior".

Other nurses involved in the euthanasia programme acquiesced in the organized killing while at the same time maintaining a moral rejection of murder. As one nurse commented, "If I had been told to hit a patient with a hammer on the head, then I would have known that it was murder, and I would have refused under all circumstances to do it."¹⁴ Another nurse said, "Because I saw no connection [between taking patients into the 'death chamber' and their subsequent killing], it never occurred to me to refuse."¹⁵

The text of this Nazi poster says (in translation): "A strong and healthy nurse is there only to give care to a dangerous madman. Shouldn't we be ashamed?"

Avoidance of knowledge of the details of the killing programme appeared to be one strategy for dealing with the unacceptable – "the urgent psychological need to keep the killings on the level of rumor, in the realm of the uncertain".¹⁶ Despite this, individual nurses did object to the programmed killing though, it has been argued, supervisors handled this as a form of "administrative deviance" rather than as a moral challenge and thus not a threat to the program. While the prospect of refusing to cooperate with the Nazi programme would, no doubt, have engendered considerable fear in the individual making that choice, there is no known case of a nurse who refused to participate being sent to a concentration camp.¹⁷ Steppe refers to 50 named female and male nurses who resisted Nazi policies and adds that the real number was almost certainly higher. She briefly describes two nurses who resisted; Benedict

¹³ The two nurses quoted here and the two cited below are taken from Benedict S, Kuhla J. Nurses' participation in the euthanasia programs of Nazi Germany. *Western Journal of Nursing Research* 1999; 21: 246-263. The citations were drawn from Ebbinghaus A. *Opfer und Täterinnen [Victims and Female Perpetrators]* Donauwörth: Delphi Politik, 1987.

¹⁴ Cited in Mcfarlane-Icke, p.211.

¹⁵ Cited in *ibid.* p.239.

¹⁶ *Ibid.* p.262.

¹⁷ Steppe H. Nursing in Nazi Germany. *Western Journal of Nursing Research* 1992; 14:744-53.

describes at some length the case of a third nurse involved in resistance within the camp at Auschwitz.¹⁸

The historiography of this period of nursing was given a boost by the convening, in 2004, of the first international conference on nursing and midwifery in Germany and German-occupied territories during the Nazi period.¹⁹

The same processes – though arguably not occurring within the context of abuses to the same scale or systematic approach – can be seen in the response of health professionals to political abuses in different countries throughout the second half of the twentieth century. In South Africa, for example, health professionals were a core sector in the daily operation of apartheid.²⁰ Codes of professional ethics which reflect some of the lessons learned have helped to strengthen the hand of those nurses and doctors who refuse unethical behaviour at the behest of the state though they have not proven to be a wholly effective answer to preventing such activities.

To achieve a more vigorous response by health professionals to pressure from the state to collude in human rights abuses there needs to be more attention paid to problems arising in the context of dual loyalties,²¹ support for health personnel by professional and human rights bodies and the inculcation in society of a culture of respect for human rights.

¹⁸ Steppe H. Nursing under totalitarian regimes: the case of National Socialism. In: Rafferby A, Robinson J, Elkan R (eds). *Nursing History and the Politics of Welfare*. London: Routledge, 1997; Benedict S. Maria Stromberger: a nurse in the resistance in Auschwitz. *Nursing History Review* 2006;14:189-202.

¹⁹ Shields L. Report on: Complicity and compassion: the first international conference on nursing and midwifery in the Third Reich, 10-11 June 2004, Limerick, Republic of Ireland. *Nursing Ethics* 2005;12:106-7. By contrast, there appears to be little research available into the involvement of nurses in the biological research programme in Japan prior to and during the Second World War. For an account of this programme see: Harris SH. *Factories of Death: Japanese Biological Warfare, 1932-45 and the American Cover-Up*. Revised Edition. New York: Routledge, 2002.

²⁰ Baldwin-Ravaven L, de Gruchy J, London L. *An Ambulance of the Wrong Colour: health professionals, Human Rights and Ethics in South Africa*. Cape Town: University of Cape Town Press, 1999. See also the *Final Report of the Truth and Reconciliation Commission of South Africa*, Volume 5. Health sector hearings. Cape Town: TRC, 1998.

²¹ Dual loyalties exist when a person is faced with obligations – often conflicting – to two parties simultaneously. In the context of medicine these parties are usually the patient and a third party such as an employer or government. Physicians for Human Rights, University of Cape Town. *Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms*. Boston: Physicians for Human Rights, 2002. Available at: http://www.phrusa.org/healthrights/dual_loyalty.html. Accessed 15 May 2006.

2. Nurses and professionalism

The health professions, along with the legal profession, have one of the most highly developed frameworks for self-regulation, sometimes referred to as “professionalism”.

Professionalism is a concept in harmony with the defence and promotion of human rights provided that professional bodies and individual practitioners conform to the standards on which the “social contract” is based.²² Professional bodies, as freestanding and self-regulating associations and councils, have a duty to ensure that their standards are compatible with, and advance respect for, human rights. It is difficult to conceive of a reputable body of health professional ethics that would conflict with the basic values set out in the Universal Declaration of Human Rights and with the international instruments which derive from this Declaration.²³

The professionalism of nurses has been defined in terms of what they do, what they aspire to, what qualifications they have and how they relate to other health professionals, particularly doctors.²⁴ Nursing and midwifery are overwhelmingly “feminized” disciplines (though mental health, acute nursing and military nursing can attract a higher proportion of male nurses). It is widely recognized that significant and discriminatory differentials in pay and conditions exist between male and female employees in most countries, even where labour laws include measures to address such discrimination.²⁵ This is of concern to nurses, but apart from pay, issues such as relations with other health care providers, allocation of tasks, working hours, leave arrangements (particularly with respect to parenting obligations), opportunities for training and promotion, and personal security are likely to have a gender dimension.²⁶ This means that asserting a stronger professional role for nurses requires addressing both professional *and* gender issues.²⁷

2.1 Nurses and professional ethics

The ethics of nursing has been the subject of numerous studies and publications²⁸ as well being embodied in codes and declarations adopted by specialist, national and international

²² Important characteristics of a profession are that “practising a profession requires special knowledge and training” and that “other people are rendered especially vulnerable or dependent in their relationship to the practice of the professional”. See Fullinwider RK. Professional codes and moral understanding. In: Coady M, Bloch S (eds.) *Codes of Ethics and the Professions*. Melbourne: Melbourne University Press, pp. 72-87 [citations p.73]

²³ See appendix 2.

²⁴ Tschudin V. *Nurses Matter: Reclaiming Our Professional Identity*. Palgrave Macmillan, 1999.

²⁵ See, for example, United Kingdom Department of Trade and Industry. Women and Equality Unit. *Women and men in the workplace, January 2005* Available at: <http://www.womenandequalityunit.gov.uk/research/index.htm> Accessed: 13 May 2005

²⁶ Whittock M, Edwards C, McLaren S, Robinson O. ‘The tender trap’: gender, part-time nursing and the effects of ‘family-friendly’ policies on career advancement. *Sociology of Health & Illness* 2002; 24: 305. Also, see below, p.14: ‘Violence against nurses and midwives in the workplace’.

²⁷ Davies C. *Gender and the Professional Predicament in Nursing*. Maidenhead: Open University Press, 1995.

²⁸ See for example, Bandman E, Bandman B. *Nursing Ethics Through the Life Span*, 4th edition. Prentice Hall, 2002; Benjamin M, Curtis J. *Ethics in Nursing*. Oxford University Press, 1995; Jameton A. *Nursing Practice: The*

nursing organizations.²⁹ As nursing becomes more complex the depth of the ethical framework reflects this. From a human rights perspective, three elements of nursing ethics assume a high priority: the commitment to patient care and to respecting the patient's dignity; the avoidance of doing harm; and commitment to non-discrimination. The International Council of Nurses (ICN) and many national bodies enshrine these imperatives within their codes of ethics and policy statements, detailed below.

2.1.1 Duty of care

'The nurse's primary professional responsibility is to people requiring nursing care'

Nursing has traditionally been a caring profession that places care for the patient at the heart of its role. As the ICN Code of Ethics for Nurses states, "The nurse's primary professional responsibility is to people requiring nursing care."³⁰ It is significant that a review of nursing education carried out in Australia was subtitled "Our duty of care".³¹

Breaching a duty of care, which may constitute professional negligence, may also have legal consequences, and this is having an increasingly serious impact on health workers and the way they practise in the growing litigious culture of many countries.

2.1.2 Consent

The principle of free and informed consent is a core value in the health professions. It is not just about "permission-giving" but rather about a decision-making process which is sensitive to context. It was affirmed as central to ethical health care in the Nuremberg Code³²

Ethical Issues. Englewood Cliffs, NJ: Prentice-Hall, 1984; Rumbold G. *Ethics in Nursing Practice*. Bailliere Tindall 1999; Thompson IE, Melia KM., Boyd KM. *Nursing Ethics*. Churchill Livingstone, 2000; Tschudin V. *Ethics in Nursing: The Caring Relationship*. Butterworth Heinemann, 2003.

²⁹ Apart from the international codes of the ICN and ICM, there are national codes such as those of nursing bodies in Australia (available at: <http://anf.org.au>. See 'Policies'); Canada (available at: http://cna-aiic.ca/CNA/documents/pdf/publications/PS71_Code_ethics_RN_June_2004_e.pdf); USA (available at: http://www.ana.org/ethics/code/protected_nwcoe303.htm); Maldives (available at:

<http://www.maldivesnursingcouncil.gov.mv/codeof.html>) and provincial bodies such as the Ordre des infirmières et infirmiers du Québec (Available at: http://www.oiiq.org/infirmieres/lois_reglements_pdf/deontologie.pdf). In the Philippines a law was passed in 2002 to give effect to various aspects of the regulation of nursing. Republic Act No. 9173 of 21 October 2002 is available at:

http://www.lawphil.net/statutes/repacts/ra2002/ra_9173_2002.html. Accessed 13 October 2005. For South African legislation regulating nursing (the Nursing Act, 1978, as amended) see:

<http://www.sanc.co.za/pdf/Nursing%20Act%2013.1.pdf>. At time of writing, a new Bill to regulate nursing (B26-2005) is under discussion. See: Nursing Bill. *Government Gazette* No. 27904, 12 August 2005. Available at: <http://www.polity.org.za/pdf/NursingBill26.pdf>. See comments on the proposed new bill from the Democratic Nursing Organization of South Africa (DENOSA) at

http://www.denosa.org.za/index.php?option=com_content&task=view&id=56&Itemid=2 (accessed 20 February 2006) and from the AIDS Law Project at the latter's web-site: <http://www.alp.org.za/> (accessed 14 October 2005).

³⁰ International Council of Nurses. *The ICN Code of Ethics for Nurses*. Adopted in 1953, Reviewed in 2000. Available at: <http://www.icn.ch/icncode.pdf>. Accessed: 19 May 2005.

³¹ Australian Department of Education, Science and Technology. *National Review of Nursing Education 2002: Our Duty of Care*. Canberra, 2002. Available at:

http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/default.html. (Accessed 29 May 2005)

³² See discussion in Annas and Grodin, note 8 above.

and nurses, as frontline carers, play a key role in ensuring that “the individual receives sufficient information on which to base consent for care and related treatment.”³³ As a 2001 public enquiry into paediatric heart surgery in the UK affirmed:

The process of informing the patient, and obtaining consent to a course of treatment, should be regarded as a process and not a one-off event consisting of obtaining a patient’s signature on a form. The process of consent should apply not only to surgical procedures but to all clinical procedures and examinations which involve any form of touching. This must not mean more forms: it means more communication.³⁴

As informed consent requires patient access to information, the right to information becomes an important factor in this process.³⁵

It is critical that the consent of the patient is protected as a central tenet of nursing and the other caring professions and must be sought prior to undertaking any nursing procedure. Where patients are incompetent – that is, prevented from taking decisions in an informed manner by learning difficulties, serious mental illness, young age or unconsciousness – then nurses must act in consultation with parents, guardians or other family members, with other clinicians, and in patients’ best interests.

2.1.3 Confidentiality

*‘The nurse holds in confidence personal information and uses judgement in sharing this information’.*³⁶

Confidentiality of patient information is essential to maintaining a bond of trust between the patient and the health professional and protecting the human rights of the patient. A breach of confidentiality could harm the interests of the patient as well as the therapeutic relationship. In some cases it could put the patient at risk.³⁷ However, there is no uniformly agreed legislative standard on maintaining confidentiality in specific cases.

Nurses in Europe should be aware of the importance that European human rights case law attaches to confidentiality in the relationship between patient/client and the nurse³⁸ which can

³³ *The ICN Code of Ethics for Nurses*. See note 30 above.

³⁴ The Report of the Public Inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995: *Learning from Bristol*. (Cm 5207). The Stationery Office. July 2001. Recommendations 24 and 25, p. 440. Available at: <http://www.bristol-inquiry.org.uk/>

³⁵ Coliver S. The right to information necessary for reproductive health and choice under international law. In: Coliver S (ed). *The Right to Know: Human Rights and Access to Reproductive Health Information*. University of Pennsylvania Press, 1995.

³⁶ *The ICN Code* (see above note 30)

³⁷ The issue of confidentiality and harm prevention has been at the heart of a debate about mandatory reporting of domestic violence where the issues in the balance are the right of the women to confidentiality and the need to expose and tackle violence against women. See discussion below, p.28.

³⁸ This is evident in the judgment in *Z v Finland* 1998 (25 *European Human Rights Review* 37), in which the European Court found that “the disclosure of the applicant’s identity and medical condition by the Helsinki Court of Appeal constituted a breach of Article 8” of the European Convention protecting “private and family life”. In its

only be set aside under specific circumstances, namely “in accordance with the law and [as] is necessary in a democratic society”.³⁹

In some societal contexts, privacy is seen as an important corollary to confidentiality; in others, privacy is not given the same weight. Infringing a person’s privacy may represent an attack on their dignity and could be in breach of the European Convention on Human Rights. Some commentators maintain that privacy can promote dignity⁴⁰ and it has been suggested that nurses can inadvertently violate patients’ dignity through not respecting their privacy.⁴¹

2.1.4 Patient dignity

*‘Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect’.*⁴²

Dignity is defined by the *Oxford English Dictionary* as the state or quality of being “worthy of respect”. It is in this sense that the South African Constitution (Section 10) states that: “Everyone has inherent dignity and the right to have their dignity respected and protected.”⁴³ It is an important concept within the caring professions where respect for the human dignity of all patients without discrimination is a core value. Dignified treatment can be seen at heart as caring for patients as human beings and not objects. Upholding patient dignity can be seen to affirm human rights for this reason.⁴⁴

ruling the court stated that it “will take into account that the protection of personal data, not least medical data, is of fundamental importance to a person’s enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention. Respecting the confidentiality of health data is a vital principle in the legal systems of all the Contracting Parties to the Convention. It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection those in need of medical assistance may be deterred, when revealing such information of a personal and intimate nature as may be necessary in order to receive the appropriate treatment, from seeking such assistance thereby endangering their own health but, in the case of transmissible diseases, that of the community. ... The domestic law must therefore afford appropriate safeguards so there may be no such communication or disclosure of personal health data as may be inconsistent with the guarantees of Article 8 of the Convention.” [Judgment, para. 95]

³⁹ European Convention of Human Rights, Art 8.2. Available at: <http://www.echr.coe.int/echr>. Accessed 9 May 2006.

⁴⁰ Woogara, J. Human rights and patients’ privacy in UK hospitals. *Nursing Ethics* 2001; 8 (3): 234-46.

⁴¹ *Ibid.*

⁴² *The ICN Code for Nurses*. See note 30 above. The importance of respect for human dignity is underlined by the UDHR which, at article 1, states that “all humans are born free and equal in dignity and in rights” and the Geneva Conventions which prohibit “outrages upon personal dignity, in particular humiliating and degrading treatment”. (Geneva Convention 1, 3.1c.) Other humanitarian and human rights standards emphasise respect for human dignity.

⁴³ The South African Constitution is available at: <http://www.polity.org.za/html/govdocs/constitution/saconst.html>. Accessed 12 May 2006. South African Constitutional Court rulings have underlined this constitutional provision. For example, in the case of *National Coalition for Gay and Lesbian Equality and another v Minister of Justice and others* (CCT 11/98, decided on 9 October 1998) Justice Sachs reiterated the Court’s jurisprudence on the centrality of dignity and self-worth to the idea of equality. See the case judgment at: <http://www.constitutionalcourt.org.za/Archimages/2076.PDF>. Accessed 12 May 2006.

⁴⁴ “Dignity” can also be understood in a way which *undermines* individual rights as, for example, where it is equated with a woman’s fulfilment of expectations relating to her sexuality and gender and with respect to her family’s “honour”. This conservative concept of “dignity” is not reflected in nursing or other professional ethics.

The nurse-patient relationship is central to dignified caring practice and bases itself on the responsibility of nurses to give competent, accountable care when patients need it, particularly when they are unable to care for themselves. The caring role of nurses and midwives involves the appropriate use of touch and working within the patient's intimate space, sometimes often and over an extended period of time. It is not surprising therefore that patient dignity is generally agreed to be a high priority in providing nursing care. A study that interviewed nurses and patients regarding their criteria for dignified care found that both groups valued respect, privacy and control.⁴⁵ Nurses however, also saw advocacy and time as important elements of patient dignity, while patients prioritized humour and matter-of-factness.⁴⁶ Nurses appeared therefore to have a broader perspective of dignified daily care, while patients valued more inter-personal factors.

2.1.5 Genetic information

An issue of evolving concern to nurses, particularly in developed countries, is that of consent, confidentiality and genetic information. The importance of this subject is indicated by the adoption by the UNESCO General Conference in 1997 of a Universal Declaration on the Human Genome and Human Rights. This was endorsed the following year by the General Assembly of the United Nations. The Declaration makes clear that "the free and informed consent of the person concerned shall be obtained" before any research, treatment or diagnosis affecting an individual's genetic identity (genome) is undertaken. It also specifies that "the right of each individual to decide whether or not to be informed of the results of genetic examination and the resulting consequences should be respected".⁴⁷

Nurses are likely to play important roles in the application of the tools of human genetics at community level – including around issues such as the use of sex or other genetic traits as a basis for the termination of pregnancy – and some have argued the need for a nursing declaration to address genetics, human rights and public policy.⁴⁸ This may be increasingly important as nurses become responsible for genetic assessments and counselling. The challenge has, in part, been taken up by nurses working in genetics. The International Society of Nurses in Genetics (ISONG) has adopted a number of position statements on issues such as genetic counselling for vulnerable populations, privacy and confidentiality of genetic information, and the role of the nurse.⁴⁹

⁴⁵ Walsh K, Kowanko I. Nurses' and patients' perceptions of dignity. *International Journal of Nursing Practice* 2002;8:3 143-51.

⁴⁶ *Ibid.*

⁴⁷ UNESCO. *Universal Declaration on the Human Genome and Human Rights*. Adopted 11 November 1997.

Available at: http://portal.unesco.org/en/ev.php-URL_ID=13177&URL_DO=DO_TOPIC&URL_SECTION=201.html.

UNESCO subsequently adopted an *International Declaration on Human Genetic Data* (2003). It is available at: http://portal.unesco.org/en/ev.php-URL_ID=17720&URL_DO=DO_TOPIC&URL_SECTION=201.html.

⁴⁸ Anderson G, Rorty MV. Key points for developing an international declaration on nursing, human rights, human genetics and public health policy. *Nursing Ethics* 2001; 8:259-71.

⁴⁹ These and other position papers are available at the ISONG website: <http://www.isong.org/about/position.cfm>. Accessed 24 May 2005.

2.2 Health policy development

Nurses and midwives have much to contribute to the development and implementation of health policy. This is the case at local, national and international level. It has been argued that there is an under-representation of nurses and midwives within the World Health Organization.⁵⁰ This lack of a nursing voice is recognized by the organization. One of the recommendations of the a recent strategic paper is that “mechanisms [be] established or strengthened to ensure that nursing and midwifery expertise is included in the development of health policies and programmes at all levels, including those at WHO”.⁵¹ (See also box below.)

World Health Organization – nursing and midwifery strategy 2002-2008

The World Health Organization (WHO) and its partners in this nursing and midwifery initiative have identified five key result areas, each with specific objectives and expected results which are crucial to strengthening nursing and midwifery services.

1: Health planning, advocacy and political commitment

National development and health plans provide for adequate nursing and midwifery services and expertise.

2: Management of health personnel for nursing and midwifery services

National employment policies are implemented for the nursing and midwifery workforce that are gender-sensitive, based on healthy and safe work environments and conditions, provide for equitable rewards and recognition of competencies, and are linked to a transparent career structure.

3: Practice and health system improvement

Nursing and midwifery expertise is fully integrated into decision-making processes at all levels, and health systems use best available practices for the care of individuals, families and communities.

4: Education of health personnel for nursing and midwifery services

Competent practitioners with an appropriate skill mix are available to deal effectively with the current and future challenges of practice.

5: Stewardship and governance

Stewardship and governance of nursing and midwifery services involve the government, civil society and the professions to ensure the quality of care.⁵²

⁵⁰ Oulton J. Inside view. *International Nursing Review* 2002, pp. 207-8. “We know how much work needs to be done to meet the health needs of the world’s populations and we know the tremendous contribution nurses and midwives can make. For this to happen, we need a strong nursing/ midwifery presence within WHO headquarters and regionally. This is why nursing and midwifery leadership is united in its concern that WHO employ sufficient numbers of qualified nurses and midwives; a situation that does not exist presently...”

⁵¹ WHO. *Strategic Directions for Strengthening Nursing and Midwifery Services 2002-2008*. Geneva: WHO, 2002. Available at: http://www.who.int/entity/hrh/nursing_midwifery/strategic_directions_en.pdf.

⁵² *Ibid.*

3. Violence against nurses and midwives

This section reviews the experiences of nurses in the context of violence in the field. It is a central tenet of humanitarian principles that there must be respect for the independent and neutral role of health professionals in conflict situations. Also discussed is the subject of violence against nurses in the workplace with a particular focus on human rights.

3.1 Nurses in conflict situations

Nurses working in conflict zones are at constant risk of violence. As members of the military health services, nurses can be required to work in settings such as mobile or field hospitals sometimes close to combat and occasionally may come under fire.⁵³ Nurses working to provide daily civilian care in areas of conflict are also at risk of attack by security forces or paramilitary bodies as well as by military forces.⁵⁴ Hospitals and clinics can be the accidental targets of military attack as well as being deliberately targeted in breach of the law of armed conflict. In some cases, treatment of civilians leads nursing personnel into the direct line of fire (see boxes).

Sudan: Killing of Red Crescent nurse and ambulance driver

The International Committee of the Red Cross (ICRC) reported the killing on 1 May 2005 of two members of the Sudanese Red Crescent Society by unidentified individuals who fired at their ambulance in an area east of Khartoum. Faki Mohammed Nour, the driver of the vehicle, and Hassan Mohammed Ali, a nurse, reportedly died immediately from their wounds. Mahmoud Adam Idris, a Red Crescent medical assistant accompanying them, was injured and taken to a nearby hospital. The patient who was being transported remains missing and is believed to have been abducted.⁵⁵

In Chechnya, health care personnel have been victims of ill-treatment along with other members of the community. A nurse from the village of Shali, southeast of the capital Grozny, reported her experience in a petition to the European Court of Human Rights. On 8 February 2000, Russian forces transferred her and her fellow medical personnel to Chernokozovo detention centre after detaining the group for six days in a large hole dug in the ground in Tolstoy Yurt. According to the nurse's statement, soldiers separated her and four other nurses from the male detainees, and they were stripped naked and forced to dance in front of the soldiers.⁵⁶ Such treatment not only breaches human rights standards prohibiting torture or

⁵³ Fry ST, Harvey RM, Hurley AC, Foley BJ. Development of a model of moral distress in military nursing. *Nursing Ethics* 2002; 9:373-87.

⁵⁴ See Amnesty International. *Harming the Healers*. London: ACT 75/002/2000. Available at: <http://web.amnesty.org/library/Index/ENGACTION770022000>.

⁵⁵ ICRC Sudan: Two Red Crescent staff members killed. Press release, 4 May 2005. See: <http://www.icrc.org/Web/Eng/siteeng0.nsf/html/6C3LJQ>. Accessed 9 May 2006.

⁵⁶ Human Rights Watch. *Russian Federation. Serious Violations of Women's Human Rights in Chechnya. [A Submission] To Members of the Committee on the Elimination of Discrimination against Women*. New York: HRW, January 2002. Available at: http://www.hrw.org/background/eca/chechnya_women.htm. Accessed, 17 January 2006.

other cruel, inhuman or degrading treatment, it contravenes standards of international humanitarian law prohibiting “outrages upon personal dignity, in particular humiliating and degrading treatment ... and any form of indecent assault”;⁵⁷ it also breaches the humanitarian law requirement that health personnel identifiable and acting in a health capacity be “respected and protected”.⁵⁸

Israel and the Occupied Territories: Nurse in uniform shot dead whilst treating wounded civilian

Farwa Jammal, a 27-year-old nurse from Tulkarem, was visiting her sister at the Jenin refugee camp at the time of Israeli incursions in 2002. On the evening of 2 April, concerned about a possible Israeli Defence Force (IDF) attack on Jenin, Farwa and her sister, Rufaida Jammal, went to the main hospital to stock up on first aid supplies “to be ready to [help] anyone who would need it”, according to Rufaida. Farwa and Rufaida Jammal were woken early in the morning of 3 April by loud explosions and the screams of Hani Abu Rumaila, a man who had been severely wounded. Dressed in her white nurse's uniform, marked with the red crescent symbol, Farwa Jammal left the house with her sister Rufaida, to administer first aid. According to Rufaida, they met a small group of unarmed young Palestinian men outside their home who were also trying to assist the wounded man. They had stopped to discuss the best way to proceed when IDF soldiers opened fire on the group, killing Farwa and wounding Rufaida. Rufaida Jammal told Human Rights Watch: “Before I finished talking with the men, the Israelis started shooting. I got hit with a bullet in my upper thigh. I fell down and broke my knee. My sister tried to come and help me. Then she was shot in her abdomen.”⁵⁹

3.2 Violence against nurses and midwives in the workplace

Paradoxically, those in the caring professions frequently experience violence at work. Evidence suggests that a quarter of workplace violence is directed at people working in the health care sector⁶⁰ and the ICN considers that nurses are more likely to be attacked at work than prison guards and police officers.⁶¹ Nurses are considered the health care workers most likely at risk, and female nurses are considered at the greatest risk.⁶² Considerable evidence of violence and of aggravating factors appears in the professional literature.⁶³

⁵⁷ Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), article 4 (2e). Available at:

<http://www.unhcr.ch/html/menu3/b/94.htm>. Accessed 9 May 2006.

⁵⁸ *Ibid.* article 9(1).

⁵⁹ Human Rights Watch. *Jenin: IDF Operations*. New York, May 2002, p.14.

⁶⁰ See: ILO. Joint Programme Launches New Initiative Against Workplace Violence in the Health Sector. Press release, ILO/02/49, 24 October 2002. See also: Cooper CL, Swanson N. *Workplace violence in the health sector. State of the Art*. Geneva: ILO, WHO, ICN, PSI, 2002; and di Martino V. *Country case studies: Synthesis report*. Geneva: ILO, WHO, ICN, PSI, 2002.

⁶¹ International Council of Nurses. *Nursing Matters Factsheet: Violence: A World-wide epidemic*. Available at: http://www.icn.ch/matters_violence.htm.

⁶² International Council of Nurses. *Ibid.*

⁶³ Crilly J, Chaboyer W, Creedy D. Violence towards emergency department nurses by patients. *Accident and Emergency Nursing* 2004; 12: 67-73; Henderson AD. Nurses and workplace violence: nurses' experiences of verbal and physical abuse at work. *Canadian Journal of Nursing Leadership* 2003;16(4):82-98; Gerberich SG, Church TR, McGovern PM et al. Risk factors for work-related assaults on nurses. *Epidemiology* 2005;16(5):704-9.

In a UK study, 97% of nurse respondents said they knew a nurse who had been assaulted in the previous year.⁶⁴ In 2005 a poll reported that a quarter of nurses working in the UK National Health Service (NHS) had considered resigning from their jobs because of assaults by patients, including punches, kicks and hair-pulling.⁶⁵ Figures released in October 2005 indicated that there were more than 43,000 incidents of physical assault against NHS staff working in mental health and learning disability settings in 2004/05 across England.⁶⁶ A research study in Canada found that nearly half (46%) of all nurses surveyed had experienced one or more types of violence in the last five shifts worked. Seventy per cent of those who had experienced violence had not reported it.⁶⁷

A study carried out in Kuwait⁶⁸ found that nearly half of nurses had experienced verbal violence and 7% physical violence. Abuse was most likely to come from patients and a majority of nurses believed that violence should be expected in a nurse's career.

Across the world, nursing associations and unions have called for a "zero-tolerance" policy on violence in the workplace,⁶⁹ and the need to address contributing factors, such as "working in isolation, inadequate staff coverage, lack of staff training, poor relationships within the work environment; dealing with patients and others who are under the influence of alcohol or drugs and with people who are stressed, frustrated or [grieving]".⁷⁰ Employers should be obliged to ensure the prevention of violence and a safe working environment, for example, to regulate and ensure safety of staff during home visits and late shifts.

One particular form of violence in the workplace – sexual harassment – is very common, well-documented and reported in a wide variety of settings.⁷¹ Many nursing associations and

McPhaul K, Lipscomb J. Workplace violence in health care: recognized but not regulated. *Online Journal of Issues in Nursing*. 30 September 2004 9(3), Manuscript 6. Available at: www.nursingworld.org/ojin/topic25/tpc25_6.htm. Accessed 15 February 2006.

⁶⁴ International Council of Nurses. See note 61 above.

⁶⁵ 'Quarter of nurses consider quitting over attacks by patients'. *Guardian*, 3 October 2005. Available at: <http://society.guardian.co.uk/health/news/0,8363,1583863,00.html>.

⁶⁶ NHS Press release. New Measures to Tackle Violence against Staff in Mental Health and Learning Disability Services. 19 October 2005. A training syllabus to tackle violence against frontline staff was also announced. NHS Security Management Service. Available at: <http://www.cfsms.nhs.uk/pub/cfsms/newsreleases.html>.

⁶⁷ Duncan SM, Hyndman K, Estabrooks CA et al. Nurses experiences of violence in Alberta and British Columbian hospitals. *Canadian Journal of Nursing Research* 2001; 32 (4):57-78.

⁶⁸ Adib S, Al-Shatti A, Kamal S, et al. Violence against nurses in healthcare facilities in Kuwait. *International Journal of Nursing Studies* 2002; 39: 469-78

⁶⁹ See, for example, Queensland Nurses' Union. *Zero Tolerance to Violence*. 2001. Available at: http://www.qnu.org.au/about_qnu/occupational_health_and_safety/zero_tolerance_to_violence. Accessed 13 May 2005; BBC. Nurses want 'zero tolerance' on violence. BBC news online, 9 March 1999. Available at: <http://news.bbc.co.uk/2/hi/health/292454.stm>. Accessed 13 May 2005.

⁷⁰ International Council of Nurses. See note 61 above.

⁷¹ Bronner G, Peretz C, Ehrenfeld M. Sexual harassment of nurses and nursing students. *Journal of Advanced Nursing* 2003;42:637-44; Celik SS, Bayraktar N. A study of nursing student abuse in Turkey. *Journal of Nursing Education* 2004;43:330-6; Valente SM, Bullough V. Sexual harassment of nurses in the workplace. *Journal of Nursing Care Quality*. 2004; 19:234-41; Ramanathan M, Sarma PS, Sukanya R, Viswan SP. Sexual harassment in the work place: lessons from a web-based survey. *Indian Journal of Medical Ethics* 2005; 1147-50.

governments have adopted policies to respond to this persistent problem.⁷² The International Council of Nurses recommends that governments adopt “zero-tolerance policies” to combat the incidence of violence and sexual harassment. Sexual harassment in particular can be targeted through promoting nurses’ and midwives’ dignity and rights, and through rejecting a culture in which health practitioners blame themselves for provoking abuse.⁷³

More generally, international health and labour organizations have argued that to combat workplace violence priority be given by service providers to “the development of a human-centred workplace culture based on safety and dignity, non-discrimination, tolerance, equal opportunity and cooperation”.⁷⁴ The guidelines developed by the International Labour Organization, the International Council of Nurses, the World Health Organization and Public Services International recommend organizational initiatives and reforms, action to improve the working environment, and interventions to reinforce the capacity of individuals to contribute to the prevention of workplace violence.⁷⁵ Such measures would promote and protect the human rights of nursing staff in the workplace.

⁷² See, for example: ICN *Position Statement: Abuse and violence against nursing personnel*. Available at: <http://www.icn.ch/psviolence00.htm>; New York State Nurses Association. *Nursing Advocacy and Information: Position statements. Sexual Harassment in the Workplace*. Available at: <http://www.nysna.org/programs/nai/practice/positions/position35.htm>.

⁷³ ICN. *Position Statement: Abuse and violence against nursing personnel*. Available at: <http://www.icn.ch/psviolence00.htm>. Accessed 4 October 2005.

⁷⁴ ILO, ICN, WHO, PSI. *Framework Guidelines for Addressing Workplace Violence in the Health Sector*. Geneva, 2002., p.17. Available at: <http://www.icn.ch/proof3b.screen.pdf>. Accessed 14 May 2006.

⁷⁵ *Ibid.*

4. Human rights and violations of physical and mental integrity

This section gives an overview of human rights abuses that some nurses may likely to encounter in their work and points to standards and principles which should guide their response.

4.1 Torture and other cruel, inhuman or degrading treatment or punishment

Torture and other cruel, inhuman or degrading treatment (ill-treatment) are long-standing concerns to Amnesty International.⁷⁶ From the start of its first campaign against torture in the early 1970s, the organization has been aware of the role played by health professionals in the preparations for, monitoring of, and follow up to torture and ill-treatment. The reports of medical involvement in torture during the 1970s led to declarations against such unethical behaviour being adopted by doctors, psychiatrists and nurses.⁷⁷ Nevertheless, reports of participation by health professionals continued.⁷⁸

Torture and ill-treatment are expressly prohibited under international human rights law and international humanitarian law. This absolute prohibition is a norm of customary international law, binding on all states. Individual acts of torture or ill-treatment are proscribed as crimes under international law; under specific circumstances they constitute war crimes, crimes against humanity, or acts of genocide. Acts of torture or ill-treatment are also expressly prohibited under many national constitutions and laws.

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereafter referred to as the UN Convention against Torture) places an explicit obligation on states parties to punish acts of torture, as well as attempts to commit torture and complicity or participation in torture. But the obligation under international law to bring torturers to justice applies to all states, whether or not they are parties to that treaty.⁷⁹ Acts of torture or ill-treatment are also proscribed as crimes under international law including where they are committed as war crimes or as crimes against humanity.⁸⁰

Article 1 of the UN Convention against Torture defines torture as:

⁷⁶ Amnesty International. *Report on Torture*. London: Duckworth, 1973; Amnesty International. *Torture in the Eighties*, London: AI, 1984. For a detailed study of torture and ill-treatment and its prohibition in international law see: Amnesty International. *Combating Torture: A Manual for Action*. London, 2003. Available at: <http://web.amnesty.org/pages/stoptorture-manual-index-eng>.

⁷⁷ Amnesty International. *Ethical codes and declarations relevant to the health professions*. London: AI, 2000.

⁷⁸ Amnesty International. *Involvement of medical personnel in abuses against detainees and prisoners*. London, AI Index: ACT 75/08/90, 1990; British Medical Association. *Medicine Betrayed*. London: Zed Books, 1992.

⁷⁹ *Regina v Bartle*. House of Lords, 24 March 1999, in the case of General Augusto Pinochet. Available at: <http://www.parliament.the-stationery-office.co.uk/pa/ld199899/ldjudgmt/jd990324/pino1.htm>.

⁸⁰ For definitions of war crimes and crimes against humanity, see the Statute in the International Criminal Court, Articles 7 and 8. The Statute is available at: <http://www.un.org/law/icc/statute/romefra.htm>.

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as: obtaining from him or a third person information or a confession, punishing him for an act that he or a third person has committed or is suspected of having committed, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official acting in an official capacity.⁸¹

The jurisprudence of international tribunals, regional human rights courts, UN and regional treaty body mechanisms and independent experts has shown the general understanding of the scope of torture and ill-treatment to include conditions of detention, methods of interrogation, the effect of enforced disappearances on the “disappeared” and their families, the effect of house demolitions on families left homeless, administrative detentions and more. The element of official “consent or acquiescence” in the definition of torture has meant that acts inflicted by non-state actors may be considered as torture or ill-treatment where the state has failed to exercise due diligence in preventing them. In addition, international humanitarian law and international criminal law prohibit acts of torture and ill-treatment not limited to those perpetrated by government forces, but also by members of armed groups.

Despite the absolute prohibition of these abuses, Amnesty International estimated that, in 2004, torture or other cruel, inhuman or degrading treatment or punishment was perpetrated by security forces, police and other state authorities in 104 countries.⁸² Armed opposition groups in some countries also used torture or ill-treatment on detainees during the same year.⁸³ The US-led “war on terror” which was a response to the attacks in New York and Washington, DC, on 11 September 2001 has given rise to the use of torture or ill-treatment against detainees accused of support or preparation for, or perpetration of, terrorism.⁸⁴

The UN *Principles of Medical Ethics* declares that:

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement

⁸¹ United Nations. *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (1984; entered into force 26 June 1987).

⁸² Amnesty International. *Amnesty International Report 2005*. Available at: <http://web.amnesty.org/report2005/index-eng>. Accessed 24 March 2006.

⁸³ *Ibid.*

⁸⁴ Amnesty International. *USA: AI's concerns regarding post-September 11 detentions in the USA*. AMR 51/044/2002; *USA: Beyond the law: Update to Amnesty International's April Memorandum to the US Government on the rights of detainees held in US custody*. AMR 51/184/2002; *USA: Human dignity denied: Torture and accountability in the 'war on terror'*. AMR 51/145/2004; *USA: Guantánamo and beyond: The continuing pursuit of unchecked executive power*. AMR 51/063/2005. These and related reports are available at: <http://web.amnesty.org/pages/guantanamobay-library-eng>.

to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.⁸⁵

Nurses may be called upon to carry out a number of functions that assist perpetrators of torture and other ill-treatment, in contradiction to basic ethical standards. The ICN position statement on *Nurses, Torture, Death Penalty and Participation by Nurses in Executions* states that the primary responsibility of nurses is to provide care to those under their supervision.⁸⁶ It also states that nurses “shall not voluntarily participate in any deliberate infliction of physical or mental suffering”. The statement also urges national nursing associations to provide mechanisms to support nurses in difficult situations.

Nurses may witness unethical behaviour that breaches international nursing ethics and human rights law and standards, such as punitive mutilation and judicial corporal punishment. In some countries physicians have been implicated in certifying fitness for torture or covering up the fact of torture by false certification.⁸⁷ Nurses may have been coerced or persuaded to assist in such cover-ups though data on such breaches of ethics by nurses are lacking.

Some analysts have drawn attention to the potential difficulties arising when health professionals have loyalties or duties both to an employer and to a patient. This dual loyalty can become an acute problem when one of the parties to whom the health professional feels a duty is a state with a poor human rights record.⁸⁸

Iraq: Health care staff and abuses in Abu Ghraib

*The health professionals with a responsibility for the physical and mental health of detainees who have been tortured are the dogs that did not bark.*⁸⁹

Reports that have emerged from Abu Ghraib prison in Iraq as well as from Guantánamo Bay naval base in Cuba point to the systematic torture and other ill-treatment of detainees as part of the US-led “war on terror”. The “Taguba Report: On Treatment of Abu Ghraib prisoners in Iraq”, a military inquiry, found that medical personnel were aware of abuse taking place

⁸⁵ *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.* Adopted by UN General Assembly resolution 37/194 of 18 December 1982. (Article 2).

http://www.unhcr.ch/html/menu3/b/h_comp40.htm (Accessed 30 September 2005)

⁸⁶ International Council of Nurses. Position Statement: Torture, Death Penalty and Participation by Nurses in Executions. Adopted in 1998. Available at: <http://www.icn.ch/pstorture.htm>. Accessed 21 March 2006.

⁸⁷ See, for example, Amnesty International. *Involvement of medical personnel in abuses against detainees and prisoners*, AI Index: ACT 75/008/1990; British Medical Association. *Medicine Betrayed*. London: BMA, 1992; Lucas T, Pross C. Caught between conscience and complicity: human rights violations and the health professions. *Medicine and Global Survival* 1995; 2:106-14.

⁸⁸ See Physicians for Human Rights and University of Cape Town. *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*. Boston: PHR, 2002.

⁸⁹ Hall P. Doctors and the war on terrorism [Editorial]. *BMJ* 2004;329:66.

inside the prison.⁹⁰ Commentators have suggested that military medical personnel operating inside Abu Ghraib were complicit in abuse, by providing insufficient medical care and collaborating with designing and implementing psychologically and physically coercive interrogations. There were rare cases of medical personnel directly committing abuses against prisoners. One report, citing testimonies from two detainees, notes how a doctor allowed a medically untrained guard to stitch a prisoner's wounds which arose from beating.⁹¹ Whilst no nurses are known to have been implicated in committing abuses, a number of academic commentators have noted that some nurses must have been aware of cruel, inhuman or degrading treatment being tolerated by medics, but remained silent.

4.1.1 Responding to torture

*It's time for nursing and medical schools, the military medical nursing corps, [Emergency Department] personnel, and others to begin barking, loudly, into the night.*⁹²

While some nurses may work directly with victims of torture and ill-treatment in a healing role, in practice, responding to torture and ill-treatment also means refusing flatly to participate in or contribute to torture and other ill-treatment in any way, however indirectly. In addition, response to torture and ill-treatment should include protesting, advocating and lobbying governments. Numerous health professional networks operate around the world to combat torture and cruel, inhuman or degrading treatment through campaigning at a political level.⁹³ Many national and international nurses' organisations have also spoken out to condemn torture. *The Nurse's Role in Safeguarding Human Rights*, a statement adopted by the ICN in 1983, notes that "nurses have individual responsibility but they can often be more effective if they approach human rights issues as a group".⁹⁴

Another practical response is that of treating and caring for survivors of torture and ill-treatment. Health professionals can encounter the effects of torture or ill-treatment in their daily clinical practice. There is now a substantial literature on the effects of torture, the needs of patients who have been tortured and the provision of services to this population.⁹⁵ Such

⁹⁰ *Taguba Report: On Treatment of Abu Ghraib prisoners in Iraq; Article 15- 6 investigation of the 800th Military Police Brigade*. Undated [2004]. Available at: <http://news.findlaw.com/hdocs/docs/iraq/tagubarpt.html>. See also: Amnesty International. *An open letter to President George W. Bush on the question of torture and cruel, inhuman or degrading treatment*, AMR 51/078/2004, 7 May 2004, available at:

<http://web.amnesty.org/library/Index/ENGAMR510782004>; *Beyond Abu Ghraib: detention and torture in Iraq*. MDE 14/001/2006, 6 March 2006. Available at: <http://web.amnesty.org/library/Index/ENGMDE140012006>.

⁹¹ Miles S. Abu Ghraib: its legacy for military medicine. *Lancet* 2004; 364: 725-9.

⁹² Mason DJ. 'The dogs that did not bark'. Why torture is relevant to all nurses. *AJN* 2004; 104:11.

⁹³ See AI Health Professional Network www.amnesty.org/health; Physicians for Human Rights www.phrusa.org; International Rehabilitation Council for Torture Victims www.irct.org.

⁹⁴ Amnesty International. *Ethical Codes and Declarations Relevant to the Health Professions*. Fourth Revised Edition. London: Amnesty International Publications, 2000.

⁹⁵ Başoğlu M (ed.). *Torture and its Consequences: Current Treatment Approaches*. Cambridge: Cambridge University Press, 1992; Hermansson AC, Timpka T, Thyberg M. The long-term impact of torture on the mental health of war-wounded refugees: findings and implications for nursing programmes. *Scandinavian Journal of Caring Sciences* 2003;17:317-24; Jacobsen L, Smidt-Nielsen K. *Torture Survivors - Trauma and Rehabilitation*.

patients may find their way to a specialist centre working with victims of torture or similar trauma but may also appear in primary health care settings, hospitals or specialist clinics.⁹⁶

The advances in analysing and treating the health consequences of torture and ill-treatment have not been matched, however, by an effective health professional commitment to prevent and expose torture in the settings where it is most likely to occur – places of detention.⁹⁷

The ICN has noted that nurses are often among the first to notice ill-treatment and suffering in prisoners. The ICN's position statement on *The Nurse's Role in the Care of Prisoners and Detainees* states that: "Nurses who have knowledge of ill-treatment of detainees and prisoners must take appropriate action to safeguard their rights".⁹⁸

In 2004, the medical journal, *The Lancet*, called on health care workers in the military to "break their silence" and, for those in the wider non-military medical community, to "unite in support of their colleagues and condemn torture and inhumane and degrading practices against detainees".⁹⁹ In 2005 further concern about the role of health professionals was expressed in the medical and nursing literature.¹⁰⁰ Amnesty International has long urged health professionals to speak out against torture and contribute to ending this practice.¹⁰¹

4.2 Violence against women

The extent of violence against women is a human rights scandal. The Council of Europe has stated that domestic violence is the major cause of death and disability for women aged 16 to 44 in the region and accounts for more death and ill-health than cancer or traffic accidents.¹⁰² In other regions high levels of violence against women are seen.

Copenhagen: IRCT 1997; Jaranson J, Popkin MJ (eds). *Caring for Victims of Torture*. American Psychiatric Publishing, 1998; Peel M, Iacopino V (eds). *The Medical Documentation of Torture*, London, Greenwich Medical Media, 2002; Randall GR, Lutz E. *Serving Survivors of Torture: A Practical Manual for Health Professionals and Other Service Providers*. Washington, DC: American Association for the Advancement of Science, 1991; Wilson JP, Drozdek B (eds). *Broken Spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims*. New York: Brunner-Routledge, 2004;

⁹⁶ Eisenman DP, Keller AS, Kim G. Survivors of torture in a general medical setting: how often have patients been tortured, and how often is it missed? *Western Journal of Medicine* 2000;172:301-4; Miller JL. Post-traumatic stress disorder in primary care practice. *Journal of the American Academy of Nurse Practitioners*. 2000; 12:475-82.

⁹⁷ Glittenberg J. The tragedy of torture: a global concern for mental health nursing. *Issues in Mental Health Nursing* 2003; 24(6-7):627-638; Miles S. Abu Ghraib: Its legacy for military medicine. *Lancet* 2004;364:725-729.

⁹⁸ International Council of Nurses. *Nurses' Role in the Care of Prisoner and Detainees*, 1998. Available at: <http://www.icn.ch/psdetainees.htm>.

⁹⁹ Editorial. How complicit are doctors in abuses of detainees? *Lancet* 2004; 364: 725-9.

¹⁰⁰ Wilks M. A stain on medical ethics. *Lancet* 2005; 366: 429-31.

¹⁰¹ See, for example, Amnesty International. *Combating Torture: a Manual for Action*. London, 2003, Chapter 8. Available at: <http://web.amnesty.org/library/index/engACT400012003>. (See also recommendations at the end of this report.)

¹⁰² Parliamentary Assembly of the Council of Europe, Domestic Violence against Women, Recommendation 1582. Adopted 27 September 2002. Available at: <http://assembly.coe.int/Documents/AdoptedText/TA02/EREC1582.htm>. Accessed 9 May 2006.

Such abuses result from discriminatory laws and practices, and repressive gender roles. While some states have been willing to address these issues, others have shown themselves to be unwilling or unable to do so. Gender-based abuses experienced by women and girls throughout the world range from harmful traditional practices such as genital mutilation or virginity testing to punitive or disciplinary violence such as “honour killing” (see below p.34).

In working with survivors of violence, nurses bring their own experiences and opinions. One study of primary health care nurses in South Africa, found that nurses accepted gender-based violence as a cultural reality.¹⁰³ The authors of this study suggest that the role nurses play – as health professionals and as members of the community – needs to be examined before training schemes in the treatment of violence can be established.

The specialist skills needed to deal with violence against women requires that health professionals receive continuing education. Governments and health policy makers should ensure that all health personnel are given gender-sensitive training on violence against women.¹⁰⁴ Public awareness raising programmes should run alongside health professional training to ensure that violence against women is widely perceived as unacceptable.

4.2.1 Violence and reproductive health

Violence against women frequently damages or jeopardizes their reproductive health. In some cases the woman’s sexual identity or reproductive capacity is a focus for gender-based violence. In the UK, 25% of women experiencing domestic violence are assaulted for the first time during pregnancy.¹⁰⁵ Nurses and other health carers are therefore likely to see the evidence of such abuses within a professional context.

4.2.1.1 Rape and other sexual violence

Definitions of what constitutes rape differ according to jurisdiction. Definitions have commonly referred to vaginal penetration of a woman or girl by a man in the absence of consent. This definition is now evolving in some states to reflect the fact that rape does not always involve physical force, but can involve other forms of coercion including abuse of power, psychological oppression or taking advantage of a coercive environment, or other factors which make the victim incapable of giving genuine consent. There is also a widening of the understanding of the nature of sexual penetration, the role of non-penetrative acts and the inclusion of men as possible victims of rape.¹⁰⁶ The Rome Statute of the International

¹⁰³ Kim J, Motsei M. “Women enjoy punishment”: attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science and Medicine* 2002;54:1243-54.

¹⁰⁴ CEDAW General Recommendation 24 article 15b (available at: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24> and 1995 Beijing Platform for Action, para 103(h). Available at <http://www.un.org/womenwatch/daw/beijing/platform/>. Accessed 3 June 2005.

¹⁰⁵ Amnesty International. A Global Outrage: Global and UK Statistics. Available at: <http://www.amnesty.org.uk/svaw/yaw/global.shtml> (citing 1997 data of the Royal College of Midwives).

¹⁰⁶ Overly restrictive definitions of rape have been criticised by human rights organizations. See, for example, Submission to the Parliamentary Portfolio Committee on Justice and Constitutional Development, Parliament of South Africa, on the draft Criminal Law (Sexual Offences) Amendment Bill, 2003, from Amnesty International

Criminal Court now prohibits rape and other forms of sexual violence as constituent acts of crimes against humanity and war crimes, which are crimes under international law.¹⁰⁷ Other acts which can constitute crimes against humanity or war crimes include sexual slavery, enforced prostitution, enforced sterilization, other grave forms of sexual violence, and torture or other inhumane acts intentionally causing great suffering or serious injury to body or to mental or physical health.

Rape and sexual violence are not limited to those contexts covered by the Rome Statute in which they are crimes under international law. They are also committed in other contexts, by public official or other agents of the state, by members of armed groups, or by private or other non-state actors. Health policy makers should ensure that service provision includes emergency contraception, control and treatment of sexually transmitted infections, medico-legal evidence gathering and referral for specialist care or counselling. Nurses can liaise with social welfare and legal providers in following up patients. Working with partners and local communities, nurses can also promote a preventive approach to violence against women. On a macro scale this can include nurses encouraging and contributing to more research on the origins, effects and responses of violence against women that can inform policy making, law reform and health care development. In Nicaragua, doctors and some nurses have been nominated and trained by women's community groups to collect forensic data following abuse.¹⁰⁸

Nurses working in humanitarian settings

“Health care for sexual violence is often put into place in humanitarian settings due to the interest and commitment of a few dedicated nurses or midwives on staff. One example occurred in two separate refugee camps in Thailand. Two nurses working separately in reproductive health each began working closely with the refugee women's organizations. The refugee women identified that sexual violence was a serious problem but that few survivors disclosed the abuse because there were very few services available to assist them, and they feared retribution and social stigma. Over time, these two nurses gained the women's trust and established informal networks for receiving reports of sexual violence and providing life saving health care to survivors. Using medicines and supplies that were already available in

and Human Rights Watch. London and New York, AI Index: AFR 53/006/2003, 15 September 2003. Available at: <http://web.amnesty.org/library/index/engafir530062003>. Accessed 13 October 2005.

¹⁰⁷ International Criminal Court, Elements of Crimes, UN Doc. ICC-ASP/1/3, adopted September 2002; see also the Rome Statute of the International Criminal Court, adopted on 17 July 1998 (A/CONF.183/9); see also ICC-ASP/1/3(part II-B), 9 September 2002, Articles 7 and 8; both documents are available at the website of the ICC, http://www.icc-cpi.int/about/Official_Journal.html. The International Criminal Tribunals on Former Yugoslavia and on Rwanda also contributed important rulings on sexual violence. See, for example, the first conviction by the ICTY of rape as a crime against humanity. *Judgement of Trial Chamber II in the Kunarac, Kovac and Vukovic Case*, The Hague, 22 February 2001, JL/P.I.S./566-e. Summary available at: <http://www.un.org/icty/pressreal/p566-e.htm>. Accessed 12 May 2006.

¹⁰⁸ Morrison A, Ellsberg M, Bott S. *Addressing Gender-based Violence in the Latin American and Caribbean Region: A Critical Review of Interventions*. World Bank Policy Research Working Paper 3438, October 2004, p.28. Available at: http://wdsbeta.worldbank.org/external/default/WDSContentServer/TW3P/IB/2004/11/05/000160016_20041105120943/Rendered/PDF/wps3438.pdf. Accessed: 4 August 2005.

the health clinic (e.g., for wound care, STIs, emergency contraception), the nurses established basic health care response to sexual violence in two of the health clinics serving refugees along the Thai-Burma border.”¹⁰⁹

Women exposed to sexual violence are at risk of serious consequences apart from psychological trauma and related symptoms. These include physical injury, sexually transmitted infections and pregnancy. The most serious sexually transmitted infection is HIV and there is a growing awareness that post-exposure prophylaxis (PEP) – the administration of anti-retroviral medication after possible exposure to the virus – can play an important role in preventing infection in a high risk environment. These include where the perpetrator is known or suspected to be HIV positive or where there is a high prevalence of HIV in the community.¹¹⁰

4.2.1.2 Pregnancy following rape

Routine management of pregnancy is a common task for some nurses and central to the profession of midwifery. Pregnancy is a normal and usually welcome experience for most women. However, rape or other forms of sexual violence, have been used as a weapon of war, as a way of dominating the opposing force and, specifically, dominating women as the symbolic reproducers of that force.¹¹¹ In Sudan, Amnesty International reported the rape and intentional killing of pregnant women, as bearers of children of “the enemy”.¹¹² Forced pregnancy following rape can, depending on the context, amount to a war crime, a crime against humanity and a crime under international law. Women who are pregnant through rape may seek to terminate the pregnancy. Authoritative bodies that interpret human rights conventions are increasingly showing support for abortion where pregnancy is the result of rape; and where termination of pregnancy takes place in a safe environment.¹¹³ International human rights organizations have also campaigned for states to abolish the application of criminal sanctions against women seeking or having a termination of pregnancy.¹¹⁴ There appears to be no international nursing consensus on termination of pregnancy though nurses are given the option of refusing to participate in abortions in some jurisdictions.¹¹⁵

¹⁰⁹ Vann B. Sexual violence in populations affected by armed conflict. *WHO Health in Emergencies* January 2005, Issue no. 20. Available at: http://www.who.int/hac/network/newsletter/HiE_January_2005.pdf. Accessed: 5 January 2006.

¹¹⁰ For a review of issues and extensive bibliography see: Roland M. *HIV Post-Exposure Prophylaxis Following Non-Occupational Exposures. Background Paper for WHO Consultation, September 3 – 5, 2005*. Available at: <http://hivinsite.ucsf.edu/pdf/p01-kb-new/kbr-07-02-07-roland.pdf>. Accessed 11 May 2006.

¹¹¹ Olujic MB. Embodiment of terror: gendered violence in peacetime and wartime in Croatia and Bosnia-Herzegovina. *Medical Anthropology Quarterly* 1998;12(1):31-50.

¹¹² Amnesty International. Sudan: Rape as a weapon of war – sexual violence and its consequences. AI Index: AFR 54/076/2004.

¹¹³ See Paragraph 8.25 of the Programme of Action of the 1994 Cairo International Conference on Population and Development.

¹¹⁴ CEDAW General Recommendation No. 24. Paragraph 31(c) states that “When possible, legislation criminalizing abortion could be amended, to remove punitive measures imposed on women who undergo abortion”.

¹¹⁵ See, for example, the UK Abortion Act (1997).

4.2.1.3 Coerced sterilisation and other population control measures

In the five years between 1996 and 2000, more than 250,000 women – mostly poor and from remote rural areas – underwent coerced sterilization, without a proper consent process, during the implementation of a family planning policy in Peru.¹¹⁶ While the national family planning programme stated that women should be fully informed and permitted to choose their method, which included sterilization, the goals and quotas for sterilizations set for service providers tended to undercut a policy of choice.¹¹⁷ In July 2002, the Peruvian health ministry revealed that between 1995 and 2001, 331,600 women had been sterilized and 25,590 men had vasectomies as part of a public health programme aiming to cut the birth rate in the country's poorest regions. Most of those targeted were indigenous people from under-privileged areas in the Andean sierra, the Amazon, and shantytowns around Lima. The report from the health ministry stressed that participants in the programme had been threatened and bribed with food, and none were properly informed about the procedure or its consequences.¹¹⁸ The problem was not only that such operations were carried out coercively but also that many women did not receive adequate post-operative care and, as a consequence, suffered health problems; some even died.¹¹⁹ (See box below for one such case which came to the Inter-American Commission).

Peru: government sterilisation policy

In 1995 Hilaria Supa Huaman, an indigenous farmer from Laguna Pampa in Peru, came under strong pressure from the village nurse to undergo tubal ligation surgery. The nurse was working under the government's family planning policy in place at the time. Hilaria commented that the nurse had said to her, "[D]o you want to breed like a pig? Your husband will be angry if you do nothing". Without any detailed information, Hilaria underwent the surgery, but found it difficult to recover due to the physically demanding nature of her work.¹²⁰

In 2003, the Inter-American Commission on Human Rights settled a case with the Peruvian government of an indigenous woman, María Mamerita Mestanza Chávez, who had died after being sterilized against her will.¹²¹ Peru conceded that the then government had violated "the right to humane treatment, the right to life, and the right to equal protection of the law, and of the obligation to respect rights without discrimination for reasons of sex,

¹¹⁶ Miranda JJ, Yamin AE. Reproductive health without rights in Peru. *Lancet* 2004; 363: 68-69.

¹¹⁷ Amnesty International. *Peru: Truth and Reconciliation Commission – a first step towards a country without injustice*. AI Index: AMR 46/003/2004.

¹¹⁸ Barthelemy F. Peru: the scandal of forced sterilisation. *Le Monde Diplomatique* [English language edition.] Available at: <http://mondediplo.com/2004/05/08sterilisation>. Accessed 18 February 2005.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

¹²¹ Inter-American Commission on Human Rights. *María Mamerita Mestanza Chávez v. Peru*, Case 12.191, Decision on Admissibility, Report no.66/00, 3 October 2000. Available at: <http://www.cidh.oas.org/annualrep/2000eng/ChapterIII/Admissible/Peru12.191.htm>. Accessed: 13 May 2005; Settlement, Report no.71/03, 22 October 2003, <http://www.cidh.oas.org/annualrep/2003eng/Peru.12191.htm>, accessed 9 March 2006.

social origin, economic status, birth, or any other social condition” protected by the American Convention on Human Rights¹²² and other regional and international human rights treaties.

There were reported instances of health professionals themselves who underwent operations in order to meet targets that had been set. Some analysts have commented on the way that the Peruvian government’s actions converted some health care providers from advocates for human rights into often unwitting “participants in the systematic abuse of women’s rights”.¹²³ They suggest that any solution to the problem of forced sterilisation must take into account the “roles and rights of health professionals, as well as those of patients”. Part of the “friendly settlement” by the government in the case of María Mamerita Mestanza Chávez was that the government of Peru undertook to make changes to the laws and public policies on reproductive health and family planning.

Roma women in Slovakia were also alleged to have been forcibly sterilized under the communist government and during the 1990s.¹²⁴ Although the government agreed to investigate the claims, Amnesty International expressed concern in 2003 that despite its repeated appeals, no independent investigation was being conducted. Moreover, AI was concerned about reports of intimidation and continued harassment of victims, witnesses and human rights defenders. Campaigning continued throughout 2004 to ensure the Slovak government met required standards for investigation of the issue.¹²⁵

Wherever women are subject to coerced sterilisation or deprived of the information necessary to make an informed choice, nurses are likely either to be participants in unethical behaviour which breaches international human rights standards or at least to face ethical challenges, sometimes in circumstances where they may be pressured by senior staff to participate in clearly unethical behaviour.¹²⁶

In some countries women are forced to submit to unwanted termination of pregnancy and nurses are very likely to be involved in this, whether voluntarily or under pressure. In China serious violations against women and girls continue to be reported as a result of the enforcement of the family planning policy, including forced abortions and sterilizations. These have been occurring over a long period. For example, Mao Hengfeng was sent to a labour camp for an 18-month period of “re-education through labour” in April 2004 for persistently petitioning the authorities for redress concerning a forced abortion she had had 15 years earlier. At that time she became pregnant in violation of China’s family planning policy which requires families to have no more than one child. At the labour camp she was reportedly tied, suspended from the ceiling and severely beaten. She had been detained

¹²² Cook RJ, Dickens BM, Fathalla MF. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Oxford University Press, 2003, p.173.

¹²³ Miranda JJ, Yamin AE. Reproductive health without rights in Peru. *Lancet* 2004; 363: 68-9.

¹²⁴ Slovakia was part of the unitary state of Czechoslovakia under communist government until 1989. The post-1989 non-communist state split into the Czech Republic and the Slovak Republic in January 1993.

¹²⁵ Amnesty International. *Women, violence and health*. London, AI Index: ACT 77/001/2005.

¹²⁶ For analysis of sterilization practices from ethical, legal, health and human rights standpoints, see Cook *et al* (above, note 123).

several times in the past in psychiatric units where she had been forced to undergo unnecessary electro-shock “therapy”.¹²⁷

In March 2005, family planning officers in Linyi city, Shandong province, China reportedly began to subject many local women to forced abortions including women who already had two children. Several women fled in order to escape the operations, but the authorities effectively held their relatives hostage until they returned. Chinese central authorities later stated that they would investigate these reports of “illegal practices” in Shandong. Some Linyi officials have been removed from their posts, but no further action appears to have been taken against them or others who may have sanctioned the policy. A local self-trained legal advisor, Chen Guancheng, was placed under a form of house arrest for attempting to sue local officials over the abuses.¹²⁸

4.2.2 Nurses, midwives and domestic violence

Domestic violence is a global problem and responsible for significant morbidity and mortality. The WHO has reported that nearly 70% of all women murder victims worldwide are killed by their male partners.¹²⁹ Domestic violence is rooted within a complex economic, social and gendered framework. In response to the complexity of the problem, international organizations and health professional bodies have advocated an integrated approach that closely links health and social care with legal rights.¹³⁰ As health practitioners, nurses are likely to encounter the effects of domestic violence in hospitals, in community health care centres and on home visits. As a key point of contact between patient, community and the health and social welfare system, nurses have a vital role in recognizing, treating and acting for the prevention of violence.

Domestic violence is frequently seen as a private matter and not treated as a crime by the authorities. In many cases of domestic violence, women – the primary victims of such abuse – do not wish nurses or other health professionals to inform the authorities. A tension exists therefore, between the obligation of the nurse to respect the wishes of the patient, and the nurse’s responsibility to work for and maintain the patient’s well-being.¹³¹ In California, USA,

¹²⁷ Amnesty International. *Report 2005: The state of the world’s human rights*. London: AI, 2005.

¹²⁸ See Amnesty International *Urgent Actions*, ASA 17/037/2005 and updates, ASA 17/040/2005, ASA 17/005/2006. See also the report from the Network of Chinese Rights Defenders, available at <http://crd-information.blogspot.com/2005/11/violence-in-enforcing-family-planning.html>.

¹²⁹ World Health Organization. *World Report on Violence and Health*. Geneva: WHO 2002, p. 118. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/. Accessed 23 May 2006.

¹³⁰ UNFPA. United Nations Security Council Open Debate on Security Council Resolution 1325, Women, Peace and Security. Responding to the Needs of Victims of Gender-Based Violence. Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA, 28 October 2004. Available at: <http://www.unfpa.org/news/news.cfm?ID=523&Language=1>; Burke Draucker C. Domestic violence: the challenge for nursing. *Online Journal of Issues in Nursing* 2002;7(1) Available at: http://www.nursingworld.org/ojin/topic17/tpc17_1.htm

¹³¹ Nurses themselves can be victims of intimate partner violence. In Canada, Ms Lori Dupont was stabbed to death while on duty at the Hôtel-Dieu Grace Hospital in Windsor, Ontario, 12 November 2005. Her former partner, a doctor in the same hospital, was found shortly after the murder unconscious in his car; he was charged with her murder but he died two days later. (Milne C. The long road to prevention. *Medical Post*, 3 February 2006; http://www.medicalpost.com/mpcontent/article.jsp?content=20060202_192408_6080, accessed 8 February 2006);

health care professionals are obliged by law to report domestic injuries to local law enforcement agencies. However, a study of California physicians noted that, while most believed mandatory reporting may have benefits, it also carried potential risks to women's safety (by, for example, exposing her to a violent reaction of a partner) and expressed concerns with violating codes of medical ethics. A majority said that they would not comply with reporting requirements if the patient objected.¹³² The issue of whether or not to implement a policy of screening for domestic violence has adherents and sceptics and a definitive position has yet to emerge within the profession.¹³³

4.2.2.1 Spousal veto of treatment

Nurses should be aware that the practice of spousal veto – a male partner vetoing the medical and nursing treatment offered to his female partner, including the use of family planning services – constitutes an act negating a woman's right to privacy, autonomy in decision-making, and to be free from discrimination. The Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) places obligations on governments to protect these and other rights of women.¹³⁴ The imposition of such a veto also constitutes a breach of a woman's right to equal access to health care services and is a form of discrimination incompatible not only with CEDAW but also with the right to health provisions of the International Covenant on Economic, Social and Cultural Rights (ICESCR). Where spousal veto acts as a barrier to family planning services – in sub-Saharan Africa, for example – it also represents a serious threat to women's lives and health, and can even be linked to women's deaths where they are unable to access urgent medical care.¹³⁵ All governments have an obligation to take steps to end spousal veto of access to health care wherever it occurs and health professionals have a role in persuading communities of the importance of women's unimpeded access to health services.

Amnesty International delegates met a nurse in Papua New Guinea who had suffered brain damage following frequent and severe violence at the hands of her partner; she was no longer able to work as a nurse. See: AI. Abuse of women endemic in Papua New Guinea. *The Wire*, February 2006. Available at: <http://web.amnesty.org/wire/February2006/PNG>.

¹³² Rodriguez MA, McLoughlin E., Bauer HM, Paredes V, Grumbach K. Mandatory reporting of intimate partner violence to police: Views of physicians in California. *American Journal of Public Health* 1999; 89(4) 575-78.

¹³³ Taket A, Wathen CN, MacMillan H. Should health professionals screen all women for domestic violence? *Plos Medicine* 2004 October; 1(1): e4. Available at:

<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=523827>. Accessed 18 October 2005. See also: Walton Moss BJ, Campbell JC. Intimate partner violence: implications for nursing. *Online Journal of Issues in Nursing* 2002; 7 (1). Available at: http://www.nursingworld.org/ojin/topic17/tpc17_5.htm; and Campbell J. Intimate partner violence: Issues for the health care system. *Women's Health Issues* 2001;11:381-5.

¹³⁴ The text of the Convention on the Elimination of all Forms of Discrimination against Women is available at: <http://www.un.org/womenwatch/daw/cedaw/cedaw.htm>

¹³⁵ Cook R, Maine D. Spousal veto over family planning services. *American Journal of Public Health* 1987;77:339-44.

4.2.3 Trafficking and forced prostitution

Trafficking in human beings occurs for numerous reasons, all based on the profitability of moving individuals by deceit or coercion from one place to another.¹³⁶ According to the Palermo Protocol, trafficking means:

the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.¹³⁷

Trafficking is a major human rights problem which causes severe harm to those exploited. A report of the International Labour Organization (ILO)¹³⁸ suggests that a minimum of 2.45 million people are victims of trafficking at any one time. Of this number, around half are found in the Asia-Pacific region. Women and girls make up 98% of those forced into commercial sexual exploitation. In addition to the use or threat of force associated with trafficking, women are placed at further risk of sexual and other violence from “owners” or clients, with exposure to damaging psychological and physical effects.¹³⁹ Women and girls are also at risk of sexually transmitted infections, including HIV, and unwanted pregnancies.

This is an area of growing importance in the work of nurses in many parts of the world. However, working with trafficked women carries some risks to the women involved. The WHO *Ethical and Safety Recommendations in Interviewing Trafficked Women*, published in 2003, note that:

¹³⁶ The difference between migration and trafficking was well articulated in a report from the Asia Foundation: “While all trafficking involves migration, not all migration is trafficking. Many women voluntarily choose to migrate. If such migration is not accompanied by coercion or deception and does not result in forced labor or slavery-like conditions, it is not trafficking.” Asia Foundation, Population Council. *Prevention of Trafficking and the Care and Support of Trafficked Persons in the Context of an Emerging HIV/AIDS Epidemic in Nepal*. Asia Foundation, 2001. Available at: <http://www.asiafoundation.org/pdf/NepalTrafficking.pdf>.

¹³⁷ Palermo Protocol [the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime, (Art.3). Available at:

http://www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf.

Accessed 18 May 2006.

¹³⁸ International Labour Organization. *A Global Alliance against Forced Labour. Global Report under the Follow-up to the ILO Declaration on Fundamental Principles and Rights at Work*. Geneva: ILO, 2005. Available at: http://www.ilo.org/dyn/declaris/DECLARATIONWEB.DOWNLOAD_BLOB?Var_DocumentID=5059. Accessed 5 January 2006.

¹³⁹ One woman who entered Kosovo through trafficking knowing that she would work in the sex industry was quoted in an AI report: “this is not what I expected. I thought I would be paid ...I would get to choose my clients. This is not prostitution.” See: Amnesty International. *Kosovo (Serbia and Montenegro): “So does it mean that we have the rights?” Protecting the human rights of women and girls trafficked for forced prostitution in Kosovo*. AI Index: EUR 70/010/2004. Available at: <http://web.amnesty.org/library/index/engeur700102004>.

interviewing a woman who has been trafficked raises a number of ethical questions and safety concerns for the woman, others close to her, and for the interviewer. Having a sound understanding of the risks, ethical considerations, and the practical realities relating to trafficking can help minimize the dangers and increase the likelihood that a woman will disclose relevant and accurate information.¹⁴⁰

The uncertain legal status of trafficked women who are both victims of crimes and undocumented migrants can impede the woman's access to health care. Trafficked women may feel reluctant to speak freely to a nurse or other health carer out of fear of, for example, prosecution or deportation.

AI believes that, in accordance with General Recommendation 19 of CEDAW, states must exercise due diligence to prevent, investigate, prosecute and punish acts of violence against women, whether those acts are perpetrated by state agents or private persons and regardless of the victims' immigration status or area of work.¹⁴¹ However, the majority of perpetrators are currently not brought to justice. Instead, trafficked women may be seen as wrongdoers and deported, sometimes back to the place from which they were previously trafficked. Addressing these breaches of women's rights in the context of trafficking and sexual exploitation requires a coordinated response involving a range of actors. Nursing staff can contribute their own clinical experience to this discussion and to policy development.

To address the well-documented haste with which governments expel trafficked women, the Council of Europe Convention on Action against Trafficking in Human Beings calls, at article 13, for a reflection period for those found to have been trafficked to allow "the person concerned to recover and escape the influence of traffickers and/or to take an informed decision on cooperating with the competent authorities".¹⁴² Amnesty International urges authorities to ensure that all trafficked women and children detained by law enforcement officers are fully informed of their rights and how to access them, including the rights to independent legal counsel and an independent and impartial interpreter, as well as information about all of the options available to them.

4.2.4 Harmful practices

4.2.4.1 Female genital mutilation (FGM)

It is estimated that more than 130 million women and girls worldwide have been subjected to the practice of cutting or mutilating the external genitalia – formerly known as female

¹⁴⁰ Zimmerman C, Watts C. *WHO Ethical and Safety Recommendations for Interviewing Trafficked Women*. London School of Hygiene and Tropical Medicine, 2003. Available at: <http://www.oscebih.org/documents/1372-eng.pdf>. Accessed: 19 April 2005.

¹⁴¹ See also the 11 principles articulated in the *Recommended Principles and Guidelines on Human Rights and Human Trafficking Report of the United Nations High Commissioner for Human Rights to the Economic and Social Council*. ECOSOC document E/2002/68/Add.1, available at: <http://www.unhchr.ch>.

¹⁴² The Convention is available at: http://www.coe.int/T/E/human_rights/trafficking/PDF_Conv_197_Trafficking_E.pdf.

circumcision and now more widely described as female genital mutilation (FGM) or cutting (FGC).¹⁴³ FGM is a traditional practice undertaken in many parts of the world in the name of various cultural, religious and aesthetic justifications all of which are premised on patriarchal values.¹⁴⁴ FGM is practised in countries of East and West Africa, and by some populations in the Arabian Peninsula, and has spread to other regions through immigration.¹⁴⁵ It takes different forms – from the partial or total removal of the clitoris (clitoridectomy), the removal of the entire clitoris and the cutting of the labia minora (excision), or the removal of all external genitalia and the stitching together of the two sides of the genitals leaving just a small opening for the passing of urine and menstrual blood (infibulation).

Female genital mutilation can have dire health consequences for women and girls, which can include haemorrhage, infection, urinary dysfunction, shock and death. Long-term complications can include infertility, and painful urination, menstruation and intercourse. Women giving birth may experience gross tearing, postpartum haemorrhage, sepsis and death.¹⁴⁶ Increasingly, women fleeing the prospect of FGM have claimed asylum, although the number of successful cases remains small.¹⁴⁷ Nevertheless the progressive rise in migration ensures that the issue is one increasingly coming to the attention of health workers outside the regions where FGM has historically been practised.¹⁴⁸

A number of national and international organizations have developed training packages for nurses and midwives, in order to raise awareness and enable health workers to advocate against the practice. The WHO has designed teaching materials especially for nurses and midwives working where the practice is most prevalent.¹⁴⁹

Despite the potentially devastating health effects of FGM on girls and women, a purely health-oriented critique may have the unintended consequence of increasing pressure to involve health professionals and to have the procedure regulated and carried out in a clinic or

¹⁴³ See the WHO fact sheet on FGM, available at: <http://www.who.int/mediacentre/factsheets/fs241/en/>. Accessed 18 March 2006.)

¹⁴⁴ Amnesty International. *Women, violence and health*. AI Index: ACT 77/001/2005, 18 February 2005.

¹⁴⁵ Cook RJ, Dickens BM, Fathalla MF. Female genital cutting (mutilation/circumcision): ethical and legal dimensions. *International Journal of Gynaecology and Obstetrics* 2002; 79:281-7.

¹⁴⁶ Cook RJ, Dickens BM, Falhalla MF. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Clarendon Press 2003; Amnesty International. *Women, violence and health*. AI Index: ACT 77/001/2005. Available at: <http://www.amnesty.org/library/Index/ENGACT770012005>.

¹⁴⁷ In the USA, in the landmark case of the *Matter of Kasinga* (1996) the court ruled that “female genital mutilation, which results in permanent disfigurement and poses a risk of serious, potentially life-threatening complications, can be the basis for a claim of persecution”. Although asylum was granted in the case under appeal opened the door to other potential claims on the basis of FGM, it did not establish this abuse as a specific ground for asylum. See: Amnesty International USA. *Women’s human rights*. Available at: <http://www.amnestyusa.org/women/asylum/>. Accessed 18 October 2005.

¹⁴⁸ Thierfelder C, Tanner M, Bodiang CMK. Female genital mutilation in the context of migration: experience of African women with the Swiss health care system. *European Journal of Public Health* 2005; 15:86-90.

¹⁴⁹ World Health Organization. Materials are available at: http://www.who.int/reproductive-health/pages_resources/listing_fgm.en.html, including *Female genital mutilation –The prevention and the management of health complications: Policy guidelines for nurses and midwives*. Geneva: WHO, 2001. Available at: http://www.who.int/reproductive-health/publications/rhr_01_18_fgm_policy_guidelines/

hospital.¹⁵⁰ A study published in 2001 reported that 70 per cent of Abagusii girls in western Kenya who had been through the rite said they had been cut by a nurse or doctor, whereas a traditional practitioner had carried out the rite on virtually all of their mothers.¹⁵¹ Moves to “medicalize” the practice in an attempt to reduce negative health consequences have been opposed by numerous health bodies including the ICN¹⁵² on the grounds that FGM in any form is violence against women and constitutes a violation of basic human rights.

The Kenyan government has attempted to reduce the number of girls being subjected to the practice. The 2001 Children’s Act made FGM illegal for girls under the age of 17. Nevertheless, knowledge of the legal implications of FGM is not widespread, and the practice is still common. Evidence suggests that a community-level approach might be more successful in changing attitudes towards the practice.¹⁵³

UN General Assembly resolution 56/128 of 30 January 2002, on “*Traditional or customary practices affecting the health of women and girls*”, calls on states which have ratified CEDAW and the Convention on the Rights of the Child “to develop, adopt and implement national legislation, policies, plans and programmes that prohibit traditional or customary practices affecting the health of women and girls...and to prosecute the perpetrators of such practices”. It also calls on states to “address specifically in the training of health and other relevant personnel traditional or customary practices affecting the health of women and girls, also addressing the increased vulnerability of women and girls to HIV/AIDS and other sexually transmitted infections due to such practices”.¹⁵⁴

4.2.4.2 *Virginity testing*

So-called “virginity testing” is carried out in a number of countries in Africa, Asia, the Middle East and sporadically elsewhere.¹⁵⁵ In some cultures that place a high value on female virginity before marriage, the family of the prospective husband may request assurances that a woman or girl is a virgin prior to the marriage being celebrated. Where a test is decided upon, doctors and nurses usually are required to inspect the external female genitalia to determine

¹⁵⁰ Cook RJ, Dickens BM, Fathalla MF. *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*. Oxford: Clarendon Press 2003.

¹⁵¹ Chege JN, Askew I, Liku J. *An assessment of the alternative rites approach for encouraging abandonment of female genital mutilation in Kenya*. Washington, DC: Population Council, 2001, p.14. Available at: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_FGC.pdf. Accessed: 22 October 2005. See also Njue C, Askew I. *Medicalization of female genital cutting among the Abagusii in Nyanza Province, Kenya*. Washington, DC: Population Council, 2004. Available at: http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_FGC_Med.pdf.

¹⁵² International Council of Nurses. *Elimination of female genital mutilation*. Available at: <http://www.icn.ch/psgenital.htm>.

¹⁵³ See Chege et al., note 151 above.

¹⁵⁴ Clause 3(d), General, A/RES/56/128, 30 January 2002. Available at <http://daccess-ods.un.org/access.nsf/Get?Open&DS=A/RES/56/128&Lang=E>. Accessed 9 May 2006.

¹⁵⁵ Frank MW, Bauer HM, Arican N, Financi SK, Iacopino V. Virginity examinations in Turkey: role of forensic physicians in controlling female sexuality. *Journal of the American Medical Association* 1999; 282(5): 485-90. ‘Virginity testing leaves medical experts uneasy’, *Sunday Times*, 3 December 2004. Available at: <http://www.suntimes.co.za/zones/sundaytimesNEW/newsst/newsst1102067035.aspx>.

whether or not the woman has been sexually active.¹⁵⁶ In some areas, such as parts of southern Africa, virginity testing is undertaken by older women ostensibly to promote female chastity (or, in other words, to control young women's sexual behaviour). More recently it has been advocated in southern Africa as a means to control the spread of HIV/AIDS. However, organizations in southern Africa have expressed concern that the practice does not address male responsibility for the spread of HIV/AIDS and is inherently discriminatory. It appears to place the burden of responsibility and blame entirely on girls and young women.¹⁵⁷

The practice of virginity testing has been banned in Turkey since 2002, following the attempted suicide of five schoolgirls who were being threatened with forcible examination. Although virginity testing is regarded by the authorities as a form of gender-based violence and banned by national law, recent studies show that women in Turkey are routinely subjected to examinations by forensic physicians for both legal and social reasons.

Turkish researchers reported in a 2003 study that more than 80% of the nurses and midwives they surveyed said that they had been present during a hymen examination carried out to determine the subject's virginity; just over half the participants indicated that virginity was important and more than half disapproved of premarital sexual relations.¹⁵⁸ Moreover, even after the practice was prohibited, a study at an Istanbul hospital found that 208 women "voluntarily" underwent a virginity test for social reasons, suggesting that changing attitudes as well as laws is essential to end this practice.¹⁵⁹

The UN Special Rapporteur on violence against women has expressed concern that the practice "degrades women and is a violation of their rights" to dignity and equality, and has called on state agencies not to collaborate in the practice.¹⁶⁰ It is difficult to construe a meaningful medical rationale for a virginity test and health professionals carrying out or assisting in such examinations would appear to be complicit in unethical behaviour and a violation of a woman's human rights.

¹⁵⁶ In some jurisdictions, testing is described as being essential to determine whether sexual abuse has occurred. Given the limited objectives of the "virginity test", such an approach to the forensic investigation of alleged sexual assault is inadequate and the "test" should not be equated with a proper forensic examination.

¹⁵⁷ Scorgie F. Virginity testing and the politics of responsibility: implications for AIDS intervention. *African Studies* 2002, 61: 55-75.

¹⁵⁸ Gürsoy E, Vural G. Nurses' and midwives' views on approaches to hymen examination. *Nursing Ethics* 2003; 10: 485-96.

¹⁵⁹ Cited in: Amnesty International. *Turkey: Women confronting family violence*. London, 2004. Available at: <http://web.amnesty.org/library/index/engneur440132004>. Accessed 12 May 2006.

¹⁶⁰ Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1994/45, E/CN.4/1995/42, 22 November 1994; Report of the Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, in accordance with the Commission on Human Rights resolution 2001/49. Cultural practices in the family that are violent towards women. E/CN.4/2002/83, 31 January 2002; E/CN.4/2003/75/Add.1. International, regional and national developments in the area of violence against women 1994-2003, E/CN.4/2003/75/Add.1.

4.2.4.3 “Honour” crimes

In virtually all cultures, women are required to comply with stereotyped gender roles and discriminatory moral and behavioural codes. In some countries or communities, the penalty for infringing these codes – whether by choice or not – can be severe, including death, usually inflicted by relatives of the woman or her male partner.¹⁶¹ These acts, inflicted in the view of the perpetrators to preserve the “honour” of a family or community, are in reality crimes – sometimes described as “honour crimes”. Other “honour crimes” may see a woman being flogged, publicly humiliated, physically injured or expelled from the community.

In some countries, nurses may be confronted with the effects of violence inflicted on a woman who is perceived as having sullied the reputation of the family. She may have been raped, accused of involvement in inappropriate sexual behaviour, rejected a family’s marriage plans, or been seen alone with a man unrelated to her. The act of violence is intended to restore the “honour” of the family. Where survivors of such violence enter the health care system, issues of security of the survivor and the security of staff and other patients arise, as well as the particular challenges of providing care for the traumatized woman.

Turkey: ‘honour’ killings

In February 2004, shortly after the birth of her child, Guldunya Toren, a 22-year-old unmarried Turkish woman, was shot and wounded in the street by her two brothers. She was taken to hospital in Istanbul from where she pleaded for the police to save her. However she was left without protection and, late one night, her brothers entered the unguarded hospital and shot her in the head, killing her.¹⁶²

High rates of violence towards women have been reported in Turkey. Fifty nine per cent of women were victims of violence according to a 2001 survey at community health centres in the city of Bursa, in the northwest of the country.¹⁶³ Amnesty International has reported that violence against women is routinely ignored by both the government and the judiciary in Turkey. Investigations into violent acts against women are rare, and punishments for rapists light if they promise to marry their victims.¹⁶⁴

4.2.4.4 Early marriage

Other traditional practices that are harmful to women and that nurses and midwives may encounter in some parts of the world include early marriage, defined by the United Nations Children’s Fund (UNICEF) as the marriage of children and adolescents below the age of 18.¹⁶⁵ Early marriage can have serious mental and physical health consequences, especially if a girl is very young when married or is married against her will. Giving birth at a young age

¹⁶¹ Human Rights Watch. *Honoring the killers: Justice denied for ‘honor’ crimes in Jordan*. New York: Human Rights Watch, April 2004; 16:1(E).

¹⁶² Amnesty International. *Women, violence and health*. London, AI Index: ACT 77/001/2005.

¹⁶³ Ergin N, Bilgel N. A survey to establish the situation re violence against women in central Bursa. *Journal of Nursing*, Turkish Nursing Association, 2001, 51: 10. Cited in: *Turkey: women confronting family violence*. See note 159 above.

¹⁶⁴ *Turkey: women confronting family violence*. See note 159 above.

¹⁶⁵ UNICEF. *Early Marriage: Child Spouses*. Innocenti Digest, No. 7, March 2001, Innocenti Research Centre, UNICEF, Florence, Italy.

may result in reproductive health problems, and even death for the mother, and increased likelihood of morbidity for a child.¹⁶⁶

4.2.4.5 Other practices

Other practices impact on the autonomy and well-being of the woman. For example, “wife inheritance”, in which a woman is “inherited” by a brother or relative of the woman’s husband upon his death ignores a woman’s right to consent as well as potentially exposing her to health risks, particularly in a high HIV prevalence environment.¹⁶⁷

4.2.5 Forensic response to abuses: the role of nursing professionals

Forensic medicine is the application of medical knowledge and training to the elucidation of legal problems. Forensic medicine has a long history and has contributed greatly to the effective rule of law in many countries and in more recent times has contributed evidence in human rights cases and a framework for documentation of human rights violations.¹⁶⁸ However it is a branch of medicine continually under pressure of under-resourcing. In response to this, the training of nurses in forensic procedures has led to an increased forensic capacity, particularly in the area of sexual violence, including rape.

The effectiveness of prosecution in a case of sexual violence depends on accurate and comprehensive forensic evidence. The gathering of forensic evidence in rape cases can be thwarted for a number of reasons, including a survivor’s reluctance to undergo examination and press charges for reasons of fear, distrust, or lack of confidence that findings will be confidential. It may also reflect a wish by the woman to avoid further stress, a lack of medical resources, or a feeling among medical staff that they lack the expertise to carry out the necessary tests. In the past decade there has been a significant increase in the development of a specialized forensic nursing capacity with a special focus on sexual assault examination.¹⁶⁹ Preliminary evaluations of this work suggest that such forensic nursing programmes can be effective.¹⁷⁰

¹⁶⁶ Senderowitz J. *Adolescent Health: Reassessing the Passage to Adulthood*. World Bank Discussion Paper, no. 272. Washington DC: World Bank.

¹⁶⁷ Amnesty International. *Memorandum to the Government of Swaziland on the Sexual Offences and Domestic Violence Bill, 2005*. AI Index: AFR 55/003/2006.

¹⁶⁸ Both the American Association for the Advancement of Science (<http://www.aaas.org>) and Physicians for Human Rights (<http://www.phrusa/research/forensics/index.html>) have done pioneering work on the application of forensic medicine to human rights documentation. See also, Amnesty International. *A workshop on the application of forensic skills to the detection and documentation of human rights violations, Durban, South Africa, 3 to 5 July 1998. Final Report*. AI Index: ACT 75/012/1999; Amnesty International. *Protecting the human rights of women and girls. A medico-legal workshop on the care, treatment and forensic medical examination of rape survivors in Southern and East Africa, Durban, 2002*; McQuoid-Mason D, Pillemer B, Friedman C, Dada M. *Crimes against women and children*. Dundee University and Independent Medico-Legal Unit, 2002. Available at: http://www.dundee.ac.uk/forensicmedicine/Crimes_against_Women_and_Children/women_children.html.

¹⁶⁹ *Sexual assault nurse examiner education guidelines*. Pitman NJ: International Association of Forensic Nurses, 1997. See also: *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents*. Washington DC: U.S. Department of Justice, Office on Violence Against Women, September 2004. Available at: <http://www.ncjrs.org/pdffiles1/ovw/206554.pdf>. Accessed 12 October 2005.

¹⁷⁰ Campbell R, Patterson D, Lichty LF. The effectiveness of sexual assault nurse examiner (SANE) programs: a

Forensic researchers have developed increasingly rigorous protocols in an effort to strengthen the quality of evidence. The WHO has sponsored the development of a manual on the investigation and documentation of sexual violence directed at physicians and nurses and aimed at strengthening evidence gathering.¹⁷¹

4.3. Detainees and prisoners: challenges to the role of nurses

Human rights standards apply to prisoners as they do to free citizens. This is spelled out in the major human rights treaties such as the International Bill of Rights¹⁷², prison-related standards such as the UN Standard Minimum Rules for the Treatment of Prisoners¹⁷³ and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment¹⁷⁴, as well as in regional treaties.

Nurses are among health professionals providing health care to those in prison and detention, sometimes in situations that appear to conflict with their caring role.¹⁷⁵ Nurses must protect the right to health and the physical and mental integrity of detainees, and strive to maintain their dignity.

As noted above, *The Nurse's Role in the Care of Detainees and Prisoners*, adopted by the ICN in 1975 and revised in 1998, upholds the Geneva Conventions and the Universal Declaration of Human Rights and "condemns the use of all [interrogation] procedures harmful to the mental and physical health of prisoners and detainees".

Nurses also have a duty to advocate against ill-treatment and to refuse to witness or participate in torture. The ICN code further states that "nurses having knowledge of physical or mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or international bodies". It also rejects demands for nurses to act as security personnel by, for example, carrying out body searches

review of psychological, medical, legal, and community outcomes. *Trauma Violence and Abuse* 2005; 6(4):313-29.

¹⁷¹ World Health Organization. *Guidelines for Medico-legal Care for Victims of Sexual Violence*. Geneva: WHO, 2004; Available at:

http://www.who.int/violence_injury_prevention/resources/publications/med_leg_guidelines/en/. Accessed 12 October 2005.

¹⁷² The International Bill of Human Rights consists of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and its two Optional Protocols. Available at: <http://193.194.138.190/html/menu6/2/fs2.htm>. Accessed 14 May 2006.

¹⁷³ Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Available at: <http://www.ohchr.org/english/law/treatmentprisoners.htm>

¹⁷⁴ G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (No. 49) at 298, U.N. Doc. A/43/49 (1988). Available at: http://www.unhchr.ch/html/menu3/b/h_comp36.htm. Accessed 13 May 2006.

¹⁷⁵ Physicians for Human Rights, University of Cape Town. *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*. Boston: PHR, 2003. Available at: http://www.phrusa.org/healthrights/dual_loyalty.html. Accessed 30 March 2006.

for security reasons. There remains an inconsistency, however, with regard to intimate body searches by nurses for non-medical reasons. In the UK, for example, intimate searches of a body orifice other than the mouth can generally only be performed by a medical practitioner or registered nurse, under the authorization of a senior police officer. Consent is not legally required although it is recommended by the British Medical Association where a doctor is involved.¹⁷⁶ For non-intimate body searches, nurses of the same gender can search those detained under the 1983 Mental Health Act where there are reasonable grounds to do so and where there is authorization from the responsible medical officer.¹⁷⁷

4.3.1 Prison

The prison environment can place a strain on the ability of the nurse or midwife to provide care. Ethical and human rights standards require nurses to:

- not tolerate or participate in cruel and degrading treatment of detainees and prisoners and not accept conditions that grossly fail to meet international standards – in other words seeing such ill-treatment or poor conditions should prompt action by a nurse;
- strive to provide appropriate care to detainees and prisoners consistent with ethical standards;
- avoid breaches of confidentiality, disregard for informed consent and lack of respect for personal autonomy, all of which breach nursing ethics.¹⁷⁸

However, Amnesty International has noted the difficulty some nurses face in caring for prisoners. Around the world, health services in prisons are frequently given low priority, and training and support is inadequate. People entering prison frequently have poorer health than average, in particular having higher levels of mental illness, as well as tending to lack social skills and education. Health care provision and training for prison staff often fails to meet the standards applying in the wider society. In Kenya, in the 1990s, nurses were required to provide medical care for which they were not trained, and they were in a weak position to demand comprehensive care for prisoners. There was also a lack of ethical guidance for health professionals working in this environment. In a 1997 report, AI recommended that the Kenyan government should improve the amount and quality of ethical training for health

¹⁷⁶ British Medical Association. *Healthcare of detainees in police stations*. Second edition. London: BMA, 2004. Available at: [http://www.bma.org.uk/ap.nsf/Content/Detainees/\\$file/Detainees.pdf](http://www.bma.org.uk/ap.nsf/Content/Detainees/$file/Detainees.pdf). Accessed 9 January 2006. This remains a contentious area of forensic medicine. Recommendation No. R (98)7 of the Committee of Ministers of the Council of Europe to Member States concerning the Ethical and Organizational Aspects of Health Care in Prison (1998), recommended that physicians do not carry out intimate examinations in the absence of medical need. The Danish delegation entered a reservation stating that non-physicians should not carry out such examinations but that they should only be carried out by a physician with consent of the detainee. See discussion in CPT Working Paper, *Physicians Acting at the Authorities' Request for Non-Medical Purposes*, September 2001. Available at: <http://www.cpt.coe.int/EN/working-documents/cpt-2001-65-eng.pdf>.

¹⁷⁷ The Human Rights Committee (HRC) has stated that people “being subjected to body search by State officials, or medical personnel acting at the request of the State, should only be examined by persons of the same sex”. General Comment No.16 of the HRC para. 8. Article 17 of the International Covenant on Civil and Political rights to which GC 16 refers speaks of the “right to respect of privacy ... and protection of honour and reputation”.

¹⁷⁸ Coyle A. *A Human Rights Approach to Prison Management*. London: International Centre for Prison Studies. Available at: <http://www.kcl.ac.uk/depsta/rel/icps/publications.html>.

professionals in order to help combat torture in Kenya's prisons.¹⁷⁹ Since then, professional bodies have taken a stronger stand on human rights and NGOs have included a health perspective in their work. In 2005, nurses participated in a workshop organized by Physicians for Human Rights USA to strengthen advocacy in support of a comprehensive nursing bill and to ensure that the bill includes reference to human rights.¹⁸⁰

Any nursing care provided by the prison administration should be at least comparable to what is available in the outside community.¹⁸¹ The Basic Principles for the Treatment of Prisoners states (at Principle 9) that "prisoners shall have access to the health services available in the country without discrimination on grounds of their legal situation."¹⁸² In situations where medical facilities are inadequate, mechanisms should be in place for nurses to recommend changes. Such requests, fulfilling a duty of care to prisoners, should not jeopardize the nurse's role as an employee of the prison service. National nursing associations should provide access to confidential advice and support for prison nurses.¹⁸³

In some countries, pregnant women are chained during transport to and from detention centres or within medical facilities. In the USA, 38 state departments of corrections and the Federal Bureau of Prisons may use restraints on pregnant women in the third trimester.¹⁸⁴ Such procedures pose ethical dilemmas to those responsible for the health of the pregnant woman.

In September 2005, Samantha Luther, a prisoner in Wisconsin, was allegedly taken in handcuffs and leg shackles to the local hospital, and informed that labour was going to be induced. She was two weeks away from the due date of birth. Reportedly, her handcuffs were taken off while her shackles remained on, providing 18 inches between her ankles. The doctor ruptured her amniotic sac, and had her walk in the hospital hallway for several hours. "It was so humiliating," she said. When labour did not start, it was induced and Samantha Luther reportedly was left in her shackles until just before birth. She said, "I had shackles on up until the baby was coming out and then they took them off for me to push... It was unbelievable."¹⁸⁵

¹⁷⁹ Amnesty International. *Kenya: Detention, torture and health professionals*. London: AI Index: AFR 32/001/1997. Available at: <http://web.amnesty.org/library/Index/ENGAFR320011997>. Accessed: 27 June 2005.

¹⁸⁰ Physicians for Human Rights. Advocacy workshops. Nairobi and Eldoret, July 2005.

¹⁸¹ One step towards ensuring this principle is to make prison health part of the national health program. Under a law of January 1994, the French authorities transferred responsibility in prison health care from the Ministry of Justice to the public hospital sector. The aim of the transfer was to meet the requirement to provide for prisoners the same standard of health care as was available to the population outside prisons. As a first step all prisoners were automatically given membership of the social security, general health and maternity insurance scheme. (See Coyle A. *op. cit.* p.52.)

¹⁸² UN. *Basic Principles for the Treatment of Prisoners*. Adopted and proclaimed by General Assembly resolution 45/111 of 14 December 1990. Available at: http://www.unhcr.ch/html/menu3/b/h_comp35.htm. Accessed 12 October 2005.

¹⁸³ ICN. *Nurses' Role in Care of Prisoners and Detainees*. Geneva: ICN, 1998.

¹⁸⁴ Amnesty International USA. *Excessive Use of Restraints on Women in US Prisons: Shackling of Pregnant Prisoners*. Undated. <http://www.amnestyusa.org/women/custody/shackling.html>. Accessed 30 March 2006.

¹⁸⁵ *Ibid.*

Shawanna Nelson, a prisoner in Arkansas, had her legs shackled together throughout more than 12 hours of labour in September 2003; they were removed only at the point of delivery after repeated requests from nurses and a doctor.¹⁸⁶

The Wisconsin Department of Corrections reported in January 2006 that staff have been directed to end the use of restraints on pregnant inmates during labour, delivery and recovery. The California legislature passed a law forbidding the shackling of pregnant prisoners during labour, delivery and recovery following similar cases. International standards oppose this kind of practice. The Standard Minimum Rules for the Treatment of Prisoners states at Rule 33 that:

Chains or irons shall not be used as restraints. Other instruments of restraints shall not be used except in the following circumstances:

- (a) as a precaution against escape during a transfer;
- (b) on medical grounds by direction of the medical officer;
- (c) by order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property.

[Instruments of restraint] must not be applied for any longer time than is strictly necessary.¹⁸⁷

One authoritative report on the ethics of dual loyalty obligations has recommended that

The health professional should not perform any medical duties on shackled or blindfolded patients, inside or outside the custodial setting. The only exception should be in circumstances where, in the health professional's judgment, some form of restraint is necessary for the safety of the individual, the health professional and/or others, and treatment cannot be delayed until a time when the individual no longer poses a danger. In such circumstances, the health professional may allow the minimum restraint necessary to ensure safety.¹⁸⁸

4.3.2 Offenders with mental disorders

Many prisoners experience mental health problems. Some arrive in prison in part because of mental disorders; others have problems unrelated to their criminal behaviour and yet others develop mental illnesses within the prison. The impact of this will be felt both by prison nursing staff and nurses working in medical settings to which prisoners may be referred. A UN review of prison health listed the main issues in prison health as: substance misuse; mental illness; communicable diseases; and deaths in custody.¹⁸⁹ Studies in a number of

¹⁸⁶ Liptak A: Prisons often shackle pregnant inmates in labor, *New York Times* 2 March 2006.

¹⁸⁷ *Standard Minimum Rules for the Treatment of Prisoners*. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. Available at: http://www.unhcr.ch/html/menu3/b/h_comp34.htm. Accessed 30 March 2006.

¹⁸⁸ Physicians for Human Rights, University of Cape Town. *Dual Loyalty and Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms*. Boston: PHR, 2003. Available at: http://www.phrusa.org/healthrights/dual_loyalty.html. Accessed 30 March 2006.

¹⁸⁹ Tomasevski K. *Prison health: international standards and national practices in Europe*. Helsinki Institute for Crime Prevention and Control. UN Publication Series 21. Helsinki: United Nations, 1992.

countries have documented the high rates of mental illness in prisoners. In Australia, for example, it is estimated that 36% of women and 34% of men in custody have been admitted into a psychiatric hospital prior to their current period in detention.¹⁹⁰

In 1997, a study conducted by the Office of National Statistics, UK, found that 39% of sentenced men and 62% of sentenced women were suffering from problems such as anxiety, depression and phobias.¹⁹¹ By contrast, only 12% of men and 18% of women were found to have significant levels of neurotic symptoms among the general population.¹⁹² A conference organized in 2004 by the UK Prison Reform Trust suggested that alternatives to incarceration for mentally disordered offenders could include: early intervention schemes; accessible and appropriate health care facilities; and court diversion schemes for suicidal or acutely ill offenders.¹⁹³ It also recommended that courts be encouraged to use alternatives to custody for minor offenders and that the prison service be required to meet national health care standards. It was further suggested that an independent agency should be established to monitor health in prisons.

In prisons which have particularly harsh conditions or which appear to be designed to break the will of the prisoner, health care staff may face a dilemma as to whether to stay and assist prisoners at the risk of appearing to collude with a regime of ill-treatment or seek to leave the institution (which may in any event be difficult in institutions run under military discipline).¹⁹⁴

4.3.3 Nurses and hunger strikers in detention

Hunger strikes can pose ethical dilemmas for the hunger striker's family and supporters, for medical staff and for human rights organizations, as well as putting the hunger striker's health at risk. Extended periods of food refusal, including those conducted as part of a mass political action, can lead to deaths or long-term physical and mental deterioration. They reflect politically-motivated action; a health and ethical dimension; they touch on the moral values of the striker, carers and state decision-makers and challenge both supporters of the hunger striker and civil society organizations that work to promote human rights. Current autonomy-based ethical standards call on doctors (and arguably others) to respect patient autonomy and

¹⁹⁰ Butler T. Preliminary findings from the inmate health survey of the inmate population in the NSW correctional system. 1997. Cited in: Holmwood C, Rae D. Prison health: a different place for GPs. *Australian Family Physician* 2003; 32(10).

¹⁹¹ Singleton N, Meltzer H, Gatward R (with Coid J, Deasy D). *Psychiatric morbidity among prisoners: summary report*. Office for National Statistics. 1998. Available at: http://www.statistics.gov.uk/downloads/theme_health/Prisoners_PsycMorb.pdf

¹⁹² Meltzer H et al., *OPCS Surveys of Psychiatric Morbidity in Great Britain Report 1: The prevalence of psychiatric morbidity among adults living in private households*. London: HMSO, 1995.

¹⁹³ Stephenson P. Mentally ill offenders are being wrongly held in prisons. *British Medical Journal* 2004; 328: 1095.

¹⁹⁴ In February 2006, the UN Special Rapporteur on the right to health, together with four other UN Special Rapporteurs, issued a statement in which they drew attention to the situation of detainees held at Guantanamo Bay including the mental health effects of detention in Guantanamo and the unethical behaviour of health professionals there. See. ECOSOC. Situation of detainees at Guantanamo Bay, E/CN.4/2006/120, 15 February 2006. Available at: [http://www.ohchr.org/english/bodies/chr/docs/62chr/E.CN.4.2006.120 .pdf](http://www.ohchr.org/english/bodies/chr/docs/62chr/E.CN.4.2006.120.pdf). Accessed 19 March 2006.

to abstain from non-consensual feeding.¹⁹⁵ However some professionals oppose acquiescing in the possible self-inflicted death of a patient and are sympathetic to the involuntary feeding of the striker. Some governments require health professionals to forcibly feed hunger-striking prisoners, raising issues of dual loyalty obligations. The ethical considerations escalate as the hunger strike progresses, the questions of patient competence and best interests become more complex and the political environment evolves.

Australia: Hunger-striking unaccompanied minor in asylum detention cared for by mental health nurse

Numerous health care professionals have expressed concern about the presence of children in asylum seeker detention in Australia. In a submission to the Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention, Roshanak Vahdani, a male mental health nurse, relayed the case study of an unaccompanied 16-year-old Afghani boy, detained in an undisclosed centre.

‘I found him extremely distressed and in crisis. He cried continuously, expressing hopelessness about living and repeatedly telling me that he wanted to kill himself. He reported being depressed and agitated like this for weeks. This had been worsening in the past few days. He had thought about self-harm continuously since the Red Cross had told him that they could not find his parents. He believed them to be dead and hence saw no point in living. He had classical symptoms of a major depression for example depressed mood, suicidal ideations, sleep and appetite disturbances (he had gone on hunger strike for a few days), and severe agitation and anxiety. He refused to let me tell the authorities as he felt he would consequently be punished by being put on ‘suicide alert’...Eventually he agreed and made a contract with me not to harm himself, and I agreed to ring him daily at a regular time to see how he was. He feels somewhat better since my phone calls, but I believe he is still quite depressed and traumatised’.¹⁹⁶

Asylum seekers in detention have been noted as an emerging category of individuals frequently using this form of protest.¹⁹⁷ Caring for hunger striking asylum seekers in detention poses difficulties for nursing staff due to potential barriers such as language, different cultural norms and possible previous exposure to persecution by the authorities. These may all compromise the ability of the nurse to gain the hunger striker’s trust and to provide effective care. The complex political nature of the act and the striker’s legal position can further complicate the situation¹⁹⁸ and dual loyalty conflicts also arise.¹⁹⁹

¹⁹⁵ World Medical Association. *Declaration on Hunger Strikers*. Adopted by the 43rd World Medical Assembly Malta, November 1991 and editorially revised at the 44th World Medical Assembly Marbella, Spain, September 1992 Available at: <http://www.wma.net/e/policy/h31.htm>. The declaration makes clear that it does not apply to cases where food refusal results from a prisoner’s mental illness.

¹⁹⁶ Alliance of Professionals Concerned about the Health of Asylum Seekers and their Children. ‘1.6.2 Case study B: 16 year old boy in detention.’ In, *Submission to Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention*. May 2002. Available at: <http://www.nq-anzcmhn.org/docs/HEREOC.PDF>.

¹⁹⁷ Silove D, Curtis J, Mason C, Becker R. Ethical considerations in the management of asylum seekers on hunger strike. *Journal of the American Medical Association* 1996; 276:410-15.

¹⁹⁸ *Ibid.*

¹⁹⁹ Hall M. Frontline nursing in detention. *Australian Nursing Journal* 2004, 11(7): 32-3.

The issue of hunger strikes and forcible feeding also arose at the Guantánamo Bay naval base in Cuba where hundreds of detainees have been held, most without charge or trial, by the US authorities. Some have been held since January 2002. In 2005 there were reports that detainees were refusing food in protest at the lack of due process and ill-treatment the prisoners alleged they were experiencing. Detainees were fed artificially although they had indicated their wish to refuse food. Amnesty International received credible reports that feeding was carried out roughly and in a manner constituting cruel, inhuman or degrading treatment.²⁰⁰ Concern has been expressed by many doctors that medical staff at the naval base have breached medical ethics in carrying out this feeding.²⁰¹ Nurses also work at Guantánamo though no information is available to Amnesty International on their role in breaking hunger strikes.

4.3.4 Corporal punishment

Amnesty International statistics suggest that between 1997 and mid-2000 judicial amputations were carried out in at least seven countries and judicial floggings in at least 15 countries.²⁰² Such punishments continue to be inflicted in breach of international human rights standards which include the UN Convention against Torture. UN human rights treaty bodies – the Human Rights Committee and the Committee against Torture – have concluded that corporal punishments, such as amputations and flogging, are incompatible with the UN Convention against Torture. The Committee on the Rights of the Child concludes similarly that it is incompatible with the UN Convention on the Rights of the Child.²⁰³ In some countries, predominantly former British colonies and states applying *shari'a* (Islamic law), health professionals may be required to supervise such cruel, inhuman or degrading treatment or punishments. In a wider number of countries, prisoners are punished by reduction of diet, solitary confinement or hard labour. Nurses are likely to be required to participate in aspects of these punishments or their monitoring.

The ICN's position on torture, the death penalty and the participation by nurses in

²⁰⁰ Amnesty International. *USA. Guantánamo: Lives torn apart – The impact of indefinite detention on detainees and their families*. AMR 51/007/2006, available at: <http://web.amnesty.org/library/Index/ENGAMR510072006>. There may be circumstances where, though arguably unethical, AI would not regard non-consensual feeding as constituting cruel, inhuman or degrading treatment and the organization evaluates each case on its merits.

²⁰¹ Nicholl DJ et al. Forcefeeding and restraint of Guantanamo Bay hunger strikers. *Lancet* 2006; 367:811.

²⁰² Amnesty International. *Combating Torture: A Manual for Action*. London, 2003. Available at: <http://web.amnesty.org/pages/stoptorture-manual-index-eng>. In some countries, extra-judicial corporal punishment is also carried out.

²⁰³ The UN Special Rapporteur on Torture, Manfred Nowak. Statement to the Commission on Human Rights on Torture. 26 October 2005. Available at: <http://www.unhchr.ch/hurricane/hurricane.nsf/0/005D29A66C57D5E5C12570AB002AA156>. Accessed 1 March 2006. The Committee on the Rights of the Child, which monitors the Convention on the Rights of the Child, has consistently stated that acceptance of physical punishment of children is incompatible with the Convention. In the report of its seventh session in November 1994, the Committee stated: "In the framework of its mandate, the Committee ... has stressed that corporal punishment of children is incompatible with the Convention". Committee on the Rights of the Child. Report on the seventh session. (Geneva, 26 September-14 October 1994). CRC/C/34, 8 November 1994, p.63. In numerous country reports the CRC has drawn attention to this concern in its concluding observations and comments on states parties' reports. These are available at: <http://www.unhchr.ch/tbs/doc.nsf>.

executions, adopted in 1973 and reaffirmed in 1989, states that a nurse's primary responsibility is to those people who require nursing care, and that nurses have a duty to provide the highest possible level of care to victims of cruel, inhuman or degrading treatment. It further states that nurses shall not voluntarily participate in any deliberate infliction of physical or mental suffering, and that any act that did so would be a violation of the nursing code of ethics.²⁰⁴

4.3.6 Death penalty

Like doctors, nurses are likely to be called upon to provide routine care for prisoners being held under sentence of death. While prisoners have a human right to health care in such circumstances, the nature of death row and of capital punishment raises serious ethical issues for carers. Amnesty International regards the death penalty as the ultimate cruel, inhuman or degrading punishment which is irrevocable, can be inflicted against innocent people and violates the right to life. The ICN has termed the death penalty the "ultimate inhumanity".²⁰⁵

The manner in which the nurse's role in an execution mimics health care practice is apparent from the following description of a nurse in the USA.

On the day of the execution, the nurse dressed as if for an operation, in scrubs, mask, hat, and sterile gown and gloves. He explained to the prisoner exactly what was going to happen. He placed two IVs [intravenous lines] and taped them down.²⁰⁶

The nurse then proceeded to attach the syringe to the IV port and another person initiated the flow of sodium thiopental.

In countries where the death penalty is imposed, nurses have contested health professional involvement. In the USA, the American Nurses Association (ANA) opposes nurses' participation in the death penalty on the grounds that it contravenes the fundamental goals and ethical traditions of the profession.²⁰⁷ Other commentators echo this.²⁰⁸ Others go further, reinforcing the ICN position that nurses should call for an end to the death penalty. On a

²⁰⁴ International Council of Nurses. *Position Statement: Torture, Death Penalty and Participation by Nurses in Executions*. Adopted in 1973, reaffirmed in 1989. Available at: <http://www.icn.ch/pstorture.htm> Accessed: 19 April 2005.

²⁰⁵ *Ibid.*

²⁰⁶ Gawande A. When law and ethics collide – why physicians participate in executions. *New England Journal of Medicine* 2006; 354:1221-9

²⁰⁷ American Nurses Association. *Ethics and human rights position statements: Nurses participation in capital punishment*, 1994. Available at: <http://nursingworld.org/readroom/position/ethics/prtetcptl.htm> Accessed: 19 April 2005. One US state nursing society is reported to have dissented from this position. The North Carolina Nurses Association decided on 14 March 2003 to delete the *Position Statement on Registered Nurses' Participation in Execution* and to allow nurses to make up their own minds on participation. See also, Associated Press, 13 March 2006. Available at: <http://www.charlotte.com/mld/observer/news/local/14088954.htm>.

²⁰⁸ Holmes D, Federman C. Killing for the state: the darkest side of American nursing. *Nursing Inquiry* 2003;10:2-10; Emanuel LL, Bienen LB. Physician participation with executions: time to eliminate anonymity provisions and protest the practice. *Annals of Internal Medicine* 200;135: 922-3. Available at: <http://www.annals.org/cgi/reprint/135/10/922.pdf>, Accessed: 5 August 2005; See also: Lodder, L. Who will aid the executioner?: In Missouri, nurses have been called to replace doctors. *American Medical News* 1993; 2:11.

subject bedevilled by misinformation and misinterpretation, individual nurses and associations can “bring truth to the death penalty debate”, according to one nurse.²⁰⁹

USA: Nurses’ role in executions

A lawyer’s letter submitted to state authorities in Georgia, USA, seeking a review of medical participation in executions noted the role of nurses in the execution process: “In the execution chamber, nurses begin two peripheral intravenous lines into the condemned person” in order to facilitate the execution. However, the letter remarks, “The intravenous lines often do not go as planned. In one instance ... nurses could not begin an IV after thirty-nine minutes of sticking [the prisoner] in his hand, arm, groin, leg, and foot”.²¹⁰ A doctor was called in to attach the line. The ANA policy on nurses and capital punishment makes clear that this role is inconsistent with nursing ethics.²¹¹

Human rights bodies have been critical of participation of health professionals in executions.²¹² In a declaration first adopted in 1981, Amnesty International urges health professionals not to participate in executions and calls on health professional bodies to protect health personnel who refuse to participate in executions, to adopt resolutions making this clear, and to promote worldwide adherence to these standards.²¹³ Amnesty International campaigns for the total abolition of the death penalty.²¹⁴

Guatemala: Nurses involved in administering the death penalty

In some countries, nurses have been coerced or persuaded to assist in administering the death penalty against the ethics of both the nursing profession and the wider health professions. The first execution by lethal injection in Guatemala took place in the early morning of 10 February 1998 when Manuel Martínez Coronado was executed after a series of last-minute legal appeals were rejected by the judiciary. The entire execution was broadcast live; radio and television audiences could hear the condemned man’s three children and their mother (whom the condemned man had married the previous night in his prison cell) sobbing in the observation room as the execution took place. Execution personnel, described as nurses (but whose qualifications and identity were never revealed) were dressed in full surgical clothing.

²⁰⁹ Mogilka SM. The entire life: nursing’s obligation to bring truth to the death penalty debate. *Nursing Forum* 1997; 32:5-16.

²¹⁰ Letter from Stuckey and Manheimer, LLC., Attorneys at law, Decatur, Georgia, to the Composite State Board of Medical Examiners and others, Georgia, USA, 1 June 2005.

²¹¹ The ANA statement on nurses’ participation in capital punishment states, *inter alia*, that “Nurses should refrain from participation in capital punishment and not take part in assessment, supervision or monitoring of the procedure or the prisoner; procuring, prescribing or preparing medications or solutions; inserting the intravenous catheter; injecting the lethal solution; and attending or witnessing the execution as a nurse.” Available at: <http://www.nursingworld.org/readroom/position/ethics/etcptl.htm>.

²¹² The American College of Physicians, Human Rights Watch, The National Coalition to Abolish the Death Penalty, Physicians for Human Rights. *Breach of Trust: Physician Participation in Executions in the United States*. New York, 1994. Available at: <http://hrw.org/reports/1994/usdp/index.htm>. Accessed 14 May 2006.

²¹³ Amnesty International. *Declaration on the participation of health professionals in the death penalty*. London, 1988. Available at: <http://web.amnesty.org/pages/health-ethicsdpdeclaration-eng>. Accessed: 20 October 2005.

²¹⁴ Amnesty International. *When the State Kills....* London, 1989.

As this was unnecessary for medical reasons, the real purpose may have been to hide the identity of those participating.²¹⁵

4.3.7 Traditional punishments

In some countries, traditional punishment is used as well as or instead of punishment dictated by courts within the criminal justice system. This is the case for example with indigenous people's or other community-based justice systems. It has raised questions of human rights and ethics and particularly so where a traditional punishment is considered to contravene human rights principles and is observed or supervised by a nurse (see box).

Australia: Nurse present at traditional punishment

A nurse and police officers were present at the traditional punishment of Kevin Webb in an Aboriginal community in the Northern Territory, Australia, in 2002. Kevin Webb, accused of murder, was given a week's bail by an Alice Springs court in December 2002, during which he travelled to the community of Nyirripi to visit the family of his alleged victim, Max Brown. There, in the presence of a nurse and police officers, Brown's family carried out the traditional punishment for murder. Webb was speared 13 times in the legs and his ankle was broken.²¹⁶

The *Northern Territory News* subsequently reported that a nurse based at Nyirripi who saw Kevin Webb after the punishment was assaulted because she had provided treatment.²¹⁷

In situations where traditional justice systems exist in parallel with or simultaneously with the state's criminal justice system, tension exists between the state's duty to enforce its international human rights obligations and the state's obligation to respect the customs and culture of the community. One former nurse commented: "When I was working out there we just couldn't stand by and see a spear wound become infected without doing anything." She added that, although she didn't like it, "at the same time, when it's done, all the parties feel that justice has been done."²¹⁸ An investigation into Aboriginal customary law by the Northern Territory Law Reform Committee recommended that a government inquiry into the issue of "payback" be undertaken, in order to establish "the extent to which the traditional law punishment of payback is a fact of life in Aboriginal communities, and develop policy options for government to respond to the issue".²¹⁹

²¹⁵ Amnesty International. *Lethal injection: The medical technology of execution*. An update: September 1999, London: AI Index: ACT 50/008/1999..

²¹⁶ Fickling D. 'Australians wonder if traditional Aboriginal customs can be allied to European notions of human rights and due process: Bridging whitefella law and clan justice.' *Guardian*, 30 December 2002.

²¹⁷ *Northern Territory News*, 2 November 2002.

²¹⁸ Lowitja O'Donoghue, former chair of the Aboriginal and Torres Strait Islanders Commission (ATSIC), quoted by Fickling (see note 216 above).

²¹⁹ Northern Territory Law Reform Committee. *Towards Mutual Benefit: Report of the committee of inquiry into Aboriginal customary law*. Available at http://www.nt.gov.au/justice/docs/lawmake/ntlrc_final_report.pdf. Darwin, 2003.

AI is concerned to note that some traditional practices can restrict women's rights or are in conflict with the individual's right to life, health or physical integrity. Moreover, many communities operate parallel justice systems which often have particular negative impact on women and children, lack fair trial guarantees, and result in punishments that are cruel, inhuman, or degrading. However, human rights are universal and apply to everyone. Where traditional systems arbitrarily discriminate, or provide for cruel, inhuman or degrading punishments they need to be reformed, just as states' criminal justice systems need to be reformed if they give rise to these human rights violations.

4.4 Organ trafficking and illegal transplants

Nurses are integrally involved at several stages in cadaveric and living organ transplantation.²²⁰ These include: caring for donors and recipients; coordination of organ transport and allocation of organs; basic procedures to evaluate tissue compatibility; transplantation surgery; immediate post-operative care, in dialysis, work in critical care units, and in the provision of home health care.

While senior medical staff are responsible for obtaining consent for donation and subsequent medical procedures, in practice nurses may be asked to carry out some of the tasks. The procedures for this are well established and generally respected.²²¹ However, not all transplants are ethically based or compatible with human rights.²²² For example, in a number of countries people are tricked into "donating" a kidney or are persuaded to sell an organ, a procedure that is not compatible with WHO standards on organ transplantation.²²³

For example, in Pakistan, hundreds of brick-kiln workers enslaved by debt-bondage are reported to have each sold one of their kidneys to escape debts they have no other possibility of paying off. This is despite the 1992 Bonded Labour Abolition Act which banned bonded labour. A UN report told the story of a man who sold his kidney for 90,000 rupees (US\$ 1,500) to pay off debts to a kiln owner after nearly 10 years in bondage.²²⁴ After surgery the man could no longer work due to the effects of the operation.²²⁵

²²⁰Smith S. *Organ Transplantation: Concepts, Issues, Practice, and Outcomes*. Available at: http://www.medscape.com/viewpublication/704_about ; S.L. Smith (ed.), *Tissue and organ transplantation: Implications for professional nursing practice*. St. Louis: CV Mosby and Co., 1990.

²²¹ Martin RK. Organ transplantation: The role of the acute care nurse practitioner across the spectrum of health care. *AACN Clinical Issues* 1999; 10(2): 285-92.

²²² Rothman DJ, Rose E, Awaya T, Cohen B, et al. The Bellagio Task Force Report on transplantation, bodily integrity, and the international traffic in organs. *Transplantation Proceedings* 1997; 29:2739-45. Available at: <http://www.icrc.org/Web/Eng/siteeng0.nsf/iwpList302/87DC95FCA3C3D63EC1256B66005B3F6C>.

²²³ WHO. *Guiding Principles on Human Organ Transplantation*, Geneva, 1991. Available at: http://www.who.int/ethics/topics/transplantation_guiding_principles/en/index1.html . Accessed 12 October 2005. The Principles are widely seen as needing updating. See Nullis-Kapp C. Organ trafficking and transplantation pose new challenges. *Bulletin of the World Health Organization* 2004; 82: 715.

²²⁴IRIN News. UN Office for the Coordination of Humanitarian Affairs 'Pakistan: Focus on kidney sales by bonded labourers'. Available at: <http://www.irinnews.org/print.asp?ReportID=46508>.

²²⁵ *Ibid*. It is not uncommon for those who sell their organs to remain in poverty but with the added problem of possibly prejudiced health. See Goyal M, Mehta RL, Schneiderman LJ, Sehgal AR. Economic and health consequences of selling a kidney in India. *JAMA* 2002; 288:1589-93.

Across the central Punjab province and on agricultural estates in the southern province of Sindh, the selling of organs is reported to be still common. In the small town of Kot Momin, near Sargodha in the Punjab, 4,000 people are estimated to have sold kidneys. The problem is growing, and some private clinics employ middlemen to find donors. Each kidney, bought from donors on average for between US\$1,000 and US\$2,000, depending on the age and health of the donor, is sold to wealthy recipients for up to 10 times that amount.²²⁶

The Israeli newspaper *Ha'aretz* reported in 2003 that, according to the Ministry of Health and hospital records, about half of all Israelis who had kidney transplants in recent years obtained the organ in illegal trade from donors in Israel, Turkey, South America and eastern Europe.²²⁷

Countries such as Brazil, India and Moldova, formerly well-known sources of donors, have banned the buying and selling of organs. However, the WHO has expressed fears that this may simply drive the practice underground.²²⁸

4.4.1 Use of organs from executed prisoners

In a very small number of countries, there have been persistent reports of prisoners under sentence of death being identified as a source of organs, above all kidneys, for transplantation on a commercial basis. It is believed that issues of informed consent are not treated seriously and the possibility of such consent in the context of imprisonment under sentence of death has to be doubted. It is the policy of the International Transplant Society that the use of condemned prisoners as a source of organs is unethical²²⁹ for reasons that have been elaborated in the professional literature.²³⁰ There is also evidence that survival rates from foreign commercial transplant schemes, including prisoner “donor” transplants, may be lower than from local volunteer transplant procedures.²³¹

The country frequently cited as using executed prisoners to provide organs for transplant – the People’s Republic of China – denied for years that such a practice existed despite compelling evidence.²³² In November 2005, China’s Vice Health Minister, Huang Jiefu, finally acknowledged that organs extracted from executed prisoners were being commercially traded. He announced that new regulations were being drafted on organ transplants in an attempt to regulate the market, emphasising the principle of voluntary donation. These were

²²⁶ See note 224 above.

²²⁷ *Ha'aretz*, 5 December 2003.

²²⁸ WHO. Organ trafficking and transplantation pose new challenges. *In Focus*, 1 September 2004. Available at: <http://www.who.int/bulletin/volumes/82/9/feature0904/en/print.html> Accessed: 28th June 2005.

²²⁹ The Transplantation Society requires prospective members to sign the Society’s ethics statement which states that members “must not be involved in obtaining or transplanting organs from executed prisoners”. Available at: <http://www.transplantation-soc.org/>.

²³⁰ Guttman RD. On the use of organs from executed prisoners. *Transplantation Reviews* 1992;6(3):189-93.

²³¹ Kennedy S *et al.* Outcome of overseas commercial kidney transplantation: an Australian perspective. *Medical Journal of Australia* 2005; 182:224-7.

²³² Diflo T. Testimony of Thomas Diflo, M.D. Director of Renal Transplantation, New York University Medical Center before the Committee on International Relations of the United States House of Representatives, 27 June 2001. Available at: <http://www.laogai.org/news/newsdetail.php?id=1928>.

issued by the Ministry of Health in March 2006, but were immediately criticized by a leading Chinese transplant surgeon, Dr Chen Zhonghua, who said they failed to address the unregulated trade in organs.²³³ The British Transplant Society issued a press release on 19 April 2006 criticizing “the unethical procurement of transplant organs from prisoners executed in the Peoples Republic of China”.²³⁴

Amnesty International considers that in view of the coercive nature of the death penalty there will be few (if any) circumstances in which a prisoner can give free and informed consent to having organs removed and that staff involved in such procedures, including nurses, are almost certainly acting in breach of ethical principles. AI has argued, in addition, that use of prisoners as a source of organs in a lucrative organ trade risks distorting the timing of executions; one AI report cited testimony that police and medical institutions co-ordinated their activities, timing executions to coincide with a patient’s pre-operative procedures.²³⁵

²³³ *South China Morning Post*, 28 March 2006. The article reports that “99 per cent of the organs come from executed prisoners”.

²³⁴ British Transplantation Society, press release, 19 April 2006. Available at: <http://www.bts.org.uk/Forms/press%20release%20BTS.doc>. Accessed 12 May 2006.

²³⁵ Amnesty International. *People’s Republic of China. Executed “according to law”? - The death penalty in China*. AI Index: ASA 17/003/2004, p.52. Available at: <http://web.amnesty.org/library/index/engasa170032004>

5. Nurses, midwives and the right to health

5.1 What is the “right to health”?

The right to health is a shorthand expression for the right specified in a number of international treaties including the International Covenant on Economic, Social and Cultural Rights to which more than 150 countries are party. Article 12 of this Covenant states at paragraph 1 that “States Parties ... recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.²³⁶ The Covenant gives some pointers to how this simple statement should be understood. However in 2000 the Committee on Economic, Social and Cultural Rights (CESCR), which monitors the implementation of the Covenant, set out in a “General Comment” a detailed and authoritative statement of interpretation of Article 12.²³⁷ According to this interpretation, the right to health “is not to be understood as a right to be *healthy*” but rather as a framework of freedoms and entitlements.

The freedoms include the right to control one’s health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.²³⁸

What is health?

According to the World Health Organization, health is a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.²³⁹

In sum, “the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health”.²⁴⁰

Moreover, the right to health should be understood as extending beyond health care to “the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and

²³⁶ Available at: http://www.unhchr.ch/html/menu3/b/a_ceschr.htm. Accessed 27 February 2006.

²³⁷ The Committee is composed of 18 independent experts appointed as individuals rather than national representatives. Their interpretative comment – General Comment 14 – on the right to health represents an authoritative statement of what the right to health encompasses. See General Comment 14 of the Committee on Economic, Social and Cultural Rights, E/C.12/2000/4, 11 August 2000. Available at: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En).

²³⁸ CESCR. General Comment 14, para. 8. See note 237 above.

²³⁹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

²⁴⁰ *Ibid.* para 9.

environmental conditions, and access to health-related education and information, including on sexual and reproductive health".²⁴¹

The Committee has developed a set of criteria for assessing whether health facilities and services are compatible with human rights principles. The right to health thus contains the following "interrelated and essential" elements:

Availability. Public health and health-care provision and programmes, have to be available in sufficient quantity, dependent on numerous factors, including the country's developmental level; they will include the underlying determinants of health noted above but also hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.²⁴²

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination based on:

- policy of non-discrimination in law and in practice
- physical accessibility (including for marginalized peoples including people with disabilities)
- economic accessibility (affordability) whether privately or publicly provided
- accessibility of information, including the right to seek, receive and impart information, consistent with confidentiality of personal data.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.

Quality. Health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

State obligations to realize all human rights, including the right to health, are of three types:

- to respect: not to interfere with the exercise of a right
- to protect: to ensure others do not interfere, primarily through effective regulation and remedies, and
- to fulfil: including to promote rights, facilitate access to rights, and provide for those unable to provide for themselves

The obligation to *respect* human rights requires states to refrain from interfering directly or indirectly with people's enjoyment of human rights. This is an immediate obligation.

²⁴¹ CESCR. General Comment 14, para 11. See note 237 above.

²⁴² *Ibid.* para. 12(a)

To *protect* human rights, states must prevent, investigate, punish and ensure redress for the harm caused by abuses of human rights by third parties – private individuals, commercial enterprises or other non-state actors. This is an immediate obligation.

States have an obligation to *fulfil* human rights by taking legislative, administrative, budgetary, judicial and other steps towards the full realization of human rights. As many aspects are resource-dependent, international standards recognize that this obligation may be realized progressively. Governments must give immediate priority to meeting the minimum essential levels of each right, especially for the most vulnerable.

Increasingly included in the evaluation of health rights is the extent of participation in policy formulation and care delivery. General Comment 14 of the CESCR on the right to health notes that a “further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services ... and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels”. The Comment further states that: “The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people’s participation”.²⁴³ Article 11 of the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities specifies at rule 19 that “in the training of professionals in the disability field, as well as in the provision of information on disability in general training programmes, the principle of full participation and equality should be appropriately reflected”.²⁴⁴ One of the earliest principles elaborated in the evolving human rights discussion of HIV/AIDS was that commending a greater involvement of people living with HIV/AIDS in all aspects of work against HIV/AIDS.²⁴⁵

The Committee on Economic, Social and Cultural Rights commented that “any deliberately retrogressive measures ... would require the most careful consideration and would need to be fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources”.²⁴⁶

The right to health has been enshrined in international and regional treaties, and at least 60 national constitutions.²⁴⁷ For example, the Constitution of South Africa states that “Everyone has the right to have access to...health care services, including reproductive health care” and “no one may be refused emergency medical treatment”.²⁴⁸ The Indian Constitution²⁴⁹

²⁴³ CESCR. General Comment 14, paras. 17 and 54. See note 237 above.

²⁴⁴ UN *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*. Available at: <http://www.un.org/esa/socdev/enable/dissre02.htm>.

²⁴⁵ In 1994, during the Paris AIDS Summit, 42 governments collectively recognized the need for the greater involvement of people living with HIV/AIDS in response to the AIDS pandemic. This recognition was subsequently known as the GIPA Principle [for “greater involvement of people living with HIV/AIDS”]

²⁴⁶ CESCR. General Comment 3, para 9.

²⁴⁷ Hunt P, Nowak M et.al. *Human rights and poverty reduction: a conceptual framework*. Geneva: Office of the United Nations High Commissioner for Human Rights, 2002.

²⁴⁸ Constitution of the Republic of South Africa, Chapter 2, section 27. Available at <http://www.polity.org.za/html/govdocs/constitution/saconst.html>.

²⁴⁹ Constitution of India. See Part III at: <http://www.constitution.org/cons/india/const.html>.

guarantees the “protection of life and personal liberty” (Article 21) and this “right to life” provision has been interpreted by the Supreme Court of India as including the “right to good health”.²⁵⁰ Every country in the world is now party to at least one international treaty that guarantees either the right to health or to conditions necessary for protection of health.²⁵¹ Some of those conventions relating to health and human rights and embodied in international law are listed in the box.

International standards

A number of international and regional treaties include provisions which bear on rights to health and related human rights. The standards cited below are quoted in more detail in the Appendix:

Universal Declaration of Human Rights

“Everyone has the right to a standard of living adequate for ... health and well-being” (Article 25).

International Covenant on Economic, Social and Cultural Rights

“The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Article 12).

Convention on the Elimination of All Forms of Discrimination against Women

“States Parties shall take all appropriate measures to eliminate discrimination against women...in particular to ensure...access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning” (Article 10).

Convention on the Rights of the Child

“States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services” (Article 24).

Convention on the Elimination of All Forms of Racial Discrimination

“States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law... [and to] the right to public health, medical care, social security and social services” (Article 5).

World Health Organization Constitution

“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, economic or social condition” (Preamble to Constitution).

Additional international and regional standards can be found in the Appendices.

²⁵⁰ *M.C.Mehta v. Union of India* (1999) 6 SCC 9, para 1.

²⁵¹ World Health Organization. *Health and Human Rights*. See: <http://www.who.int/hhr/en/>.

5.2 Non-discrimination, equality and the right to health

*Whatever form...discrimination takes, at its heart is a failure to respect the inherent rights and dignity of the person or group in question.*²⁵²

The right to health must be based on a platform of non-discrimination. The CESCR has clarified that discrimination is prohibited on “grounds of race, colour, sex, language, religion, political or other opinion, nation or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health”.²⁵³ It is this prohibition that underpins all other human rights. The principle of non-discrimination is also linked to that of equality, the right to enjoy human rights on an equal basis. These principles supplement the ethical standards which require health professionals to provide care without discrimination and with the well-being of the individual foremost.

Discrimination frequently prevents individuals and groups in great need from accessing or obtaining necessary care. But it has much wider ramifications for those discriminated against, including preventing or impeding their participation in development of health policy, their access to information and their sharing of the benefits of scientific developments.²⁵⁴ Recognizing the serious adverse effects of discrimination on women, including with respect to their health, the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in 1979.²⁵⁵ Articles 10, 12 and 14 of the Convention relate specifically to health, and the elimination of discrimination and promotion of equality for women in health care and education.²⁵⁶ Racial discrimination has also been cited as a barrier to access to care for many sectors of the population²⁵⁷ and rural women have been identified as facing particular problems in accessing health care, notably midwifery services.

State parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right to have access to adequate health care facilities, including information, counselling and services in family planning.

CEDAW Article 14 2b

²⁵² Khan I. Secretary General, Amnesty International. Speech to the XV International Congress on HIV/AIDS, Bangkok, July 2004.

²⁵³ CESCR. General comment 14, para. 18. See above note 237.

²⁵⁴ Article 15 of the ICESCR specifies the right of the individual to enjoy the benefits of scientific progress and its applications.

²⁵⁵ United Nations. *Convention on the elimination of all forms of discrimination against women*. Adopted by General Assembly resolution 34/180 of 18 December 1979 (entered into force, 3 September 1981). Available at: <http://www.ohchr.org/english/law/pdf/cedaw.pdf>

²⁵⁶ See Appendix for text.

²⁵⁷ Smedley BD, Stith AY, Nelson AR (eds). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, D.C.: National Academies Press, 2003.

Nurses should be aware of how their work environment, the health system within which they operate, and their own views can be instrumental in discrimination against patients. One report²⁵⁸ makes reference to the way some primary health care nurses in South Africa perceive gender-based violence as a “cultural norm”, as nurses are heavily influenced by their social environment and experience the same levels of violence as the patients they treat. In Turkey, researchers found that more than 80% of the nurses and midwives they surveyed said that they had been present during a hymen examination carried out to determine the subject’s virginity; just over half the participants indicated that virginity was important and more than half disapproved of premarital sexual relations.²⁵⁹ In some countries nurses deny unmarried adolescents information about or supplies of contraceptives, although married adolescents would receive them without question.²⁶⁰ The CEDAW Committee has emphasised that “Gender-based violence is a form of discrimination that seriously inhibits women’s ability to enjoy rights and freedoms on a basis of equality with men.”²⁶¹

5.3 Nursing personnel and the right to the highest attainable standard of health

Nurses are key actors in respecting, protecting and fulfilling the right to health as they provide a link between the health care system and the patient. In carrying out their work, nurses should be able to provide health care and treatment that is physically and economically accessible, non-discriminatory, culturally appropriate and of a high quality.²⁶²

Rachel is a Ugandan mid-wife who came to Yei hospital in south Sudan to assist people returning to the area following the negotiated end to the long-running civil conflict in January 2005. “There is no gynaecologist, no surgeon, no medicine. Women give birth in their huts in villages and are transported to the hospital by carthorse in case of complications. But we have nothing here”. December 2005. © UNHCR.

²⁵⁸ Kim J, Motsei M. “Women enjoy punishment”: attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science and Medicine* 2002; 54:1243-54.

²⁵⁹ Gürsoy E, Vural G. Nurses’ and midwives’ views on approaches to hymen examination. *Nursing Ethics* 2003; 10: 485-96.

²⁶⁰ Center for Reproductive Law and Policy. *State of denial: adolescent reproductive rights in Zimbabwe*. New York, 2002.

²⁶¹ CEDAW General Recommendation no. 19, para. 1.

²⁶² CESCR. General Comment 14. See note 237 above.

While it is an obligation on *governments* to ensure that these conditions prevail, obviously health professionals – including nurses and their associations – have commitments to ethical and effective care as well as human rights responsibilities.

The ICN has argued that nurses should advocate policies that give priority to the health needs of the poor and other “at risk” groups while supporting the development of models for local health systems that reach those most in need of health care.²⁶³ One increasingly discussed issue is how best to counter the adverse effects of staff migration on the health systems in some countries (see discussion below, p.71).

Even where such services are not publicly funded, governments have a responsibility to ensure the provision of health services which are accessible to all including, in particular, health care relating to the gender-specific health needs of women and disadvantaged groups.²⁶⁴

Millennium Development Goals (2000)²⁶⁵

In 2000, the international community agreed the Millennium Development Goals (MDGs) of which most relate directly or indirectly to health. The MDGs are linked to a number of measurable indicators, thus allowing progress in achieving the Goals to be monitored.

- Goal 1 Eradicate extreme poverty & hunger
- Goal 2 Achieve universal primary education
- Goal 3 Promote gender equality & empower women
- Goal 4 Reduce child mortality
- Goal 5 Improve maternal health
- Goal 6 Combat HIV/AIDS, malaria & other diseases
- Goal 7 Ensure environmental sustainability
- Goal 8 Develop a global partnership for development

5.3.1 Sexual and reproductive health rights

There is an increasing body of international human rights law and commentary which sets out in authoritative terms the requirements of states to protect women’s sexual and reproductive rights. For example, states are obliged under Article 12 CEDAW to “take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning”.²⁶⁶ CEDAW also specifies that women have the right to

²⁶³ ICN. *Policy background Paper on Nursing and Development*. Available at <http://www.icn.ch>.

²⁶⁴ Amnesty International has set out principles essential to defend human rights in the context of privatization, including that involving health care. See *Human Rights and Privatization*. London: POL 34/003/2005. Available at <http://web.amnesty.org/library/index/engpol340032005>; see also, International Council of Nurses. *Policy Statement on Publicly funded Accessible Health Care*. Geneva. Revised 2001. Available at: <http://www.icn.ch/psfunded.htm>. Accessed 24 May 2006.

²⁶⁵ UN Millennium Development Goals. Available at: <http://www.un.org/millenniumgoals/>. For a UN review of progress see: UN. *The Millennium Development Goals Report 2005*. New York, 2005. Available at: <http://unstats.un.org/unsd/mi/pdf/MDG%20Book.pdf>.

²⁶⁶ See appendix 2.

decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.²⁶⁷ The Convention on the Rights of the Child requires states parties to “take appropriate measures to ensure appropriate pre-natal and post-natal health care for mothers”.²⁶⁸ According to the *Millennium Development Goals Report 2005*, “200 million women have an unmet need for safe and effective contraceptive services”.²⁶⁹ The report cites the changes in Bangladesh and Egypt where maternal mortality was reduced significantly by increasing women’s access to skilled birth attendants and better obstetric services. However the situation in sub-Saharan Africa has not changed significantly since 1990.²⁷⁰

Nurses and the Millennium Development Goals

Nursing and midwifery services contribute to the achievement of these [MDG health-related] goals in ways such as the following:

- monitoring poverty, by documenting the prevalence of underweight children, child and maternal mortality;
- promoting gender equality, by educating girls and women about health issues;
- reducing child and maternal mortality, by delivering maternal and child health services and providing access to safe, effective contraception;
- combating HIV/AIDS, malaria and other diseases, by lowering their prevalence through activities directed towards prevention and treatment and reducing stigma and discrimination;
- monitoring pollution in the environment that affects health, for example access to potable water²⁷¹

5.3.2 Privatization

The functioning of a private sector in health care does not relieve the state of its obligations to respect, protect and fulfil the right to health. The Committee on Economic, Social and Cultural Rights has noted that payment for health-care services “has to be based on the principle of equity, ensuring that these services, *whether privately or publicly provided*, are affordable for all, including socially disadvantaged groups.”²⁷² The Committee also “stress[ed] the need to ensure that not only the public health sector but also private providers of health services and facilities comply with the principle of non-discrimination in relation to persons with disabilities”.²⁷³ The Committee on the Rights of the Child (CRC) has affirmed the duty of the state to assure the right to health where the non-state sector plays a role in

²⁶⁷ Article 16.1e.

²⁶⁸ CRC, article 24.2b.

²⁶⁹ *Millennium Development Goals Report 2005*, New York: UN, p.22. Available at: <http://unstats.un.org/unsd/mi/pdf/MDG%20Book.pdf>.

²⁷⁰ *Ibid.* p.23.

²⁷¹ WHO. *Strategic directions for strengthening nursing and midwifery services*. See note 51 above.

²⁷² CESCR. General Comment 14, para. 12(b). (emphasis added; see note 237 above).

²⁷³ *Ibid.* para 26.

health care delivery. In General Comment 5, the CRC “emphasize[d] that States parties to the Convention have a legal obligation to respect and ensure that the rights of children as stipulated in the Convention, which includes the obligation to ensure that non-State service providers operate in accordance with its provisions, thus creating indirect obligations on such actors”.²⁷⁴

5.4 Barriers to effective care

Health care should be affordable, accessible, acceptable and of good quality.²⁷⁵ Many governments are failing to provide health care which meets these criteria.

A number of different factors can get in the way of nurses’ commitment to the provision of effective health care.

Economic factors: The quality of nursing care reflects issues such as staffing levels, availability and maintenance of equipment, and of accommodation for patients and staff. Where funding is not made available at the level necessary for effective care patients will receive inferior attention and nurses are likely to receive inadequate salaries and conditions. The Committee on Economic, Social and Cultural Rights (CESCR) has stated that “insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized” is a violation of the obligation to fulfil right to health.²⁷⁶

Lack of training: Nurses and midwives will provide care that reflects their training. Where training has been under-funded or has failed to meet appropriate standards, nurses (and patients) will be disadvantaged. The CESCR similarly emphasises that a part of the duty to fulfil the obligation to give sufficient recognition to the right to health, states have to ensure the sufficient training of health personnel.²⁷⁷

Lack of personnel: Shortage of trained nurses can result from inadequate intake of trainee nurses, from uneven distribution of nurses within a country, from resignations of nurses to take up other employment (or to retire) or can reflect the emigration of nurses to other countries where they seek better prospects. Availability of trained medical personnel is an important element of the realization of right to health.²⁷⁸

Nurse burnout: Burnout is frequently referred to in literature relating to nurses, mental health and human rights. Burnout has been defined as “a sense of failure and of being worn out or exhausted through excessive demands on one’s energy, strength or resources”,²⁷⁹ and is characterized by a sense of alienation from one’s job, low job satisfaction, and a deterioration in job performance. Burnout is normally associated with characteristics of the job, role

²⁷⁴ General Comment 5 of the Committee on the Rights of the Child, CRC/GC/2003/5, 27 November 2003, para.43. Available at: [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.5.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.5.En).

²⁷⁵ CESCR. General Comment 14. *The right to the highest attainable standard of health*. See note 237 above.

²⁷⁶ *Ibid.*, para. 52.

²⁷⁷ *Ibid.*, para. 36.

²⁷⁸ *Ibid.* para. 12(a)

²⁷⁹ Daley MR. Preventing worker burnout in child welfare. *Child Welfare* 1979; 5: 443-450.

conflict, working conditions, work relationships, emotional exhaustion and depersonalization.²⁸⁰ Poor working conditions, gender inequity, long hours and low wages are among the many reasons behind burnout of nurses and midwives.²⁸¹ In some cases, violence or the witnessing of violence can lead to serious consequences for the nurse and lead him or her to leave the profession.²⁸² Burnout is recognized by professional bodies and employers as a barrier to the provision of effective nursing services and of the professional development of the individual nurse.²⁸³

Japan: nurses and burnout in mental health settings

A study of mental health nurse burnout in Japan, undertaken in 2004, found that prevalence of burnout is significantly higher in community psychiatric nurses than among public health nurses in other settings. The study found work environment factors contributing to burnout to be overwork in emergency services and lack of job control.²⁸⁴

5.4.1 Nurses with disabilities

In recent years there has been a progressive, though very modest, attempt to encourage and train nurses with disabilities to bring their skills, insights and experience to nursing.²⁸⁵ Above all, such initiatives enrich the provision of nursing care to those with disabilities. By contrast, the discouragement or denial of nurse training on the grounds of disability represents a barrier to the delivery of effective care as well as denying potentially effective nurses an opportunity to contribute to this area of health care.²⁸⁶

5.4.2 Nurses and research

Increasingly nurses are becoming involved in the design and/or conduct of medical research. The principles governing research involving patients are based on fundamental precepts of professional ethics and the human rights of subjects and patients. Foremost among

²⁸⁰ Fry ST, Harvey RM, Hurley AC, Foley BJ. Development of a model of moral distress in military nursing. *Nursing Ethics* 2002; 9: 373-87.

²⁸¹ World Health Organization.: *Strategic Directions for Strengthening Nursing and Midwifery Services*. See note 51 above.

²⁸² Schwarz T. PTSD in nurses: on-the-job trauma may be driving nurses from the profession [editorial]. *American Journal of Nursing* 2005; 105(3): 13.

²⁸³ ICN press release. Stigma, Discrimination and the Conspiracy of Silence are Fuelling the AIDS Epidemic, 13 May 2003, noting that a "non-supportive and stressful work environment causes staff burnout and exhaustion".

²⁸⁴ Imai H, Nakao H, Tsuchiya M, Kuroda Y, Katoh T. Burnout and work environments of public health nurses involved in mental health care. *Occupational and Environmental Medicine* Sep 2004, 61; 9: 764-768.

²⁸⁵ Pischke-Winn KA, Andreoli KG, Halstead LK (eds). *Students with Disabilities: Nursing Education and Practice. Proceedings Manual*. Based on a conference held April 10-11, 2003 in Chicago, Illinois, sponsored by Rush University College of Nursing and Rush University Medical Center. Contents and preface of report available at: <http://www.rushu.rush.edu/nursing/disable/opening.pdf>.

²⁸⁶ The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted in 1993, is the current (though non-binding) international standard on increasing opportunities for people living with disability. At time of writing a binding international convention on disability is under discussion. See documentation at the UN *Enable* web-site: <http://www.un.org/esa/socdev/enable/index.html>. Accessed 19 October 2005.

these are: respect for the individual and his or her autonomy; obtaining informed and meaningful consent from participants; respecting and protecting the confidentiality of information received or found during the research; balancing risks to the subject and beneficial outcomes; and ensuring that methods and techniques used in research conform to accepted scientific standards.²⁸⁷ Much nursing research is based on qualitative methodology which carries its own particular risks.²⁸⁸ Nurse researchers should be accountable for the research they carry out and for the interpretation they give to findings.

5.5 Nurses and public health crises: HIV/AIDS

The United Nations and the World Health Organization estimated that in 2004, rates of people infected with the human immunodeficiency virus (HIV) rose to their highest levels ever, with an estimated 39.4 million people living with the virus across the world.²⁸⁹ Although one of the eight Millennium Development Goals²⁹⁰ is to halt and reverse the spread of HIV/AIDS, current indications are that the present response is not enough and certain areas of the world are likely to see a rapid increase in HIV rates unless dramatic action is taken.²⁹¹

HIV/AIDS is a growing health and human rights problem that has reached pandemic proportions. Lack of accurate information and stigma surrounding the disease are present across the world, partly due to a variety of taboos associated with sexual activity – and particularly involving sexual activity between men, sex involving adolescents and commercial and extra-marital sex – and intravenous drug use. Fear and discrimination resulting from lack of accurate information and stigma represent real barriers to prevention and care, and where available, treatment programmes. Inadequate knowledge of the disease and lack of power in relationships lead to insufficient access to HIV prevention services and an inability to negotiate safer sex.²⁹²

The human rights dimension of HIV/AIDS was recognized very early in the pandemic, with the WHO Global Programme on AIDS taking a lead on promoting the protection of the rights of people living with HIV/AIDS. The first international consultation on HIV and human rights took place in Geneva from 26 to 28 July 1989. A second consultation in Geneva in 1996 concluded that when human rights are protected, fewer people become infected and

²⁸⁷ For a discussion of some of the principles underlying research with human beings see: Council of International Organizations of the Medical Sciences (CIOMS). *International Guidelines for Biomedical Research Involving Human Subjects*. Geneva, 2002. Available at http://www.cioms.ch/frame_guidelines_nov_2002.htm.

²⁸⁸ Byrne M. The concept of informed consent in qualitative research. *AORN Journal* 2001; 74: 401-403. The author states that “although qualitative research does not usually involve the risk of physical harm, it carries a greater risk of social and psychological harm, particularly from breaches of privacy”.

²⁸⁹ UNAIDS/WHO. AIDS epidemic update December 2004. Geneva: UNAIDS. Available at: <http://www.unaids.org/bangkok2004/report.html>.

²⁹⁰ Goal 6 of the UN Millennium Development Goals. Available at: <http://www.un.org/millenniumgoals/>.

²⁹¹ UNAIDS/WHO. *AIDS Epidemic Update: December 2005*. Geneva: UNAIDS, 2005. Available at: http://www.unaids.org/epi/2005/doc/report_pdf.asp.

²⁹² See: UNAIDS. HIV related stigma, discrimination and human rights violations: Case studies of successful programmes. April 2005, Geneva: UNAIDS. Available at: http://data.unaids.org/UNA-docs/JC999-HRViolations_en.pdf. Accessed 24 May 2006.

those living with HIV/AIDS and their families can cope better.²⁹³ A third consultation addressed access to prevention, treatment, care and support.²⁹⁴

Human rights have been discussed and advocated in numerous inter-governmental venues including the General Assembly of the United Nations and the UN Security Council. These discussions have given rise to some important resolutions and statements including the Declaration of Commitment arising from the UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 which is due for review in 2006.²⁹⁵ UN and NGO publications have reflected a concern for human rights, and protecting basic rights is widely seen as an essential component of an effective global HIV response.²⁹⁶

Amnesty International believes that human rights violations fuel the HIV/AIDS pandemic, abuses result from the stigma associated with HIV/AIDS, and government responses to HIV can themselves violate human rights. Amnesty International regards respect for human rights as central to

successfully addressing the HIV pandemic and has outlined a program of action needed to strengthen a rights-based approach to tackling HIV/AIDS.²⁹⁷

Health professionals are not immune from prejudice²⁹⁸ and people seeking care for HIV-related problems are known to have experienced stigma and discrimination.²⁹⁹ The Pan

Libya. Health professionals on trial in Tripoli on charges of deliberately infecting children with HIV. (See box below) © AI

²⁹³ United Nations, Economic and Social Council. *Second International Consultation on HIV/AIDS and Human Rights (Geneva, 23-25 September 1996) Report of the Secretary-General E/CN.4/1997/37* 20 January 1997.

Available at: [http://www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/E.CN.4.1997.37.En?Opendocument](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/E.CN.4.1997.37.En?Opendocument).

²⁹⁴ UNAIDS. *Revised Guideline 6: Access to prevention, treatment, care and support*. Geneva, 2002. Available at: http://www.unaids.org/html/pub/Publications/IRC-pub02/JC905-Guideline6_en_pdf.pdf.

²⁹⁵ UNGASS. Declaration of Commitment on HIV/AIDS: "Global Crisis — Global Action". 27 June 2001. Available at: <http://www.un.org/ga/aids/coverage/FinalDeclarationHIV/AIDS.html>. Accessed 19 March 2006.

²⁹⁶ A range of UN documents on HIV is available at <http://www.ohchr.org/english/issues/hiv/document.htm>. See also Amnesty International. *Women, HIV/AIDS and human rights*. London ACT 77/084/2004; Human Rights Watch publications on HIV/AIDS and human rights are available at: http://hrw.org/doc/?t=hivaid_pub.

²⁹⁷ Amnesty International. Action on HIV/AIDS. ACT 75/002/2006, 11 May 2006. Available at: <http://web.amnesty.org/library/Index/ENGACT750022006>.

²⁹⁸ Surlis S, Hyde A. HIV-positive patients' experiences of stigma during hospitalisations. *Journal of the Association of Nurses in AIDS Care* 2001; 12:68-77; Pan American Health Organization. *Understanding and Responding to HIV/AIDS-related Stigma and Discrimination in the Health Sector*. Washington DC: PAHO, 2003. Available at: <http://www.paho.org/English/AD/FCH/AI/stigma.htm>. Accessed 24 May 2006.

American Health Organization (PAHO) noted in 2003 that “there has been a reduction in the extent of HIV/AIDS-related discrimination in some countries” but that some forms of stigma that preceded the epidemic – such as homophobia – remain strong.³⁰⁰

Libya: Bulgarian nurses accused of infecting patients with HIV are sentenced to death

Five Bulgarian nurses, and a Palestinian doctor, were sentenced to death by firing squad by a Libyan court in May 2004, convicted of deliberately infecting 426 children with HIV in the al-Fateh Children’s Hospital, Benghazi. A sixth Bulgarian defendant was sentenced to four years’ imprisonment and nine Libyan defendants were acquitted. Health professionals around the world protested at the convictions and sentences including the ICN which “*condemned in the strongest possible terms the imposition of the death sentence on the health personnel*”. The nurses and doctor had been held in custody since 1999. AIDS experts who testified at the trial, however, blamed the outbreak on poor hygiene and the re-use of syringes in hospital. Professor Luc Montagnier (the co-discoverer of HIV) presented a report to the court showing that the infection had started before the foreign nationals commenced working at the hospital, and spread after they ceased working there. The health professionals had initially “confessed” to the crime, but later retracted these statements, claiming they were extracted under torture. Eight members of the security forces and two others (a doctor and a translator) employed by them were tried for committing the alleged torture, and then acquitted on 7 June 2005. The health professionals appealed against the verdict against them and their case was heard by Libya’s Supreme Court on 25 December 2005. The court overturned the death sentences and ordered a retrial before a lower court. The retrial is scheduled for 13 June 2006.

There has been much speculation in the international media that the Libyan and Bulgarian governments, with assistance from the European Union and the USA, have been negotiating a political settlement of the health professionals’ case, outside the judicial process. Libyan officials had said that the government would commute the death sentences if Bulgaria paid compensation to the families of the children infected with HIV. The Bulgarian government publicly rejected the offer on the basis that accepting it would be tantamount to admitting the health professionals’ guilt. On 22 December 2005, shortly before the Supreme Court hearing, Bulgaria, Libya, the USA, the UK and the European Union agreed to establish a fund to support families in Benghazi affected by HIV/AIDS and assist in hospital modernization.

5.5.1 Protecting care through protecting rights

Nurses and midwives in professional practice treating patients with HIV/AIDS are faced with a number of challenges. All nurses can play a part in advocating for the rights of HIV/AIDS patients and combating discrimination that creates a barrier to care. The International Council of Nurses urges its national member associations to:

actively participate in sensitising and educating the public about HIV/AIDS; take measures to combat violence against women including rape, sexual abuse, child

²⁹⁹ Amnesty International. “*I am not ashamed*”. *HIV/AIDS in Guyana and the Dominican Republic*. May 2006. Available at: <http://www.amnesty.org>.

³⁰⁰ PAHO, p.7. (see note 298 above).

prostitution and trafficking; work to protect the basic human rights of people living with HIV/AIDS, their families, the public and nurses who care for those living with HIV/AIDS.³⁰¹

The Canadian Association of Nurses in AIDS Care has called for more specialist training for nurses to respond to the specific needs of HIV/AIDS patients. The Association pointed out that care for HIV/AIDS patients requires in-depth knowledge of disease prevention, health promotion, harm reduction and palliative care.³⁰²

According to UNAIDS, injecting drug use is one of the primary causes of the spread of HIV in Europe and Central Asia, where it is responsible for 80% of all HIV cases. In the Middle East, North America, South and East Asia and Latin America, HIV is prevalent in over 80% of certain populations of injecting drug users.³⁰³ Despite these figures, very little is being done to provide access to clean needles, access sterilizing materials or provide drop-off points for used needles (see example below), measures recommended by UNAIDS to combat the spread of the disease.³⁰⁴ A report from the Open Society Institute's Harm Reduction Development Program has concluded that attempts by Russia and the Ukraine to reduce drug use by increasing spending on law enforcement, at the expense of public health policies, were ineffective.³⁰⁵ This is particularly serious since "the current epidemic in Russia and Ukraine is unique in that the majority of infections continue to be linked to injecting drug use".³⁰⁶

Canada: Safe injection location started by nurse despite government opposition

A Canadian nurse started an illegal safe injection site in central Vancouver following numerous setbacks in the opening of an official site. For six months, Megan Oleson supervised injections, taught drug users safe practices and offered service referral to users. During the time she was operating the service, police arrested Megan and colleagues late one night as they walked home. According to eyewitnesses, two police officers sprayed Megan and another woman with pepper spray and beat them so severely that passers by

³⁰¹ ICN Position statement: Acquired Immunodeficiency Syndrome (AIDS) Available at: <http://www.icn.ch/psAIDS00.htm>. Accessed: 4 May 2005.

³⁰² Canadian Association of Nurses in AIDS Care. *Position statement: recognition of HIV/AIDS nursing as a specialty* Available at: <http://canac.org/english/PROGRAMS.htm>. Accessed: 3 June 2005.

³⁰³ UNAIDS. *Joint UNAIDS statement on HIV prevention and strategies for drug users*. Available at: <http://www.unaids.org>. Accessed: 12 August 2005.

³⁰⁴ *Ibid.*

³⁰⁵ Malinowska-Sempruch K, Hoover J, Alexandrova A. *Unintended consequences: Drug policies fuel the HIV epidemic in Russia and Ukraine*. New York: International Harm Reduction Development Program, Open Society Institute 2003. Available at: http://www.soros.org/initiatives/ihrd/articles_publications/publications/unintendedconsequences_20030414/unintended_consequences.pdf. Accessed: 12 August 2005.

³⁰⁶ *Ibid.* p.12.

called an ambulance.³⁰⁷ Some months later an official safe injection location opened in September 2003.³⁰⁸

In 2004 Megan Oleson received the Award for Action on HIV/AIDS and Human Rights presented by the Canadian HIV/AIDS Legal Network and the New York-based Human Rights Watch. A spokeswoman for the Vancouver Area Network of Drug Users said, “(Oleson) showed incredible courage...An RN can behave in a socially responsible manner even when they’re being persecuted”.

The Canadian HIV/AIDS Legal Network commented that Megan Oleson’s “success in mobilizing and empowering communities in the face of powerful opposition has served to protect and promote health and human rights and has resulted in increased awareness of the many issues affecting vulnerable and neglected communities in Vancouver and across Canada”.³⁰⁹

Prisoners across the world are at risk of infection and those prisoners infected with HIV suffer discrimination. A 2003 Human Rights Watch report on Kazakhstan³¹⁰ described how, until 2002, compulsory HIV testing for pre-trial prisoners had forced them to be segregated in special wards. The report also indicated that other prisoners are at risk of contracting the disease due to “overcrowded conditions, limited access to prevention services, unprotected sex and sexual abuse, and needle sharing in prison”.³¹¹ While segregated from the rest of the prison population, men were not given any treatment for their condition. Nurses interviewed in the report described the challenges in caring for HIV-positive prisoners and noted that prisoners were angry and aggressive. At times, tensions in the HIV wards mounted to such a degree that, in protest, prisoners smeared doorknobs with their blood, went on hunger strike and threatened to prick staff with syringes covered with their blood.³¹²

The particularities of HIV/AIDS require public health specialists to address issues which formerly remained on the fringes of the public health discourse and in many countries are not the material of daily media discussion – ensuring clean needles for drug users; protection of the health of women and men engaged in commercial sex; and promotion of safer sexual practices, particularly among adolescent girls. Some of this health promotion work may conflict with laws and practices in many countries.³¹³ There is a need for a wider appreciation that ensuring the most effective care for patients requires the protection of carers, educators and human rights defenders.

³⁰⁷ Canadian HIV/AIDS Legal Network. *Awards for Action on HIV/AIDS and Human Rights 2004 Canadian Recipient (category: individual): Megan Oleson*. Available at:

http://www.aidslaw.ca/Maincontent/awards/national_ind-recipient2004.htm Accessed: 2 June 2005.

³⁰⁸ Hainsworth J. Nurse wins award for rebel safe-injecting site: AIDS campaigner ‘acted when others dragged their feet’ on downtown drug woes. *Vancouver Sun*, 13 September 2004, p. B7.

³⁰⁹ Canadian HIV/AIDS Legal Network, see note 307 above.

³¹⁰ Human Rights Watch. *Fanning the flames: How human rights abuses are fueling the AIDS epidemic in Kazakhstan* June 2003:15(4)D. Available at: <http://hrw.org/reports/2003/kazak0603/kazak0603.pdf>. Accessed 12 August 2005.

³¹¹ *Ibid.* p.43.

³¹² *Ibid.*

³¹³ Restrictions placed by funders such as the US President’s Emergency Plan for AIDS Relief (PEPFAR) on access to funding for work with intravenous drug users and sex workers reflect this governmental discomfort.

Amnesty International reported that, in 2004, HIV educators in Jamaica and Honduras continued to work despite hostility and prejudice, resulting in increasing recognition and support from local and human rights activists.³¹⁴ In numerous countries the failure to support HIV/AIDS advocates is blocking the open discussion of HIV and the development of accessible and non-stigmatising services for people living with HIV/AIDS.

Containing HIV/AIDS requires effective international cooperation, including through funding. However, governments providing aid and funding should not set conditions that deny people access to life-saving information, commodities and services such as condoms and harm reduction measures.

5.5.2 Good practice in AIDS care

In southern Africa, AIDS has long reached crisis proportions and providing effective health care to HIV/AIDS patients remains a major challenge. The spread of the disease is swallowing already limited resources, compromising the ability of health workers to provide adequate care, and leaving frontline staff at elevated risk of contracting HIV themselves as practice based on universal precautions is threatened. Nevertheless, UNAIDS has drawn attention to several examples of individuals who are demonstrating high quality, innovative care.³¹⁵ (See box below.)

HIV/AIDS awareness project for nurses and midwives in Zambia

Olive Ng'andu trained as a nurse and midwife in the 1960s. She currently manages an HIV/AIDS project for nurses and midwives that was established in 2002 in response to growing concern around the epidemic within the profession. The project, located at the Zambian Nurses Association offices and jointly funded by the Norwegian Agency for Development Cooperation (NORAD) and the Norwegian Nurses Association, aims to give nurses and midwives essential information on HIV/AIDS, develop their skills in clinical management and prevention of the spread of HIV, challenge stigma by encouraging nurses to be tested for the infection, and gives support to nurses and midwives who have HIV and AIDS. Prior to the project being set up, a ZNA survey showed that knowledge of the virus among health workers was limited. The survey also revealed that there was a general feeling of being worn down by a chronic lack of resources. Part of the project's aim is to engage nurses in the process of education and training. Olive Ng'andu commented: "the challenges we face are so enormous, and Africa's resources are very few; if you wait to get what you need, you will wait forever. We feel it's best to sit down among ourselves and say, 'Friends, how can we best solve this problem?'"³¹⁶

³¹⁴ Amnesty International. *Amnesty International Annual Report 2005*. AI Index: POL 10/001/2005, 25 May 2005.

³¹⁵ UNAIDS. *Where there's a will there's a way: Nursing and midwifery champions in HIV/AIDS care in Southern Africa*. June 2003, UNAIDS/03.19E Geneva: UNAIDS. Available at: http://data.unaids.org/Publications/IRC-pub02/JC900-Midwives_Nursing_en.pdf. Accessed 24 May 2006..

³¹⁶ *Ibid.* pp.29-31.

Nurses and midwives can play a key role in promoting good infant feeding practices in the context of HIV/AIDS (as well as more widely within society). Breastfeeding has long been recommended as the best source of nourishment for the child. However, the transmissibility of HIV to the infant via breast milk has posed problems to those advising on safe feeding practices. WHO concluded that when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, all breastfeeding by HIV-infected mothers should be avoided.³¹⁷ Otherwise, exclusive breastfeeding during the first months of life followed by early, rapid cessation and substitution with alternatives is recommended. While HIV-positive mothers should be provided with counselling on infant feeding options, there should also be an effort to ensure positive perceptions of and attitudes towards breastfeeding within the general population. In addition, the unnecessary use of breast-milk substitutes by mothers who do not know their HIV status or who are HIV-negative should be avoided. Health workers can help to reduce rates of postnatal transmission of HIV and increase child survival by providing HIV-infected mothers with accurate information on infant feeding. However, some may not find the current recommendations coincide with their own values or practices, particularly where there are high levels of malnutrition in the community.³¹⁸ More work is needed to promote good practice and to support grass roots health workers and the mothers they work with.³¹⁹

5.5.3 Nurses and midwives with HIV/AIDS and those at risk of infection

As with the general population, incidents of health workers contracting HIV are on the increase. A South African study has estimated that about 20% of ancillary health staff between the ages of 18 and 35 had HIV, with 13% of doctors, nurses and other health professionals having the disease.³²⁰ Between 1997 and 2001 South Africa experienced a 6.7% fall in nurses registering with the South African Nursing Council. A South African study recommended that more students be trained to combat the consequent decline in nurses.³²¹

In an effort to protect the health and safety of health staff, the International Labour Organization, in conjunction with the World Health Organization, has drawn up guidelines to promote functional and healthy medical workforces.³²² Recommendations centre on prevention of transmission risks; social dialogue between key stakeholders; clear and prevalent information and education; and a focus on gender and the particular risks and

³¹⁷ WHO. *HIV and infant feeding: framework for priority action*. Geneva, 2003. Available at: <http://www.who.int/child-adolescent-health/>. Accessed 30 March 2006.

³¹⁸ Piwoz EG, Owens Ferguson Y, Bentley ME, Corneli A et al. Differences between international recommendations on breastfeeding in the presence of HIV and the attitudes and counselling messages of health workers in Lilongwe, Malawi. *International Breastfeeding Journal* 2006, 1:2. Available at: <http://www.internationalbreastfeedingjournal.com/content/1/1/2>. Accessed 30 March 2006.

³¹⁹ For the perspective of a US nurse working in Africa, see: Dohrn JE. Breastfeeding in the HIV epidemic: a midwife's dilemma in international work. *Online Journal of Health Ethics*, 2005; 1(1). Available at: <http://ethicsjournal.umc.edu/ojs/viewissue.php?id=2>

³²⁰ Shisana O, Hall EJ, Maluleke R, Chauveau J, Schwabe C. AIDS/HIV prevalence among South African health workers. *South African Medical Journal* 2004; 94: 846-850.

³²¹ Shisana O, et al. *Ibid.*

³²² ILO/WHO. Joint ILO/WHO guidelines on health services and HIV/AIDS. Geneva: ILO, 2005. Available at: <http://www.ilo.org/public/english/dialogue/sector/techmeet/tmehs05/guidelines.pdf>.

experiences of women working in a health care environment. Nurses should, according to the ICN, have access to information about the prevention of HIV/AIDS as well as supplies and protective equipment. Nurses should also have access to appropriate post-exposure follow-up care and monitoring, including immediate first aid and documentation.³²³ However, access to post-exposure prophylaxis for nurses is far from universal and reluctance on the part of health staff to report occupational exposure or take prophylactic medication has been noted.³²⁴

HIV-positive nurses and midwives have the right of access to confidential counselling and to necessary treatment in order to best protect their own health and the health of those they work for. Where necessary on medical grounds, their duties could be modified, so the risk to their patients or themselves is reduced. They should also be provided protection from discrimination such as job or housing loss.³²⁵

Balancing the risks to nursing staff and the treatment needs of patients will not always be simple in high prevalence countries. In Zambia, for example, the high prevalence of HIV and tuberculosis co-infection can lead to nurses (particularly those who are HIV-positive) being reluctant to treat patients with tuberculosis because of the real risk of infection. Efforts to reduce risks to nurses and patients include providing treatment on an outpatient basis, especially in urban areas of the country, reducing congestion at health centres, ensuring an uninterrupted provision of supervised chemotherapy, and the reduction of health workers' workload.³²⁶

5.6 Other actual and potential health crises

5.6.1 Tuberculosis (TB)

Tuberculosis (TB) is a continuing health concern across the globe. According to the World Health Organization's 2005 survey, there were 15.4 million cases of the disease in 2003, 8.8 million of which were new cases. Of those 8.8 million, 674,000 were also infected with HIV. An estimated 1.7 million people died from TB in 2003, including 229,000 people co-infected with HIV,³²⁷ and two million are thought to have died in 2002. In 2004 there were an estimated 8.9 million new cases; a further 1.7 million people died of the disease.³²⁸

³²³ International Council of Nurses. *Position statement: Impact of HIV/AIDS on Nursing/Midwifery Personnel*. Adopted 1995, revised 2000. Available at: <http://www.icn.ch/psHIV00.htm>. Accessed 24 May 2006.

³²⁴ Zelnick J, O'Donnell M. The impact of the HIV/AIDS epidemic on hospital nurses in KwaZulu Natal, South Africa: nurses' perspectives and implications for health policy. *J Public Health Policy* 2005;26(2):163-85.

³²⁵ *Ibid*; ICN. *Impact of HIV/AIDS on Nursing/Midwifery Personnel*. Position Statement, 2000. Available at: <http://www.icn.ch/psHIV00.htm>. Accessed 25 May 2006.

³²⁶ Chanda, D, Gosnell D. The impact of tuberculosis on Zambia and the Zambian nursing workforce. *Online Journal of Issues in Nursing* 2006 (31 January 2006), Vol. 1 No. 1, Manuscript 3. Available: www.nursingworld.org/ojin/topic29/tpc29_3.htm

³²⁷ World Health Organization. *Global Tuberculosis Control: surveillance, planning, financing*. WHO Report 2005. Geneva: World Health Organization (WHO/HTM/TB/2005.349), p.1. Available at: http://www.who.int/tb/publications/global_report/2005/en/. Accessed 5 October 2005.

³²⁸ Dye C. Global epidemiology of tuberculosis. *Lancet* 2006; 367:938-40.

The increasing HIV epidemic in eastern Europe and in China will also increase the number of people with TB resulting from HIV infection. TB is currently a major cause of death among people living with HIV/AIDS.³²⁹

Nurses working in primary care roles are often the first to identify and manage suspected communicable diseases. In some settings, TB programmes can be led by nurses who are in a

Nurses in the tuberculosis hospital in Nukus in the Karakalpakstan region of Uzbekistan which has the highest levels of tuberculosis in the former Soviet Union. © Panos 2000.

key position to advocate for TB control programmes.³³⁰ The ICN has issued guidelines for nurses pertaining to patient-centred care through the short course of directly observed treatment (DOTS) for TB.³³¹

The World Health Organization reported in 2005 that 182 countries employed DOTS strategies during 2003, and that as a result of such strategies, global TB prevalence fell globally by 5% between 2002 and 2003. The same report noted that in 2003, global TB

³²⁹ World Health Organization. TB/HIV: Research priorities in resource limited settings. Report of an expert consultation, 14-15 February 2005, Geneva, Switzerland, p.3. Available at: http://whqlibdoc.who.int/hq/2005/WHO_HTM_TB_2005.355.pdf. Accessed: 5 October 2005.

³³⁰ Marais F. Tuberculosis Control: A Nurse-Led Model with Case Management. London: Foundation for Nursing Studies, 2002.

³³¹ ICN. *TB Guidelines for Nurses in the Care and Control of Tuberculosis and Multi-drug Resistant Tuberculosis*. Available at: <http://www.icn.ch/tb/guidelines.htm>. Accessed: 20 April 2005.

prevalence was falling or stable in five out of six WHO regions, with the exception of the Africa region, where incidence had been rising more quickly in areas of HIV prevalence. The net result is that global figures of TB are currently rising at 1% on an annual basis.³³² On World TB Day 2006, an increase in levels of drug-resistant TB was announced, underlying the growing risk posed by the disease. TB in prisons remains a major concern.

5.6.2 Avian Influenza

In 2005, the avian influenza virus (bird flu) spread in epidemic proportions among poultry in China, Cambodia, Indonesia Thailand, and Viet Nam. In its severest form – highly pathogenic avian influenza (HPAI) – bird flu can be fatal on the first day of developing symptoms. It is this severe form of bird flu that was first reported to have infected domestic poultry, ducks, pigs, tigers and some humans in Asia during late 2004.³³³

The World Health Organization and medical researchers have predicted that if the avian flu virus mutates to become infectious through direct transmission between humans, it could cause a worldwide pandemic.³³⁴

In treating communicable diseases, nurses are also at risk of contracting diseases themselves. Two nurses in Hanoi, Viet Nam, were confirmed to have contracted the virus from a single patient who was thought to have infected other family members.³³⁵ According to the WHO, as of 3 April 2006, some 190 human cases have been reported across Cambodia, China, Indonesia, Thailand, Turkey, and Vietnam since the end of December 2003, resulting in a death rate of slightly over 50%.³³⁶ These have overwhelmingly been cases where the virus has been acquired directly from an infected bird.

Measures recommended by WHO to combat the spread of the disease include the formulation of an influenza pandemic plan to which nursing professionals and nursing association representatives can contribute.³³⁷ Such measures have implications for human

³³² World Health Organization. TB/HIV: Research priorities in resource limited settings Report of an expert consultation, 14-15 February 2005, Geneva, Switzerland. Available at: http://whqlibdoc.who.int/hq/2005/WHO_HTM_TB_2005.355.pdf. Accessed: 8 August 2005.

³³³ World Health Organization Regional Office for South East Asia and Regional Office for Western Pacific. *World Health Organization and ASEAN+3 Health Ministers Meeting on Avian Influenza* 25-26 November 2004. Available at: http://w3.whosea.org/LinkFiles/FAQ_Avian-Faq.pdf. Accessed: 12 August 2005.

³³⁴ World Health Organization. *Assessment of risk to human health associated with outbreaks of highly pathogenic H5N1 avian flu influenza in poultry*. 14 May 2004. Available at: http://www.who.int/csr/disease/avian_influenza/assessment2004_05_14/en/index.html. Accessed: 12 August 2005; Barclay WS, and M Zambon, Pandemic risks from bird flu. *British Medical Journal* 2004; 328:238-239 (31 January); Horimoto T, Kawaoka Y. Influenza: Lessons from past pandemics, warnings from current incidents. *Nature Reviews Microbiology* 2005; 3, 591-600.

³³⁵ Sheridan M. Pandemic fear as bird infects nurses. *Sunday Times*, 13 March 2005. Available at: <http://www.timesonline.co.uk/article/0,,2087-1522982,00.html>. Accessed: 12 August 2005.

³³⁶ World Health Organization. Cumulative Number of Confirmed Cases of Avian Influenza A/(H5N1) Reported to WHO. 3 April 2006. Available at: http://www.who.int/csr/disease/avian_influenza/country/en/index.html

³³⁷ World Health Organization, Department of Communicable Disease Surveillance and Response Global Influenza Programme. *WHO checklist for influenza pandemic preparedness planning*. Geneva: WHO. Available at: https://www.who.int/csr/resources/publications/influenza/en/CDS_CSR_GIP_2005_4.pdf. Accessed: 12 August 2005.

rights, both in terms of their adequacy in protecting the rights of the population to life and health, and also with regard to proportionality and respect for individual civil and political rights, such as rights of association and of movement.

5.6.3 Other acute infections

5.6.3.1 Severe Acute Respiratory Syndrome (SARS)

SARS was first reported in China in March 2003, reflecting possible infection in February 2003 or as early as November 2002.³³⁸ It created worldwide alarm and provoked the implementation of drastic control measures in many countries. Health workers were among the early population groups infected. In 2003, the International Council of Nurses commented that the outbreak of SARS could leave nurses anxious regarding their own infection, and ostracized by their communities and families for fear of becoming infected.³³⁹ In Taiwan during the same year, over 160 health workers resigned or refused to treat SARS patients in hospital, reflecting the high levels of anxiety in the community. In response, the government threatened to remove their practice licenses.³⁴⁰ In Canada, nurses in Toronto refused to work on specialist SARS wards, and called for a government inquiry into the handling of the epidemic.³⁴¹ The Chinese government introduced draconian measures to control SARS, including the threat of the death penalty, for those breaking public health laws.³⁴²

In response to the epidemic's effect on the health sector workplace, a Sectoral Working Paper published by the International Labour Office suggested a number of measures. These included: timely information dissemination, practical training of health professionals to prevent the spread of SARS, participatory risk assessment and control, special attention for older workers and immune compromised persons, attention to small facilities and rural sectors, psychological and social support to SARS patients, and involvement of all workers in occupational health and safety regulations. The paper recommended that long-term strategies

³³⁸ WHO later defined their surveillance period as starting on 1 November 2002 "to capture cases of atypical pneumonia in China now recognized as SARS" and regarded SARS as emerging "in Guangdong Province, in southern China in November 2002". See WHO Case Definitions of SARS:

<http://www.who.int/csr/sars/casedefinition/en/>. Accessed 9 June 2005; and WHO. Consensus document on the epidemiology of severe acute respiratory syndrome (SARS). Geneva: WHO, p.12, available at: <http://www.who.int/csr/sars/en/WHOconsensus.pdf>. Accessed 19 March 2006.

³³⁹ International Council of Nurses. The impact of Severe Acute Respiratory Syndrome (SARS) on health personnel. SEW News: N° 2, April – September 2003, Geneva. Health professionals accounted for an estimated 18% of SARS-related deaths during this period.

³⁴⁰ Central Intelligence Agency USA. *SARS Down But Still a Threat*. Intelligence Community Assessment August 2003 NIC ICA 2003-09. See: http://www.odci.gov/nic/special_sarsthreat.html. (Commenting that "Most healthcare workers in countries hit by SARS toiled long hours under dangerous conditions.")

³⁴¹ Sibald B. Right to refuse work becomes another SARS issue. *Canadian Medical Association Journal* 2003; http://www.cmaj.ca/news/20_06_03.shtml. Accessed: 8 August 2005; Central Intelligence Agency. *SARS Down But Still a Threat*. Intelligence Community Assessment, August 2003, NIC ICA 2003-09. http://www.odci.gov/nic/special_sarsthreat.html;

³⁴² Amnesty International. *China: Threat of death penalty for breaches of SARS regulations*. London: ASA 17/024/2003, May 2003; Chan K. SARS and implications for human rights. Carr Centre for Human Rights, 2005. Available at: [http://www.ksg.harvard.edu/cchrp/pdf/SARS.CaseStudy.\(Final\).pdf](http://www.ksg.harvard.edu/cchrp/pdf/SARS.CaseStudy.(Final).pdf)

in public health, including development of the workforce, would help in the future fight against SARS and other as yet unknown diseases.³⁴³

5.6.3.2 Other diseases

The occasional outbreak of the highly lethal Ebola virus (which causes death in 50-90% of clinically ill cases) or other haemorrhagic viruses poses acute risks to the population and to health care personnel responding to the needs of the sick. Ebola provokes high levels of fear in affected communities and poses a serious risk of infection to staff where they do not use correct infection control precautions and adequate barrier nursing procedures.³⁴⁴ This underlines the need to provide both detailed information and protective strategies to health workers as well as information to the community.

Pakistan. A nurse treats a child injured in the earthquake which struck the Kashmir region on 21 November 2005. © Paktribune.com

5.6.4 Nurses and natural disasters

The tsunami in south and southeast Asia of 26 December 2004³⁴⁵ and the hurricane that caused great damage to the city of New Orleans and the surrounding region of southern USA in August 2005³⁴⁶ both illustrated the devastating impact of natural disasters on communities and individual well-being. Situations such as these also served to highlight the interplay of human rights and government policy in the context of humanitarian crises including discrimination in the provision of emergency health care to victims of natural disasters. These situations impact on the role, capacity and responsibility of nurses who are called on to join

³⁴³ Wiskow C. *Sectoral Working Paper No.206: The impact of Severe Acute Respiratory Syndrome (SARS) on health personnel*. Geneva: International Labour Office. Available at: <http://www.ilo.org/public/english/dialogue/sector/papers/health/wp206.pdf>. Accessed: 12 May 2005.

³⁴⁴ WHO. Ebola haemorrhagic fever. Fact sheet no.103, May 2004. Available at: <http://www.who.int/mediacentre/factsheets/fs103/en/index.html>.

³⁴⁵ Fletcher LE, Stover E, Weinstein HM (eds.) *After the Tsunami: Human Rights of Vulnerable Populations*. Berkeley: Human Rights Center, University of California, Berkeley; Honolulu: East-West Center, October 2005; ActionAid International. *Tsunami Response: A Human Rights Assessment*. London: ActionAid International, January 2006.

³⁴⁶ A committee of the US House of Representatives reported on the US government response to Hurricane Katrina on 15 February 2006. The report (*A Failure of Initiative: Final Report of the Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina*. Washington DC: US House of Representatives, 15 February 2006) is available at: <http://www.gpoaccess.gov/katrinareport/mainreport.pdf> (with the appendices available at: <http://www.gpoaccess.gov/katrinareport/appendices.pdf>). Accessed 17 February 2006.

the response to disaster. Nurses working on the ground are able to provide care but also to provide information to central disaster management teams. Health care and other emergency relief should be based on human rights principles: it should be available, adequate, acceptable and of good quality. It should be provided in a non-discriminatory way.³⁴⁷

5.7 Migration and asylum

5.7.1 Nurses, refugees and asylum seekers

Asylum seekers and refugees are not a homogeneous group and have a myriad of health needs, resulting from differing backgrounds and life experiences as well as the experience of the individual prior to and during flight.³⁴⁸ In addition, the health needs of individual asylum seekers and refugees will differ according to their gender and age. Social status, ethnic or other origin might create other factors that impact on people's health needs. However, there are certain issues that health practitioners find common to many asylum seekers and refugees who may have experienced the mental and physical consequences of torture, such as chronic physical pain, post-traumatic stress disorder and depression. Exposure to other traumas such as loss of, or separation from, family, witnessing violence, or taking part in military action, can also have detrimental health effects. Furthermore, many women and girls have experienced gender-based violence, including rape, especially in armed conflict.

It is important to note, however, that not all signs of psychological distress signify mental illness. A number of commentators have emphasized that reactions to the distress of exile frequently represent a normal reaction to a stressful experience and that care should be taken not to label asylum seekers with diagnoses which could further stigmatize them.³⁴⁹ Nevertheless, if untreated in the country of asylum, individuals' mental and physical health can worsen, and can be exacerbated by the situation in which asylum seekers may find themselves. Stressors include a lack of access to an adequate standard of living including poor housing, ongoing uncertainty regarding asylum status, lack of knowledge of the whereabouts of family and friends, and social isolation, or even lack of access to health care.³⁵⁰

In many refugee camps in Africa, interruptions in the food provision of the World Food Programme or others have meant that many thousands of refugees are facing severe

³⁴⁷ See also *Code of Conduct of the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief*. Available at: <http://www.ifrc.org/publicat/conduct/code.asp>.

³⁴⁸ Burnett, A., Peel, M. Asylum seekers and refugees in Britain: health needs of asylum seekers and refugees. *British Medical Journal* 2001; 322:544-7; Pumariaga AJ, Rothe E, Pumariaga JB. Mental health of immigrants and refugees. *Community Mental Health Journal* 2005;41(5):581-97; Drennan VM, Joseph J. Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing* 2005;49(2):155-63; Silove D. The challenges facing mental health programs for post-conflict and refugee communities. *Prehospital Disaster Medicine* 2004;19(1):90-6.

³⁴⁹ Burnett A, Peel M. Asylum seekers and refugees in Britain: health needs of asylum seekers and refugees. *British Medical Journal* 2001;322:544-7; Burnett A, Peel M. Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence. *BMJ* 2001;322:606-9.

³⁵⁰ International law, including the ICESCR, recognises the right to health of everyone, not only of nationals or citizens under the jurisdiction of the state. Under the European Convention on Human Rights, the right to health includes the right to provision of emergency or urgently-need treatment.

malnutrition.³⁵¹ Along the Thai/Myanmar border, Burmese migrant workers and asylum-seekers/refugees living outside refugee camps often have poor access to health care in Thailand. Although those migrants who have registered for an official work permit in principle are eligible to receive primary health care at public health clinics for 30 baht (less than one US dollar), they often choose to pay for private medical care instead, citing discrimination by Thai health workers. Burmese living in refugee camps near the Thai-Myanmar border generally have very good health care, as a result of the presence of several international aid agencies there. In some areas of the border, small clinics have been set up by both international and Burmese NGOs to serve this at-risk population. Burmese in Thailand are also more likely to have communicable diseases such as malaria and tuberculosis, partly because of the lack of medical care across the border.³⁵²

As frontline health care professionals, nurses frequently find themselves treating recently arrived asylum seekers and refugees. Due to language differences and differing cultural norms, nurses may feel themselves unable to offer adequate care. Governments should make provisions available for transcultural health care, such as translated health information targeted to the particular needs of asylum seekers, and on-site interpreters. In some countries, asylum seekers can either move of their own accord or be moved by the authorities between accommodation sites; therefore, innovations such as hand-held medical records which patients can carry with them can also assist nurses and other carers.

Australia: Nurse unable to carry out duty of care to asylum seekers in detention

In a submission to the Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention, Wayne Lynch, who worked as a registered nurse, and subsequently as a counsellor at Woomera detention centre, commented that he was unable to provide appropriate care to detainees as he was provided with no office space, no interpreter and carried a heavy workload (as the only counsellor for staff and up to 1000 detainees). Nor were his recommendations heeded by staff. He made the following statements:

“A 10-year-old boy was physically abused on two occasions by guards. After no action was taken against the guards by management, I recommended that it was a case of child abuse and should be reported to Family and Youth Services. I was advised by management that if I did this, I would find myself in a lot of trouble.

“A 26-year-old detainee was continuously self-harming (slashing, swallowing glass). He had been handcuffed to a bed in a room and required exceptional amounts of IV/IM sedation. Management wanted this to be administered in the compound under nursing observation and would not agree to his release to hospital. Eventually the medical officer agreed with me and we were able to force relocation to hospital for appropriate treatment.

“A 60 year old woman with neurological deficits was not transferred to hospital upon advice of medical and nursing staff. Management believed that it was psychosomatic.

³⁵¹ See, for instance, “Starvation looms over refugees in Zambia as lack of funds forces aid cuts – UN” at <http://www.un.org/apps/news/story.asp?NewsID=17110&Cr=Zambia&Cr1=aid>. Accessed 13 February 2006.

³⁵² Amnesty International. *Thailand: The Plight of Burmese Migrant Workers*. London: AI Index: ASA 39/001/2005. See also box above (p.23).

Eventually this detainee was diagnosed as having had a stroke and was transferred to Villawood.

I faced frequent challenges from management/DIMA [Department of Immigration and Multicultural Affairs] and guards who argued that presenting physical and mental ill health in detainees was psychosomatic and contrived to achieve an outcome, and that any referral or relocation outside the centre was inappropriate.”³⁵³

Forensic nurses have a specific role to play in recognizing and evaluating past abuse and torture. Provision of services requires a good understanding of transcultural health beliefs and practices and thorough documentation of evidence. In describing torture events or injuries, patients can evoke responses in the practitioner such as disbelief, distress or outrage. For this reason, nurses should receive regular supervision, training and support.³⁵⁴

Aside from the health problems asylum seekers and refugees may encounter, increasingly restrictive asylum policies may influence the care that nurses are able to provide. In the case study below, the ability of a nurse to carry out his duty of care was frequently hindered by the asylum system in which he was working.

In some jurisdictions asylum seekers face indefinite detention while the process of evaluating their asylum claim proceeds. Detention can last for years – with the asylum seeker having no information about how and when detention will end – and this can lead to a serious deterioration in the mental health of those detained.³⁵⁵

5.7.2 Nurses and midwives as refugees: transferring skills

Numerous refugees have professional health care training. In countries around the world these skills are being lost or inadequately used in the host country. In 2003, a database assembled by the British Medical Association listed 839 refugee doctors in the UK.³⁵⁶ Many of them found it hard to find information, to pass registration exams with the General Medical Council and find medical jobs.³⁵⁷ Many refugee health professionals are denied the ability to put their skills to use in their country of asylum, due in part to the fact that many are unable to bring with them during their flight evidence of their qualifications. Even when they have managed to bring this documentation with them, many find that these are not recognized by their country of asylum. However, the ability of refugee health workers to fill vacancies in host

³⁵³ Alliance of Professionals Concerned about the Health of Asylum Seekers and their Children. 2.4.3 Case Study M: duty of care. In: *Submission to Human Rights and Equal Opportunity Commission Inquiry into Children in Immigration Detention*. May 2002. Available at: <http://www.nq-anzcmhn.org/docs/HEREOC.PDF>.

³⁵⁴ Boersma RR. Forensic nursing practice with asylum seekers in the USA – advocacy and international human rights: a pilot study. *Journal of Psychiatric and Mental Health Nursing* 2003; 10: 526-533.

³⁵⁵ Amnesty International. *United Kingdom. Seeking Asylum is Not a Crime: Detention of people who have sought asylum* London: AI Index: EUR 45/015/2005, available at: <http://web.amnesty.org/library/Index/ENGEUR450152005>.

³⁵⁶ Hogg C. Refugees ready to solve nursing crisis. *BBC News*, 13 February 2003. Available at: <http://news.bbc.co.uk/1/hi/health/2758165.stm>.

³⁵⁷ BMA. *The refugee doctors database*. December 2003, Available at: <http://www.bma.org.uk/ap.nsf/Content/refugee+docs+-+about+database?OpenDocument&Highlight=2.refugees>
Accessed: 27 May 2005.

country health services is slowly being recognized – some examples of good practice are noted below.

Nurses no longer working in nursing

The USA has approximately 500,000 nurses not engaged in nursing, while South Africa has 35,000, Ireland 15,000 and Kenya 4,000. (Oulton J. Inside View. *International Nursing Review* 2004, p200.)

A project to support refugee nurses was established by the Portuguese section of the Jesuit Refugee Service in Lisbon in September 2004. It aimed to support non-EU nurses, whose academic qualifications did not match those of professionals in Portugal, to obtain recognition of their qualifications.

The Jesuit Refugee Service commented that the scheme helped to reduce nurse shortages in Portugal. At the end of 2004, 10 nurses were training in hospital and health care settings. A further 174 nurses had applied for the programme.³⁵⁸

Refugee organizations, employment agencies and local health authorities in the UK are also working to promote refugees into the nursing workforce. In 2004, the UK government announced more funding for the Refugee Health Professional Steering Group, set up in 2001 to provide training and support for refugee health

Norway. Sara, a Somali migrant, working as a midwife in one of the major hospitals in Oslo. © Panos 2003

professionals. Projects include language courses, clinical skills courses, job clubs to give interviewing practice and work shadowing and attachment schemes.³⁵⁹ The Leeds Initiative for Overseas Nurses in the UK, part of Leeds Hospitals National Health Service (NHS) Trust, has developed a programme to train refugee nurses. The free 12-week programme is offered to refugees trained in health care or nursing in their country of origin, and aims to improve English language skills, increase understanding of nursing and other health care roles in the NHS and give participants the confidence to progress to higher education. The education

³⁵⁸ Jesuit Refugee Service Portugal. *JRS Activities and Plans in 2005: Recognition of Qualifications* Available at: <http://www.jrseurope.org/countries/portugal.htm>. Accessed: 3 June 2005.

³⁵⁹ United Kingdom. *New Moves to Support Refugee Nurses and Doctors*. Government Press Release (WHER); 19 July 2004.

coordinator and founder of the project have commented that refugees are an untapped resource for the NHS.³⁶⁰

5.7.3 Migration of nursing and midwifery personnel

International migration is a complex phenomenon and frequently results from social, political and economic factors, especially low salaries, and poor conditions and job prospects. It can have positive outcomes for the migrating individuals as well as having an impact on health sector capacity in both countries of emigration and of settlement. It is a phenomenon with complex interactions with human rights principles.³⁶¹ The right of health professionals to migrate in order to seek better employment conditions and skill development should be protected.³⁶²

The reasons cited by nurses and midwives for emigration include: low salary and remuneration; limited career prospects; feelings of lack of respect or value placed in health workers by country/system; concern about poor governance and management of the health system; and concern about poor retirement benefits and prospects.³⁶³ The failure of the international community to support the building of health systems and training of personnel in resource-poor countries are part of the problem as is the poor recruitment and retention policies on the part of some governments.

The depletion of skilled nursing and midwifery staff in developing countries, accompanied by an increase in the active recruitment of trained staff from developing countries by employers facing nursing shortages in wealthy countries, is often portrayed as a problem caused by migration. However, it is clearly a result of inequalities between source and destination countries³⁶⁴ and it is these which need to be addressed. The inflow of health professionals into high-income countries can represent an important percentage of health sector personnel. According to the Nursing and Midwifery Council in the UK, over one third of nurses entering the UK health system for the first time were trained abroad.³⁶⁵ The impact of emigration on the source country is often disproportionate to the impact of this migration on the country of destination. For example, the number of nurses from Mauritius obtaining

³⁶⁰ *Lincolnshire Echo*. 'Refugees in West Yorkshire with skills in nursing and health care can now access an educational programme that could see them working in the NHS'. 31 January 2005:4.

³⁶¹ Bueno de Mesquita J, Gordon M. *The International Migration of Health Workers: A Human Rights Analysis*. London: Medact, 2005. Available at: http://www.medact.org/hpd_brain_drain.php, accessed, 16 January 2006.

³⁶² See *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (Migrant Workers Convention). Available at: http://www.unhchr.ch/html/menu3/b/m_mwctoc.htm.

³⁶³ These were reasons given by nurses from Ghana. See: Buchan J, Dovlo D. *International Recruitment of Health Workers to the UK: A Report for the Department For International Development*. DFID HSRC, London, UK, 2004. Cited in Buchan J, Kingma M, Lorenzo FM. *International migration of nurses: trends and policy implications*. Geneva: ICN, 2005, p.10. Available at: <http://www.icn.ch/global/Issue5migration.pdf>.

³⁶⁴ Bueno de Mesquita J, Gordon M. See above note 361.

³⁶⁵ Of 33,257 nurses and midwives making an initial registration to the Nursing and Midwifery Council in 2004/5, 11,477 were from overseas. More than half (6,211) were from India and Philippines. See: Nursing and Midwifery Council. *Statistical analysis of the register 1 April 2004 – 31 March 2005*. London, August 2005. Available at: <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=856>. Accessed: 16 January 2006.

permits to work in the UK in 2002 constituted a tiny percentage of UK-registered nurses for example, but represented nearly 14% of Mauritius' nursing capacity.³⁶⁶

The World Health Assembly, at its 57th session in 2004, adopted a resolution that urged member states to develop strategies and means to:

mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems; [and] mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin...³⁶⁷

The ICN, in its position statement, *Nurse Retention, Transfer and Migration*, "recognises the right of individual nurses to migrate", while "acknowledging the adverse effect that international migration might have on health care quality". It condemns the practice of recruiting nurses to countries where authorities have failed to address the human resource planning and problems that nurses experience.³⁶⁸ The International Confederation of Midwives (ICM) has also addressed the issue of the migration of midwives, seeking to balance the interests of the individual midwife and the health systems from which they may emigrate.³⁶⁹

Countries of origin should ensure that allocated funding, including targeted overseas development aid, is utilised to develop and maintain health care systems, including by ensuring that health care professionals are able to enjoy just, favourable and dignified conditions of work,³⁷⁰ and by doing so strengthening the rights and perceived value of health staff. Countries of destination, too, can work to provide adequate reparation to international staff and adopt recruitment measures that encourage domestic workers to train as health professionals.³⁷¹ Other recommended measures have suggested recruitment only from those countries with a surplus of staff³⁷² and planned exchanges whereby workers from developed or developing countries could work abroad.³⁷³

³⁶⁶ Dovlo D, Martineau T. *A Review of the Migration of Africa's Health Professionals*. Harvard University Joint Learning Initiative Working Paper 4-4, January 2004. Available at: <http://www.globalhealthtrust.org/doc/abstracts/WG4/DovloMartineauFINAL.pdf>.

³⁶⁷ World Health Assembly. International migration of health personnel: a challenge for health systems in developing countries. Resolution WHA57.19, 22 May 2004. Available at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf. Accessed 13 October 2005.

³⁶⁸ ICN *Position statement: Nurse retention, transfer and migration*. Adopted in 1999. Available at: <http://www.icn.ch/psretention.htm>. Accessed: 19 April 2005.

³⁶⁹ International Confederation of Midwives. *Position Statement: Ethical Recruitment of Midwives*. Available at: <http://www.internationalmidwives.org/Statements/Ethical%20recruitment%20of%20midwives.pdf>. Accessed: 5 August 2005.

³⁷⁰ CESCR. General Comment 18, paras. 2, 7 and 30.

³⁷¹ Bueno de Mesquita J, Gordon M. *The international migration of health workers: a human rights analysis*. London: Medact 2005; Baird V. A migrant nurse's story. *New Internationalist* 379 June 2005.

³⁷² Buchan J. Nurses moving across borders: 'brain drain' or freedom of movement? *International Nursing Review* 2001; 48:65-7.

³⁷³ Baird V. A migrant nurse's story. *New Internationalist* 379, June 2005.

Some commentators have recommended that an ethical dimension be incorporated into the health professional recruitment policy of high-income countries in order to encourage good practice. The UK government adopted a code of practice for the recruitment of health professionals from abroad³⁷⁴ though this has been criticized as inadequate.³⁷⁵

Following the ICN Congress in Taiwan in May 2005, the Commission on Graduates of Foreign Nursing Schools and the ICN launched the International Centre on Nurse Migration. The Centre is intended to provide “an international resource for the development, promotion and dissemination of research, policy and information on nurse migration”.³⁷⁶ Further calls have been made for an international body to regulate and co-ordinate migration in order to prevent exploitation and ensure that the rights of health workers are upheld.³⁷⁷ Several authors have echoed these recommendations.³⁷⁸

States must ensure protection of the rights of health workers who move across borders, including the right to be free from discrimination in destination countries.³⁷⁹ The international community must ensure in addition that developing countries are enabled to provide an adequate health service to their population, including through providing targeted and additional development resources to increase the capacity of health systems. The principle underpinning these efforts should not be to restrict mobility, but to ensure equity in care and to ensure that all individuals are able to enjoy access to their right to

³⁷⁴ Department of Health, United Kingdom. *Code of Practice for the international recruitment of healthcare professionals*. London, 2004. Available at: <http://www.dh.gov.uk/assetRoot/04/09/77/34/04097734.pdf>.

³⁷⁵ Mensah K, Mackintosh M, Henry L. *The 'skills drain' of health professionals from the developing world: a framework for policy formulation*. London: Medact, 2005. Available at: <http://www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf>. Accessed 6 October 2005.

³⁷⁶ ICN Press release: CGFNS and ICN launch new 'International Centre on Nurse Migration', Geneva, 24 May 2005. Available at: <http://www.intlnursemigration.org/news.shtml#1>.

³⁷⁷ Baird V. (See above, note 373)

³⁷⁸ Buchan J (see note 372 above); Bueno de Mesquita J, Gordon M (see note 371 above); Mensah K, Mackintosh M, Henry L. *The 'skills drain' ... Op.cit.* See the review of strategies to address retention of health professionals in Dovlo and Martineau, loc. cit. pp.48-9.

³⁷⁹ The rights enjoyed by nurses as migrant workers are set out in the *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families*, adopted by General Assembly resolution 45/158 of 18 December 1990. Available at: http://www.unhcr.ch/html/menu3/b/m_mwc_p3.htm. See ILO. *Towards a fair deal for migrant workers in the global economy*. Geneva: International Labour Organization, 2004; Allan H, Larsen JA. “We need respect”: *experiences of internationally recruited nurses in the UK*. London: Royal College of Nurses, 2003. Available at: <http://www.rcn.org.uk/downloads/international/irn-report-we-need-respect.pdf>. Accessed 20 February 2006.

adequate health.³⁸⁰ Equitable access to health care for all remains a difficult but essential goal for both countries of origin and destination.³⁸¹

³⁸⁰ Mensah K, Mackintosh M, Henry L. *The 'skills drain' of health professionals from the developing world: a framework for policy formulation*. London: Medact, 2005. Available at:

<http://www.medact.org/content/Skills%20drain/Mensah%20et%20al.%202005.pdf>. Accessed 6 October 2005.

These authors note that, in the specific case of Ghana, and more generally, the benefits of migration to migrants' home countries are substantial, but do not compensate for the negative health service impacts. They suggest that incentives are needed to keep trained staff within their own country (p.4). For more general discussion of the movement of nurses in particular see: Kingma M. *Nurses on the Move: Migration and the Global Health Care Economy*. Cornell University Press, 2005.

³⁸¹ In addition to the loss of trained staff abroad there is also the issue of skills deployment within the country. External financial pressures can have an impact on domestic health policy. For example, in Kenya, approximately 5,000 newly trained nurses are unemployed, despite a need for a further 7,000. A health worker employment embargo enforced by the International Monetary Fund (IMF) as part of cuts in public spending, means that no new nurses can be employed. See Baird V. A migrant nurse's story. *New Internationalist* 379; June 2005.

6. Populations at risk

Members of certain groups may be at a particular risk of violence and ill-treatment or neglect compared to others. Elsewhere in this document, gender-based violence and its implications for nurses and midwives have been discussed. This section addresses the risks faced by children, particularly those in institutions; people in mental health institutions; people with physical disabilities; and elderly people. All these groups are known to be at particular risk of human rights abuse.³⁸²

6.1 Children

The Convention on the Rights of the Child recognizes and urges respect for the human rights of children.³⁸³ In particular, Article 19 calls for legislative, administrative, social and educational actions to protect children from all forms of violence, including abuse and neglect. [...]

Some nurses will have professional responsibilities directly focusing on children though all nurses should be prepared to work with children. “Curricula for medical and nursing students, graduate training programmes in the social and behavioural sciences, and teacher training programmes should all include the subject of child abuse and the development within organizations of responses to it”.³⁸⁴

In recent years there have been a number of inquiries in several countries into the abuse of children in the home and in institutions. Staff whose primary responsibility is to care for and protect children – and this can include nurses – are sometimes the perpetrators of abuse.³⁸⁵ Abuses against children who are refugees or internally displaced have also been reported.³⁸⁶

Nurses, on the other hand, may find themselves in a position where they are aware of abuses and in a position to take action, either through observations in clinics and health centres or through a programme of nurse home visits.³⁸⁷ Equally, school nurses can be early

³⁸² See: Gallagher B. The extent and nature of known cases of institutional child sexual abuse. *British Journal of Social Work*, 2000; 30:795-817; Wierucka D, Goodridge D. Vulnerable in a safe place: institutional elder abuse. *Canadian Journal of Nursing Administration* 1996;9:82-104; Pring J. *Silent Victims*. London: Gibson Square Books, 2003. Violence against older women happens predominantly in a domestic setting. See, for example, Brandl B, Horan DL. Domestic violence in later life: an overview for health care providers. *Women's Health* 2002;35(2-3):41-54.

³⁸³ The Convention on the Rights of the Child, ratified by all states member of the UN bar the US and Somalia considers a child to be “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.” (Article 1)

³⁸⁴ World Health Organization. *World Report on Violence*. Geneva: WHO, Chapter 3, pp.79-80.

³⁸⁵ Pring (see note 382 above) describes the long-running abuse of residents in an institution for people with learning disabilities in the United Kingdom. The principal abuser was a former nurse and social worker who was the home's director.

³⁸⁶ Amnesty International. *Women, violence and health*. London, ACT 77/001/2005, 18 February 2005.

³⁸⁷ MacMillan HL, Canadian Task Force on Preventive Health Care. Preventive health care, 2000 update: prevention of child maltreatment. *Canadian Medical Association Journal* 2000;163(11):1451-8

witnesses to the effects of child abuse in the home, school or community. This represents an important avenue to contribute to child protection; equally, “whistle-blowing” by nurses – where colleagues or others are involved in abuses or where there is a lack of action by the authorities – can accelerate the implementation of measures to better protect an at-risk child.

One likely outcome of judicial investigation into child abuse is that decisions will be taken about the future living arrangements of the child. However, whatever that arrangement might be, the Convention on the Rights of the Child specifies (at provisions 12.1 and 12.2) that, taking account of their age and maturity, children should be consulted on any matters likely to affect them such as their living arrangements and parental access.³⁸⁸ The Convention also stresses, at Article 3, that in any such measures or decisions concerning the child, “whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration”.

Apart from playing a role in protecting children from abuse, health professionals have a vital role in ensuring the health and well-being of the child. “While only States are parties to the Covenant [on Economic, Social and Cultural Rights] and thus ultimately accountable for compliance with it, all members of society – individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector – have responsibilities regarding the realization of the right to health. States parties should therefore provide an environment which facilitates the discharge of these responsibilities.”³⁸⁹

6.2 People with mental or physical disabilities

Institutionalized people with mental illnesses, learning difficulties/disabilities or physical disabilities face higher than average risks of physical and sexual abuse.³⁹⁰ Those living in a domestic setting also are at risk of violence from carers or family members.

In 2001, Amnesty International reported that mentally disabled women in Bulgaria being held at a state institution in the village of Sanadinovo were being subjected to conditions that amounted to cruel, inhuman and degrading treatment. Some inmates were being held in cages because the staff claimed that “they had misbehaved”.

³⁸⁸ Convention on the Rights of the Child. Available at: <http://www.unicef.org/crc/crc.htm>. Accessed 17 October 2005.

³⁸⁹ Committee on Economic, Social and Cultural Rights. General Comment 14 (2000) on the right to health. This paragraph was cited (and concurred with) in the General Comment 5 (para. 56) of the Committee on the Rights of the Child. Available at: [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.5.En](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.5.En)

³⁹⁰ Balogh R, Bretherton K, Whibley S, Berney T, Graham S, Richold P, Worsley C, Firth H. Sexual abuse in children and adolescents with intellectual disability. *Journal of Intellectual Disability Research* 2001;45:194-201; Sequeira H, Hollins S. Clinical effects of sexual abuse on people with learning disability: critical literature review. *British Journal of Psychiatry* 2003;182:13-9; Hassouneh-Phillips D. Understanding abuse of women with physical disabilities: an overview of the abuse pathways model. *ANS Advances in Nursing Science* 2005;28:70-80.

Independent experts quoted by Amnesty International described conditions in such institutions as constituting “a slow death”.³⁹¹ The institution was subsequently closed down by the government after international protest. Male residents also faced cruel and degrading conditions that led, in the case of one institution, to closure but with the residents being transferred to an even more remote facility, where it was doubtful whether staff would have more qualifications or training than the previous care home.³⁹²

In 2002, the NGO Mental Disability Rights International (MDRI) received reports concerning cases of sexual harassment, exploitation, rape, or other forms of violence at three institutions in Kosovo.³⁹³ The management of the institution and UN authorities were informed about cases of abuse at a facility for people with mental disabilities; however, known abusers had not subsequently been removed from day-to-day contact with former victims. At Pristina University Hospital, MDRI had also received reports about sexual abuse of women by staff. A year later, MDRI continued to express concern at the lack of progress in effectively addressing abuses. The same organization has published reports on abuses of people in institutions in several other countries.³⁹⁴ A common thread in these reports is the shortage of well-trained and equipped staff, including nurses.

Sierra Leone. The 'Kissy Home' psychiatric hospital in Freetown is the only such facility in a country which has been estimated to have 100,000 people suffering from severe psychological problems. Patients can be chained to their beds or to the floor, where they sit in their own excrement. Treatment is only available to those whose families can pay for it. © Panos

³⁹¹ Amnesty International. *Urgent Action: Bulgaria*. London, AI Index: EUR 15/001/2001.

³⁹² Amnesty International. *Bulgaria: where are the men of Dragash Voyvoda?* London, AI Index: [EUR 15/005/2003](http://www.unhcr.org/refugees/15/005/2003). Principles 7 and 9 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) emphasise the rights of patients to be treated ethically, in their community, and with a minimum of intrusiveness. By extension these principles should also apply to people living with intellectual disabilities. The Principles are available at: <http://www.unhcr.ch/html/menu3/b/68.htm>. (Accessed 12 October 2005.)

³⁹³ Mental Disability Rights International. *Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo*. Washington DC: MDRI, 2002. Available at: <http://www.mdri.org/publications/index.htm>.

³⁹⁴ Visit <http://www.mdri.org>.

6.3 Elderly patients

6.3.1 Witnessing the effects of violence

In high income countries, the proportion of older citizens has been increasing over past decades as life expectancy rises.³⁹⁵ Some health carers are reporting an increase in the level of physical, mental and economic abuse as well as increased signs of neglect of older patients by family members and institutions.³⁹⁶ Community nurses may well be the first to see signs of such abuse and to respond to the needs of the abused older person.

6.3.2 Violence in institutions

“Elder abuse” has been defined as any act or omission that results in harm or threatened harm to the health or welfare of an older person.³⁹⁷ The US organization the National Committee for the Prevention of Elder Abuse has made the distinction between domestic abuse, institutional abuse and self-neglect, which can take the form of physical, psychological, or financial abuse or exploitation, or neglect.³⁹⁸ Much abuse is perpetrated by carers within the family, or constitutes self-neglect; however, some reports suggest that neglect can also take place in health care settings.³⁹⁹

Violence and other forms of ill-treatment against elderly people in institutions can have physical, mental, social and legal dimensions and can be perpetrated, experienced or witnessed by residents.⁴⁰⁰ Staff – including nursing staff – can also be perpetrators or witnesses of violence against elders and may sometimes face violence by elderly residents. In some cases, elderly residents may be at risk of death at the hands of staff carrying out what they regard as “euthanasia”, although without the knowledge or consent of those affected.⁴⁰¹

³⁹⁵ In 1995, the World Health Organization reported that “although Europe, Japan and the USA currently have the ‘oldest’ populations, the most rapid changes are being seen in the developing world, with predicted increases in some countries of up to 400% in people aged over 65 during the next 30 years”. WHO. *World Health Report 1995*. Geneva: World Health Organization. Available at:

http://www.who.int/whr/1995/media_centre/executive_summary1/en/print.html. However, in the developing world the impact of HIV/AIDS, under-addressed diseases and poverty combine to reduce average life expectancy. In 2005, the average life expectancy of men and women in the African region is 46 and 48 years respectively, compared to 68 and 77 respectively for men and women living in the European region (WHO. *World Health Statistics 2005*. Geneva: WHO. Available at: <http://www3.who.int/statistics/> Accessed: 27 June 2005.

³⁹⁶ Kurrle S. Elder abuse. *Australian Family Physician* 2004;33:807-12; Baker MW, Heitkemper MM. The roles of nurses on interprofessional teams to combat elder mistreatment. *Nursing Outlook* 2005;53(5):253-9.

³⁹⁷ World Health Organization. *Health and Ageing – A Discussion Paper*. Geneva: WHO, 2001. Available at: http://whqlibdoc.who.int/hq/2001/WHO_NMH_HPS_01.1.pdf. Accessed 5 August 2005.

³⁹⁸ See: National Committee for the Prevention of Elder Abuse, Washington DC. <http://www.preventelderabuse.org/elderabuse/elderabuse.html>.

³⁹⁹ Nerenberg L. Abuse in nursing homes. *National Center on Elder Abuse Newsletter*, May 2002, available at: <http://www.elderabusecenter.org/default.cfm?p=abuseinnursinghomes.cfm>, accessed 16 January 2006.

⁴⁰⁰ Hirsch RD. Violence against elderly people and its prevention in nursing care institutions in Germany. In: Habermann M, Uys LR (eds). *Violence in Nursing: International Perspectives*. Frankfurt Am Main: Peter Lang, 2003, pp. 113-39.

⁴⁰¹ *Ibid.* See: German nurse accused of killing 29 patients. *Guardian* 8 February 2006. Available at: <http://www.guardian.co.uk/germany/article/0,,1704951,00.html>. “I wanted to save the patients suffering and free them from hopelessness,” the accused man was quoted as saying. Accessed 27 February 2006. Seriously ill

Nurses have a key role to play in eliminating neglect in the home, and in health care settings, and in ensuring that the dignity and wellbeing of elderly patients is safeguarded. d'Oliveira and colleagues suggest that steps to reduce abuse and violence in health care should start during student training, and that effective communication skills are key.⁴⁰² The ICN have commented that nurses can identify victims and older persons at risk of abuse because of their role in service delivery, screening and health promotion. Within this role, nurses can work in partnership with others to document abuse, minimize its negative consequences, and aim to reduce its prevalence⁴⁰³.

6.4 Sex workers

Women and men who are involved in commercial sex work are engaged in a form of work that carries a number of serious risks, including violence and sexually transmitted infections. In addition illicit drug use, discrimination, debt, criminalization and exploitation are significant other problems.⁴⁰⁴ This is a complex social issue in which health carers can both contribute to the health and well-being of individual sex workers as well as to wider policy discussion.⁴⁰⁵

patients can also face the same risks. See BBC news online. "French 'Madonna of euthanasia' jailed", 31 January 2003, describing the sentencing of a nurse in France to 10 years' imprisonment for the killing of 10 patients. Available at: <http://news.bbc.co.uk/1/hi/world/europe/2714831.stm>. Accessed 27 January 2006. These examples illustrate one of the difficulties in discussing the subject of euthanasia. The word is applied to a range of situations, from the murder of elderly and/or suffering people or people who are sick and unwanted to the hastened or assisted death of those suffering irreversible and painful illness, and at their informed request. The motivation of euthanasia in this latter sense is compassion. Euthanasia remains one of the most contentious ethical and moral questions facing nursing and other healthcare staff. (There are other difficult end-of-life issues such as the withdrawal of life-prolonging care from the terminally ill, withdrawal of life-support from people in a persistent vegetative state, and physician-assisted suicide. These are widely discussed in the literature.) On euthanasia see: Verpoort C, Gastmans C, De Bal N, De Casterlé BD. Nurses' attitudes to euthanasia: a review of the literature. *Nursing Ethics* 2004; 11: 349-365.

⁴⁰² d'Oliveira AFPL, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. *Lancet* 2002;359:1681-85.

⁴⁰³ International Council of Nurses. Nursing matters: Elder Abuse. *Op. cit.*

⁴⁰⁴ Amnesty International. *Women, violence and health*. London, ACT 77/001/2005, 18 February 2005.

⁴⁰⁵ For discussion of a harm reduction approach to addressing the vulnerability of sex workers in which health care personnel will have an important role see: Rekart ML. Sex-work harm reduction. *Lancet* 2005; 366:2123-34.

7. Responding to human rights abuses: the nursing role

Professional associations and individual nurses and midwives can play a greater role in combating human rights violations and promoting human rights awareness within the nursing professions.

7.1 Advocacy

Amnesty International's commitment to preventing and ending grave abuses of the rights to physical and mental integrity, freedom of conscience and expression, and freedom from discrimination, within the context of its work to promote all human rights,⁴⁰⁶ is supported by many national and international professional nursing bodies.

The Nurse's Role in Safeguarding Human Rights, a statement adopted by the ICN in 1983, notes that "nurses have individual responsibility but they can often be more effective if they approach human rights issues as a group".⁴⁰⁷

Nurses can be confronted by human rights violations as witnesses, when they or colleagues are put under pressure to ignore, participate in or cover up violations, or in the documenting or exposure of abuses. In the section below, various avenues of advocacy are explored, with reference to specific case examples.

Nurse human rights activism in action

Many nurses are engaged in human rights activism around the world. Ken Agar-Newman is one of them. Ken has been a member of Amnesty International in Canada for more than two decades. He is a critical care nurse working in a recovery unit for patients after open heart surgery at Royal Jubilee Hospital in Victoria, Canada. He also is a founding member of the Victoria Coalition for the Survivors of Torture and was involved in the inception and early development of the Vancouver Association for the Survivors of Torture. He is married with three children.

Ken is a long-standing member of the Anglophone Canadian AI health professional network where he is a coordinator of the nurses' committee. He has been particularly active around issues of torture and cruel treatment as well as human rights education pointing out that all governments have an obligation outlined in the UN Convention against Torture to ensure nurses are taught about the nursing care of government sponsored torture victims—a requirement that is almost universally ignored by governments. He also envisions an international impartial body that would regulate health ethics world-wide. "Currently there is an enormous gap where unethical behaviour by health workers, such as participation in torture and the death penalty, is being overlooked."

The recent resurgence of the use and advocacy for torture by western governments has

⁴⁰⁶ See the Amnesty International mission statement at <http://web.amnesty.org/pages/aboutai-statute-eng#top>.

⁴⁰⁷ Amnesty International. *Ethical Codes and Declarations Relevant to the Health Professions*. Fourth Revised Edition. London: Amnesty International Publications, 2000.

prompted him to write prolifically to nursing associations, journals, military medics and governments to challenge this acceptance or tolerance of torture. Ken's dream is to see a comprehensive response by the health sector worldwide to confront the worst human rights violations. "Health professionals can act like one nation with one vision," he says. "We can place humanity and compassion on the agendas of our health organizations, our military services, multi-national corporations, and governments in order to mobilize the money and action required."

When asked how it is possible for a busy nurse to do so much campaigning, Ken says: "It does not take so much time or energy to write a letter. Never tiptoe around a bully – they will eventually crumble. Each of us, even as an individual, has a lot of power. Our power comes from persistence, from caring to learn about an issue, from standing up to be counted, from holding fast to our dreams of a safe world for all people."

"Nurses are privileged in being rooted in the communities we serve. This coupled with our scientific methodology and our knowledge gives us a special obligation to translate human rights issues into the political arena. If everyone who felt angry about a human rights abuse would even write a short note to a parliamentarian, a newspaper or an embassy; the voice of ordinary people is effective. This is the core belief that led to Amnesty International's creation but it is a tool used by communities and activists around the world." Ken's final advice to nurses is: "your views are worth communicating and never, never, never give up."

7.1.1 Professional bodies

The adoption of human rights principles as part of the ethical framework of nurses or midwives represents a commitment to defend important values and constitutes a starting point for professional advocacy. Some organizations have undertaken specific initiatives in support of nurses' rights – the support by the ICN for Bulgarian nurses imprisoned in Libya is an example (see above p.60) – but NGOs also have much to contribute in encouraging rights-oriented advocacy. The US organization Physicians for Human Rights, working with the local nursing association, sponsored a workshop in 2005 with Kenyan nurses to strengthen professional advocacy for a better national nursing bill.⁴⁰⁸ There appears to be a potential space for fruitful dialogue between nursing professional bodies and NGOs concerning areas of shared human rights concerns.

International Days for Midwives and Nurses

The International Confederation of Midwives established the idea of an International Day following suggestions and discussion among member associations in the late 1980s, and launched the initiative formally in 1992. The International Day of the Midwife is celebrated on 5 May each year. In 2005 the theme was "Midwives and women – a partnership for health".⁴⁰⁹

The International Council of Nurses organizes an action each year on 12 May. In 2005 it

⁴⁰⁸ See note 180 above.

⁴⁰⁹ The press release is available at: <http://www.internationalmidwives.org>. Accessed 14 February 2006.

organized a campaign against harmful counterfeit medicines as the theme for International Nurses Day. The ICN distributed an information and action toolkit and encouraged nurses to take action against substandard medicines.⁴¹⁰ In 2006 the theme focuses on safe staffing as a life-saver for patients.

Another form of advocacy is represented by giving recognition to human rights activism by nurses. An example of this is the Health and Human Rights Award given by the International Council of Nurses. The award was created in 2000 with the goals of calling attention to ICN's values and commemorating nursing's commitment to human rights.⁴¹¹ The International Centre for Nursing Ethics based at Surrey University, UK, also gives the Human Rights and Nursing Award annually (formerly biennially) to recognize the human rights advocacy of individual nurses.⁴¹²

7.1.2 Individuals

Advocacy for asylum seekers

A nurse formerly employed in an asylum detention centre in Woomera, Australia, found that the company managing the centre was not fulfilling its obligations to detainees. On reflecting for the need for nurses to advocate on behalf of patients, she wrote:

"...nurses must speak out whenever they believe patients are disadvantaged or patients' rights are violated. This holds especially true in detention settings where treatment choices are not an option, and usual avenues of complaint and support are restricted... The code of ethics compels nurses to do whatever is necessary to preserve the integrity of nursing practice. A company employing registered staff with professional obligations should expect nothing less."⁴¹³

Individual nurses are the actors who make ethics and human rights real – in the clinic, hospital and home. This report cites examples of actions taken by individual nurses. By working with their professional body, human rights organizations, social justice movements or just responding to abuses they witness, nurses can strengthen respect for human rights and access of individuals to justice.

7.2 Nurses, midwives and human rights education

In a 2005 statement on nursing and human rights, Amnesty International emphasized the need for continuing professional and human rights education as nurses increasingly encounter complex ethical decisions in their daily work while facing violence in the workplace.⁴¹⁴ The

⁴¹⁰ The information and action toolkit is available at: <http://www.icn.ch/indkit2005.htm>. Accessed 28 October 2005.

⁴¹¹ For details see: <http://www.icn.ch/awards.htm#hh>. Accessed 19 October 2005.

⁴¹² International Centre for Nursing Ethics, <http://www.eihms.surrey.ac.uk/Resethics.htm>. Accessed 19 October 2005.

⁴¹³ Rogalla B. Nursing behind razor wire: a question of ethics. *Australian Nursing Journal* 2001; 8(9):21.

⁴¹⁴ Amnesty International urges a stronger human rights role for nurses and midwives. AI Index: ACT 75/002/2005, available at: <http://web.amnesty.org/library/Index/ENGACTION750022005>.

need for national and international nursing associations to involve themselves in human rights education is one recognized by the United Nations Educational, Scientific and Cultural Organisation (UNESCO) in its Recommendations of Human Rights Teaching, Information and Documentation. As long ago as 1987, UNESCO called for the promotion by its Director General of:

training in human rights of professionals, particularly those concerned by human rights, such as magistrates, doctors, *nurses*, police officers, journalists, those in positions of responsibility in the armed forces, personnel of refugee camps, frontier guards, etc., through their national and international organizations, and promot[ion of] the cause of human rights...⁴¹⁵

The ICN has called for “all levels of nursing education curricula [to] include the following: recognition of human rights issues and violations, such as torture and death penalty; awareness of the use of medical technology for executions; and recognition of the nurse’s right to refuse participation in executions”.⁴¹⁶

If the values of human rights are to contribute to the ethical framework and conduct of nursing then they need to be included in the education of nurses and midwives. Limited evidence suggests that such teaching is scarce.⁴¹⁷ However, a number of existing human rights conventions and declarations call for the education of health personnel – something which has yet to be adequately addressed.

7.2.1 International obligations regarding human rights education

Through ratifying international human rights treaties, such as the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and agreeing to international Programmes for Action, such as the Beijing Platform for Action, governments have committed themselves to ensuring that nurse training includes “comprehensive, gender-sensitive courses on woman’s health and human rights”⁴¹⁸ thus “enabling health-care workers to detect and manage the health consequences of gender-based violence”.⁴¹⁹ Furthermore, the Plan of Action prepared by the 2nd UN Regional Seminar on Traditional Practices affecting the Health of Women, 4-8 July 1994, recommended that governments provide courses on the health impact of female genital mutilation and other traditional practices in the training programmes for medical and paramedical personnel.⁴²⁰

⁴¹⁵ UNESCO. 1987 Malta Recommendations on Human Rights Teaching, Information and Documentation, para 3.3. Available at : http://portal.unesco.org/shs/en/ev.php-URL_ID=1687&URL_DO=DO_PRINTPAGE&URL_SECTION=201.html. Accessed 3 June 2005. [Emphasis added]

⁴¹⁶ International Council of Nurses. Torture, Death Penalty and Participation by Nurses in Executions. Adopted 1998.

⁴¹⁷ Chamberlain M. Human rights education for nursing students. *Nursing Ethics* 2001; 8: 211-22.

⁴¹⁸ CEDAW General Recommendation 24 article 31f. Available at: <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>. Accessed 3 June 2005.

⁴¹⁹ CEDAW General Recommendation 24 article 15b and 1995 Beijing Platform for Action, para 103(h). Available at <http://www.umn.edu.humanrts/instree/e5dplw.htm>. Accessed 3 June 2005.

⁴²⁰ See <http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/9c17306277af5e4f8025672b003c9275>. Accessed 3 June

International human rights law – specifically the UN Convention against Torture – also obliges governments to ensure that education on torture is included in the training of health professionals, including nurses, whose work frequently brings them into contact with people who have been detained against their will and who may thus be at risk of human rights abuses.⁴²¹ Education on this theme should also take into account that virtually *any* health professional may find themselves working with a patient who has been tortured or otherwise ill-treated.

Yemen. Training of village midwives at the regional hospital in Ibb, 2000. © Panos. Yemen became the third country in the Middle East region to implement a leadership and management training scheme for nurses run by the Central Nursing Directorate with the cooperation of the International Council of Nurses (ICN) in Geneva, and supported by World Health Organization (WHO). The first 29 students graduated in April 2006

However, in 2001, of the 140 States who had ratified the UN Convention against Torture, only Denmark is known to have made human rights education provision for nursing students.⁴²² Given the importance of ethics, a strong case can be made for ensuring that all nurses and midwives receive information about how fundamental human rights relate to their practice both during their training and regularly throughout their careers.

7.2.2 Education and training for nurses

A study conducted in 2001 in the UK⁴²³ found only three previous references to studies on human rights education in the training of health professionals.⁴²⁴ In his survey of nurse educators, Chamberlain found that general awareness of international law and standards was

2005.

⁴²¹ Article 10 of the UN Convention Against Torture states that 'each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of.... medical personneland other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment'. http://www.unhchr.ch/html/menu3/b/h_cat39.htm. Accessed 3 June 2005. See Jacobsen L, Smidt-Nielsen K. *Torture Survivors - Trauma and Rehabilitation*. Copenhagen: IRCT 1997.

⁴²² Chamberlain M. See above, note 417.

⁴²³ *Ibid*.

⁴²⁴ See: Sonis J, Gerenflo D, Jha P. Teaching of human rights in US medical schools. *JAMA* 1996;276: 1676-78; Brenner J. Human rights education in public health graduate schools. *Health and Human Rights* 1997; 2:129-39; Vincent A, Ferguson S, Forrest D. Human rights and medical education [letter]. *Lancet* 1994; 343: 1435.

good, with 90%, 78% and 59% demonstrating awareness of the International Bill of Rights (comprising the Universal Declaration of Human Rights and International Covenants on Civil and Political Rights and Economic, Social and Cultural Rights), the UN Convention of the Rights of the Child and the UN Convention against Torture (in particular, Article 10 on education), respectively. Fifty-nine per cent were aware of the International Council of Nurses' statement on the Nurse's Role in Safeguarding Human Rights. Topics taught weighed heavily towards domestic rather than international human rights issues. The primary barrier to the inclusion of human rights education in the curriculum was pressure on timetabling; problems around the assessment of human rights education were also mentioned.

7.2.3 Education and public health implications

A number of authors have recommended that a strong ethical framework that promotes human rights and social justice can enable nurses to contribute to the building of healthy communities.⁴²⁵ The World Health Organization has defined the characteristics of a healthy community as: a clean and safe physical environment; an environment that promotes social harmony and actively involves everyone; an understanding of the local health and environment issues; community participation in finding local solutions to local problems; the existence of accessible and appropriate health services; and sustainable use of available resources for all.⁴²⁶ Through education that incorporates the ethics of social justice, nurses may aid government and international efforts to achieve optimum health for populations.⁴²⁷

7.2.4 Resources

Nurse educators have suggested that case-study-based teaching may be a particularly effective approach to teaching.⁴²⁸ Other interactive methods used by teachers included group discussions, debates, formal lectures, videos and project work. The internet has emerged over recent years as an important resource, particularly in the developed world. A number of non-governmental organisations and institutions have produced human rights resources published on the internet⁴²⁹ or distributed through other means.⁴³⁰ There nevertheless remains a shortage of adaptable and relevant human rights education material – particularly case-based – for nurses and midwives.

⁴²⁵ Zahner S. Ethics content in community health nursing textbooks. *Nurse Educator* 2000; 24:186-194; Chafey K. Caring is not enough: ethical paradigms for community-based care. In: Spradley B, Allender J. (eds) *Readings in Community Health Nursing*. Fifth Edition. Philadelphia: Lippincott; 1997:211-220.

⁴²⁶ Howard G, Bogh C, Goldstein G, Morgan J, Pruss A, Shaw R, Teuton J. *Healthy villages: a guide for communities and community health workers*. Geneva: World Health Organization, 2002. Available at: <http://whqlibdoc.who.int/publications/9241545534.pdf>. Accessed: 31 May 2005.

⁴²⁷ Zahner S. Ethics content in community health nursing textbooks. *Nurse Educator* 2000; 24:186-94.

⁴²⁸ Zahner S. *Ibid.*; Chamberlain M. Human rights education for nursing students. *Nursing Ethics* 2001; 8: 211-22.

⁴²⁹ See, for example, the courses listed at the Human Rights Internet website: <http://www.hri.ca/education/>

⁴³⁰ Amnesty International German Medical Group. *Human rights requires cultivation*. [Teaching pack] Bonn: AI German Medical Group, 1996 (Available in German only).

8. Recommendations

As this paper shows, there is a wide range of professional concerns in the working life of nurses and midwives which have an impact on their own human rights and those of patients and colleagues. The following recommendations aim at enhancing the role of nurses and midwives so that their role strengthens the respect and protection of human rights for themselves and others.

8.1 To the international community

Nurses are a key resource in improving global health. The international community should contribute to maximising the effectiveness of this sector.

- Support international cooperation on training and health care delivery in a form which is consistent with international human rights requirements.
- Understand and respond to the positive and negative aspects of nurse migration; in particular ensure that the cost of training of nurses does not become a form of subsidy by poor countries to the wealthy North.

8.2 To states

8.2.1 Right to health

States should ensure that the right to the highest attainable standard of physical and mental health is respected, protected and fulfilled.

- Governments should ensure that adequate levels of nurses and midwives are trained and employed and that all parts of the country are adequately served by trained personnel.
- Where health services, including nursing services, are in the private sector, governments should nevertheless ensure that everyone have access to good quality health care.

8.2.2 Professional regulation and responsibilities

While governments should not take a “hands on” approach to the management of nursing at clinical level they should provide an enabling environment in which effective, secure and professional work can be carried out by nurses to the benefit of the community.

- Governments should ensure that draft legislation regulating the employment of nurses and midwives, their functions and working conditions, is reviewed by nursing

organizations and adequately reflects the skills and professionalism of nursing personnel.

- Ensure that nursing and its regulation is carried out in a transparent and accountable way with limitations on openness applying only where strictly necessary for reasons of protecting the legitimate privacy of staff, patients or third parties.
- Maximize the extent to which nurses are managed by and accountable to senior health professionals for their clinical work.
- Nurses working in “closed” environments such as prisons or other institutions should be encouraged to undertake periods of rotation in other clinical environments.

8.2.3 Ethical behaviour

Nurses should work in an environment in which human rights are institutionalized and a fundamental part of the value system. Governments should:

- Ensure that nurses are made aware of the need to respect human rights in their practice, including principles of non-discrimination, respect for individual dignity and physical and mental integrity, and the right of all people to the highest attainable standard of physical and mental health
- Nurses working in custodial settings should work in an environment in which clinical need is paramount, non-discrimination is a fundamental value and in which human rights generally are respected. Where nurses witness abuses they should be encouraged to report them.
- Ensure that nurses working in settings where there is a high risk of human rights violations are able to draw on independent sources of advice and support outside the existing professional framework on the institution – and will not be penalised for doing so.

8.2.4 Defend nurses’ and midwives’ security

Apart from any strengthening of professionalism within nursing, governments must take greater measures to protect nurses’ security in the health care delivery system and in areas where human rights violations occur.

- Security for nurses and midwives within the health services and in areas of human rights abuse should be strengthened.
- Nurses acting as human rights defenders should benefit from the respect and protection states are obliged to offer to such defenders.

8.2.5 Understand the effects of nurse and midwife migration

The movement of trained nurses and midwives between countries has positive effects both for the individual and for the country of origin and country of settlement (such as cultural enrichment, sharing of skills, receipt of financial remittances from staff abroad, improvement of professional standards in the country of origin, eventual return of experienced and trained staff to their country of origin). But it also can have negative effects (loss of skilled staff, increased training requirements, need to increase expenditure to retain staff).

- There is a need for awareness of the positive and negative effects of movement of health workers, including nurses, particularly on the country of origin of the health workers.
- Existing “ethical” governmental approaches to foreign nurse recruitment need to be audited and properly implemented. Countries lacking such approaches should introduce them.
- Notwithstanding the above, the rights of nurses to freedom of movement and employment should be respected and the potential benefits of such movement maximized.
- Nursing associations could advocate for action by national governments to contribute to the strengthening of health care and nursing practice in countries with a significant net outflow of health professionals.

8.2.6 Address harmful practices

Nurses and midwives in many countries see the consequences of harmful practices which impact on women and girls and may be required or persuaded to participate in such practices, some of which constitute human rights violations. Governments can stop abuses and prevent their negative consequences by public education and law reform. In particular:

- Female genital mutilation (FGM) should be made illegal and nurses, midwives and other health care workers prohibited in law from performing or assisting in FGM. Nurses should receive adequate training in how to approach girls and women suffering the long-term consequences of FGM, including during pregnancy and childbirth.
- Education and, where appropriate, legislation should be used to address the gender-specific, discriminatory and scientifically dubious practice of “virginity testing”. Governments should work towards the abolition of this practice.
- Governments should exercise due diligence to prevent, investigate and prohibit all practices that constitute violence against women and girls (such as child marriage and “wife inheritance”). Nurses may be in a position to contribute to health-oriented community education.

8.2.7 Forensic nursing

Governments should examine the potential advantages of training nurses to fulfil a forensic role within the criminal justice system, thus expanding the capacity of the criminal justice system to respond to crime, including violence directed at women and children. Where training is developed and implemented nurses who qualify from such training should be employed in forensic work. Governments should thus:

- Introduce, or increase the level of, forensic nursing training and its recognition as a discipline within the criminal justice system.
- Ensure that nurses qualifying in forensic nursing are employed effectively to strengthen forensic services and to contribute to the consolidation of this growing area of nursing.
- Ensure that a human rights dimension is included in forensic nursing training.

8.3 To national nursing and midwifery associations and regulatory bodies

8.3.1 Professionalism

Strengthening the professionalism and accountability of nurses and midwives could strengthen the capacity of nurses to act more effectively to defend nurses' rights and the role of nurses.

- Concepts of professionalism should be linked to adherence to ethics and human rights principles
- Professionalism and professional ethics should be strengthened and promoted among national association and members, with regard to qualifications, professional responsibilities and accountability.
- Education and further training in both technical and ethical aspects of nursing need to be regularly reviewed and made a central thread of nurse and midwife education during his or her professional life.
- Accreditation standards and regulatory framework should be harmonized to ensure that nurses achieve standardized qualifications which meet minimum standards.
- Nurses and midwives should be made aware at the time of their entry into the profession (and regularly thereafter) of the human rights and ethical obligations which flow from their work.

8.3.2 Security of nurses and midwives

Nursing and midwifery professional bodies should continue to place a high priority on the security of their members.

- Further measures should be implemented to increase active support for nurses and midwives, including, statements by governments on non-acceptability of violence against nursing staff, training in negotiating skills and anger diffusion for staff at highest risk, and prosecution of those responsible for violence against staff.

Institutions in which nursing and midwifery are practised should be places where high priority is placed on ethics by all levels of management and staff.

- Nursing associations and regulatory bodies should audit institutions for ethical management, for respecting the rights of staff and patients and for the accuracy and integrity of information they publish

8.3.3 Nurses and human rights violations

Nursing bodies should ensure that nurses and midwives can play an effective role in protecting human rights. They should also monitor abuses targeted at nurses and strengthen their response at national and international level.

- Nursing associations should ensure that their codes of practice and ethics address adequately the role and responsibilities of nurses and midwives with respect to the human rights of patients and the citizens. In particular the prohibition on professional involvement in torture or other ill-treatment, the death penalty and harmful traditional practices should be made clear.
- Associations should ensure that professional ethics and codes of behaviour apply throughout the profession in all work settings.
- Victims of human rights violations involving professionals should have a mechanism to initiate a complaint and to have it properly addressed by professional regulatory bodies as well as by the criminal justice system.
- Nursing associations should review their role as defenders of nurses at risk to ensure that they are able to mount the most effective intervention in such circumstances. Unless it appears likely to put individuals at risk, associations might campaign or publicize the cases of individual nurses or bodies of nurses in danger of, or suffering, human rights violations.
- Nursing associations should examine mechanisms for establishing a presence and visibility in high risk situations in order to reduce the risk of human rights violations

as well as speaking out on ethical and human rights aspects after episodes of human rights abuse.

- Nurses' and midwives' associations should address issues of stigma and discrimination in health care through awareness campaigns and encouraging the challenging of unacceptable behaviour. This is particularly important with respect to HIV/AIDS and mental health but is also relevant to a number of other health issues.
- Nursing associations should ensure that nursing research relevant to social issues, such as the health and human rights aspects of sex work, are communicated to government and to policy forums.
- Nursing associations should ensure that they have clear channels of communication with the government, including relevant ministries and the parliament, to ensure that effective mobilisation of nursing skills, strengthening of nursing capacity and protection of nurses' and midwives' rights is guaranteed.
- Nursing associations should collaborate within regional treaty areas (for example, the Council of Europe) to ensure the effective mobilisation of nursing skills, strengthening of nursing capacity and protection of nurses' rights.

8.3.4 Nurses, midwives and the right to health

Nursing bodies can contribute to the strengthening of respect for the right to health by:

- Explicitly acknowledging the link between the work of the nursing profession and the rights of citizens to highest attainable standard of physical and mental health
- Ensuring that a rights-based analysis is used to frame any submission from a nursing body to government and health funders in support of increased or modified health expenditure or changes to health policy
- Ensuring information on human rights is included in publications directed at nurses and midwives.

8.3.5 Responding to human rights abuses

Professional bodies can play an important role in strengthening the ethics and ethical awareness of nurses who may be confronted by human rights abuses as well as playing a protective role for those nurses at risk of abuse.

- Nursing associations and regulatory bodies should ensure that nurses and midwives are kept abreast of developments in the field of ethics and human rights, including matters related to national legislation, international human rights standards relevant to nursing and standards arising from within the international profession.
- Nursing organizations should address concerns about the plight of individual nurses to the governments responsible for the safety of those at risk as well as offering professional bodies in affected countries their solidarity and any practical help which might be feasible.
- Nursing bodies should encourage nurses and midwives to view their work within a framework of promoting the human rights of patients and should make nurses aware of the UN Declaration on Human Rights Defenders

8.4 To nurse educators

8.4.1 Human rights and nursing ethics

- National nursing associations and nurse and midwife educators should audit the human rights and ethics content of teaching courses and ensure that basic concepts of human rights and nursing ethics are given adequate space in training programs.
- As health and reproductive technologies and techniques advance, new ethical questions will be raised. It is important that nursing ethics be kept constantly under review to respond to developments. Particular attention should be given to ethical and human rights aspects of sexual and reproductive health.
- Professional and human rights training should be made more available throughout a nurse's or midwife's career.
- Ensure that the advocacy role of nurses and midwives and the monitoring of human rights violations are addressed in teaching courses.
- Educators should develop links with health organizations and stimulate and contribute to training programmes and research on subjects such as the effects of economic globalisation on the right to health.
- Nurse educators can contribute to writing academic articles on nursing and human rights and encourage engagement with the periodic monitoring of human rights by the UN bodies.

8.5 To individual nurses and midwives

Nurses are frequently the first contact point for the patient in the health care system. This means that they can witness the effects of human rights violations on individuals and the

effects these have on families and communities.. Individual nurses can play an important role in affirming the rights of the individual patient; can breathe life into the ethics of the nursing profession; and can contribute to the strengthening of the nursing role in civil society. In particular, nurses can articulate the links between health and human rights and advocate for more effective health care services. Nurses should be encouraged to engage in the study of human rights and implement a rights-based approach to health care.

Appendix 1

A1. Key international nursing ethics and policy statements

A1.1 International Council of Nurses⁴³¹

Abuse and Violence against Nursing Personnel, 2000. Available at:

<http://www.icn.ch/psviolence00.htm>

Armed Conflict: Nursing's Perspective, 1999. Available at: <http://www.icn.ch/psarmed.htm>.

Nurses and Human Rights, 1998. Available at: <http://www.icn.ch/pshumrights.htm>.

Rights of Children, 2000. Available at: <http://www.icn.ch/pschildrights00.htm>.

Torture, Death Penalty and Participation by Nurses in Executions, 1998.

<http://www.icn.ch/pstorture.htm>.

A1.2 International Confederation of Midwives⁴³²

Debt cancellation and other economic policies that affect health and especially safe motherhood, 2002. Available at: [http://www.internationalmidwives.org/Statements/Debt cancellation and other economic policies that affect health and safe motherhood.pdf](http://www.internationalmidwives.org/Statements/Debt%20cancellation%20and%20other%20economic%20policies%20that%20affect%20health%20and%20safe%20motherhood.pdf).

Female genital mutilation, 1999. Available at:

<http://www.internationalmidwives.org/Statements/Female%20genital%20mutilation.pdf>.

Midwives and the abuse of women and children, 2002. Available at:

[http://www.internationalmidwives.org/Statements/Midwives and the abuse of women and children.pdf](http://www.internationalmidwives.org/Statements/Midwives%20and%20the%20abuse%20of%20women%20and%20children.pdf).

Women, Children and Midwives in Situations of War and Civil Unrest, 1999. Available at:

<http://www.internationalmidwives.org/Statements/War%20and%20Civil%20Unrest.htm>.

⁴³¹ The International Council of Nurses (ICN) is a federation of national nurses' associations representing nurses in 128 countries. The ICN was founded in 1899 and is the widest reaching international organisation for health professionals. Its head office is located in Geneva.

⁴³² The International Confederation of Midwives (ICM) currently has 83 members – all autonomous midwifery associations – from 70 countries in four regions: Africa, Asia Pacific, the Americas and Europe. Each member association sends delegates to the ICM Council, which is the Confederation's overall governing body. The ICM's head office is located in The Hague.

Appendix 2. Health rights in international and regional human rights standards

A2.1 International standards

A2.1.1 Universal Declaration of Human Rights⁴³³

Article 25.

(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

A2.1.2 International Covenant on Economic, Social and Cultural Rights⁴³⁴

Article 7

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work which ensure, in particular:

- (a) remuneration which provides all workers, at a minimum, with:
 - (ii) a decent living for themselves and their families in accordance with provisions of the present Covenant
- (b) safe and healthy working conditions;

Article 10

(3) ... Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

⁴³³ Full text available at: <http://www.un.org/Overview/rights.html>.

⁴³⁴ Full text available at: Available at: http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

A2.1.3 Convention on the Rights of the Child⁴³⁵

Article 3

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health.

Article 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

⁴³⁵ Full text available at: <http://www.unhchr.ch/html/menu3/b/k2crc.htm>.

2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.

Article 24

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

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

- (a) To diminish infant and child mortality;
- (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- (d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

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

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

Article 32

1. States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.

Article 37

States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment. Neither capital punishment nor life imprisonment without possibility of release shall be imposed for offences committed by persons below eighteen years of age;

Article 39

States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

A2.1.4 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 436

Article 1

For the purposes of the ... Convention, the term “discrimination against women” shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 10

States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: [...]

- (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

- (b) To have access to adequate health care facilities, including information, counselling and services in family planning;

A2.1.5 Convention on the Elimination of All Forms of Racial Discrimination⁴³⁷

Article 5

⁴³⁶ Full text available at: <http://www.ohchr.org/english/law/pdf/cedaw.pdf>.

⁴³⁷ Full text available at: http://www.unhchr.ch/html/menu3/b/d_icerd.htm.

In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...]

(b) The right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual group or institution; [...]

(e) Economic, social and cultural rights, in particular: [...]

(iv) The right to public health, medical care, social security and social services;

A2.1.6 Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment⁴³⁸

Principle 22

No detained or imprisoned person shall, even with his consent, be subjected to any medical or scientific experimentation which may be detrimental to his health.

Principle 24

A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

Principle 25

A detained or imprisoned person or his counsel shall, subject only to reasonable conditions to ensure security and good order in the place of detention or imprisonment, have the right to request or petition a judicial or other authority for a second medical examination or opinion.

A2.1.7 Standard Minimum Rules for the Treatment of Prisoners⁴³⁹

22. (1) At every institution there shall be available the services of at least one qualified medical officer who should have some knowledge of psychiatry. The medical services should be organized in close relationship to the general health administration of the community or nation. They shall include a psychiatric service for the diagnosis and, in proper cases, the treatment of states of mental abnormality.

(2) Sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals. Where hospital facilities are provided in an institution,

⁴³⁸ Full text available at: http://www.unhchr.ch/html/menu3/b/h_comp36.htm

⁴³⁹ Full text available at: http://www.unhchr.ch/html/menu3/b/h_comp34.htm.

their equipment, furnishings and pharmaceutical supplies shall be proper for the medical care and treatment of sick prisoners, and there shall be a staff of suitable trained officers.

(3) The services of a qualified dental officer shall be available to every prisoner.

23. (1) In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment. Arrangements shall be made wherever practicable for children to be born in a hospital outside the institution. If a child is born in prison, this fact shall not be mentioned in the birth certificate.

(2) Where nursing infants are allowed to remain in the institution with their mothers, provision shall be made for a nursery staffed by qualified persons, where the infants shall be placed when they are not in the care of their mothers.

24. The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all necessary measures; the segregation of prisoners suspected of infectious or contagious conditions; the noting of physical or mental defects which might hamper rehabilitation, and the determination of the physical capacity of every prisoner for work.

25. (1) The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.

(2) The medical officer shall report to the director whenever he considers that a prisoner's physical or mental health has been or will be injuriously affected by continued imprisonment or by any condition of imprisonment.

26. (1) The medical officer shall regularly inspect and advise the director upon:

- (a) The quantity, quality, preparation and service of food;
- (b) The hygiene and cleanliness of the institution and the prisoners;
- (c) The sanitation, heating, lighting and ventilation of the institution;
- (d) The suitability and cleanliness of the prisoners' clothing and bedding;
- (e) The observance of the rules concerning physical education and sports, in cases where there is no technical personnel in charge of these activities.

(2) The director shall take into consideration the reports and advice that the medical officer submits according to rules 25 (2) and 26 and, in case he concurs with the recommendations made, shall take immediate steps to give effect to those recommendations; if they are not within his competence or if he does not concur with them, he shall immediately submit his own report and the advice of the medical officer to higher authority.

33. Instruments of restraint, such as handcuffs, chains, irons and strait-jacket, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:

- (a) As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;

- (b) On medical grounds by direction of the medical officer;
(c) By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority. [...]

62. The medical services of the institution shall seek to detect and shall treat any physical or mental illnesses or defects which may hamper a prisoner's rehabilitation. All necessary medical, surgical and psychiatric services shall be provided to that end. [...]

82. (1) Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.
(2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management.
(3) During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.
(4) The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

83. It is desirable that steps should be taken, by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care. [...]

91. An untried prisoner shall be allowed to be visited and treated by his own doctor or dentist if there is reasonable ground for his application and he is able to pay any expenses incurred.

A2.1.8 Geneva Conventions

The Geneva Conventions contain detailed information about the rights and obligations of health personnel in conflict. The four Geneva Conventions (GC) of 1949 make numerous references to health and to medical personnel. They are:

- Convention (I) for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949.
- Convention (II) for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea. Geneva, 12 August 1949.
- Convention (III) relative to the Treatment of Prisoners of War. Geneva, 12 August 1949.
- Convention (IV) relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949.⁴⁴⁰

⁴⁴⁰ The full text of all four Conventions is available at the web-site of the International Committee of the Red Cross: <http://www.icrc.org/ihl.nsf/WebCONVFULL?openview>. Accessed 18 August 2005.

GC I, for example, states at article 3 that “The wounded and sick shall be collected and cared for.” (The same article is found in the other three Conventions.). A section on personnel (starting at article 24) deals extensively with health care personnel. Article 36 and subsequent articles deal with medical transport. The other three GCs also contain provisions relating to health personnel and health care.

A2.2 Health rights in regional treaties and declarations

A2.2.1 African [Banjul] Charter on Human and Peoples' Rights⁴⁴¹

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States Parties to the present 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.

A2.2.2 Additional Protocol to the American Convention in the Area of Economic, Social and Cultural Rights (“Protocol of San Salvador”)

Article 10 Right to Health

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
 - a. Primary health care, that is, essential health care made available to all individuals and families in the community;
 - b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
 - c. Universal immunization against the principal infectious diseases;
 - d. Prevention and treatment of endemic, occupational and other diseases;
 - e. Education of the population on the prevention and treatment of health problems, and
 - f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

⁴⁴¹ Full text available at: [http://www.africa-union.org/Official_documents/Treaties %20Conventions %20Protocols/Banjul%20Charter.pdf](http://www.africa-union.org/Official_documents/Treaties%20Conventions%20Protocols/Banjul%20Charter.pdf).

A2.2.3 Revised Arab Charter on Human Rights

(Adopted by the Summit of the League of Arab States in May 2004; yet to come into force)

Article 38

Every person has the right to an adequate standard of living for himself and his family, that ensures their well-being and a decent life, including food, clothing, housing, services and the right to a healthy environment. The States parties shall take the necessary measures commensurate with their resources to guarantee these rights.

Article 39

(a) The States parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the right of the citizen to free basic health-care services and to have access to medical facilities without discrimination of any kind.

(b) The measures taken by States parties shall include the following:

1. Development of basic health-care services and the guaranteeing of free and easy access to the centres that provide these services, regardless of geographical location or economic status;
2. Efforts to control disease by means of prevention and cure in order to reduce the mortality rate;
3. Promotion of health awareness and health education;
4. Suppression of traditional practices which are harmful to the health of the individual;
5. Provision of basic nutrition and safe drinking water for all;
6. Combating environmental pollution and providing proper sanitation systems;
7. Combating smoking and abuse of drugs and psychotropic substances.

Article 34 (b)

Every worker has the right to the enjoyment of just and favourable conditions of work which ensure ... as well as the rules for the preservation of occupational health and safety and the protection of women, children and disabled persons in the place of work.

Article 40

(c) The States parties shall take all necessary measures to curtail the incidence of disabilities by all possible means, including preventive health programmes, awareness raising and education.

Appendix 3: Useful Websites

Organisation	Website
<i>Amnesty International (AI)</i>	http://www.amnesty.org
<i>Human Rights Education Association (HREA)</i>	http://www.hrea.org
<i>Human Rights Watch</i>	http://www.hrw.org
<i>International Association of Forensic Nurses</i>	http://www.forensicnurse.org/
<i>International Confederation of Midwives (ICM)</i>	http://www.internationalmidwives.org
<i>International Council of Nurses (ICN)</i>	http://www.icn.ch
<i>International Federation of Health and Human Rights Organizations (IFHHRO)</i>	http://www.ifhhro.org
<i>International Labour Organization</i>	http://www.ilo.org/
<i>International Rehabilitation Council for Torture Victims (IRCT)</i>	http://www.irct.org
<i>Physicians for Human Rights (PHR)</i>	http://www.phrusa.org
<i>United Nations (UN)</i>	http://www.un.org
<i>UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Health</i>	http://www.ohchr.org/english/issues/health/right/
<i>World Health Organization (WHO)</i>	http://www.who.int

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