INTEGRATING A HEALTH RIGHTS PERSPECTIVE INTO HEALTH CARE PROFESSIONAL TRAINING AND SERVICE

PAPER PREPARED FOR COLLOQUIUM ON "EXPLORING A RESEARCH AGENDA FOR THE CO-PRODUCTION OF KNOWLEDGE REGARDING HEALTH, SAFETY AND JUSTICE IN AFRICA"

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I INTRODUCTION

The premise of this paper is that both international law's and South African law's legal recognition of the right to the highest attainable standard of mental and physical health has implications for the perspective with which health care professionals engage in the process of health care services provision.[1] Perspective as used herein refers to the knowledge, attitudes, methods and approaches which health care professionals (HCPs) possess and apply in the provision of health care services.[2] A "health rights perspective" is discernible from and indicated by the plethora of rights that can collectively be referred to as "health rights". I refer to "health rights" because the concern with the individual's and society's health also concerns other human rights, other than the right to the highest attainable standard of mental and physical health (the right to health).

Other rights guaranteed in international human rights law and in the South African Constitution also have impact to the concern with man and society's health. These rights include the right to life; the right to dignity; the right to freedom from cruel, inhuman and degrading treatment; the right to security of the person; the right to a

[1] The right to health is given legal recognition at the international level in the Universal Declaration of Human Rights [Article 25]; the International Covenant on Economic, Social and Cultural Rights [Article 12]; International Convention on the Elimination of All Forms of Racial Discrimination [Article 5(e)(iv)]; Convention on the Elimination of All Forms of Discrimination Against Women [Article 11(1)(f)]; Convention on the Rights of the Child [Article 24]; Convention on the Rights of Persons With Disabilities [Article 25] and the International Convention on the Rights of All Migrant Workers and Members of Their Families [Article 28]. In South Africa Article 27(1)(a) and Article 27(3) give legal recognition to the right to health.

[2] See HPCSA *Core Competencies for Undergraduate Students in Clinical Associate, Dentistry and Medical Teaching and Learning Programmes in South Africa* referring to "knowledge, skills, attitude and character" at p. 2.

healthy environment; and the right of persons subject to any form of detention to conditions of detention consistent with human dignity, including medical treatment.

In this paper I make a general distinction between three clusters of rights which are of application to the health care service context, and which inform the nature and principles of the health rights perspective.[3] The three clusters comprise of:
(a) patients' rights which are primarily concerned with safeguarding the patient's autonomy, physical integrity, privacy and dignity in the context of health service provision;
(b) the health care professional's rights which are concerned with safeguarding the freedoms of the HCP and protecting his life, dignity, physical and moral integrity, and labour rights in the course of pursuing health care services delivery;
(c) the rights which impose positive obligations on the State to provide equitable, accessible and quality health care services to its population, and their specific impact to the nature and character of the HCP which is produced by the health education and training system and the manner in which the HCP pursues his service within the health care services context.

The concept of justice is elusive and is capable of being given various meanings in various concrete circumstances. For current purposes I concern myself with three dimensions of justice, which are derived from or related to the right to health:

- Accountability of the health care professional in the process of delivering health care services;
- Equitable provision of health care services; and
- Fairness of treatment for health care professionals.

The question of safety and justice in health care services provision is considered herein for how it impacts on the nature and content of the curriculum for the training

[3] In comparison refer to the Committee on Economic, Social and Cultural Rights' General Comment No. 14 in which the Committee refers to the fact that the right to health comprises of freedoms and entitlements. The Committee states: "The right to health contains both 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." [para. 8]

of HCPs and the manner in which the health education system prepares HCPs for their role in public health education. And also for the obligations that flow from it for HCPs, patients and the State.

II THE HEALTH RIGHTS PERSPECTIVE AND ITS IMPLICATIONS TO HEALTH CARE SERVICES PROVISION

The health rights perspective I am referring to can be defined as the approach, methodology and provision of health services by the making of the assumption that health care service as an activity is primarily aimed at the fulfilment of the right to the highest attainable standard of mental and physical health generally, and the promotion and protection of human rights, particularly those human rights aimed at safeguarding and enhancing the individual's and society's state of health. In this perspective the health system with its multitude of laws, powers, rights and duties conferred on those who administer it and HCPs is legitimised by reference to how it serves to safeguard and enhance the attainment of the highest attainable standard of mental and physical health by both individuals and society. Clearly this should impact on the manner in which we engage in the process of health care service delivery, and also the manner in which HCPs are trained and the manner in which they provide health care services.

It has to be considered that the individual and society's state of health, and the state of healthiness of the environment in which the individual and the community live are critical to the pursuit and attainment of the purposes of life. Hence the protection of these rights as legally guaranteed rights. Furthermore in terms of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) the State bears the obligation to progressively realise the right to the highest attainable standard of mental and physical health. The attainment of this right is the objective of the World Health Organisation (WHO), as stated in its Constitution.[4]

The centrality of health to pursuit of life and its purposes also implies that the individual has the responsibility for the promotion of his own health and that of

[4] Preamble to the Constitution of the World Health Organisation, 1946.

society, and also to the protection of the environment, or at least certainly to desist from acts that degrade and/or impair the environment.

The question of legitimacy of the health care system also has to be considered in light of the powers that laws and regulations confer on the qualified HCP in respect of the life, physical and mental integrity of the patient, particularly when issues such as the administration of medicines and related substances and involuntary medical treatment procedures are considered. Thus to me the perspective of the HCP, which comprises of his knowledge, attitude, approach and methods, must be legitimate, reasonable and justifiable. And as I try to illustrate in this paper the health rights normative framework serves the purpose of enhancing legitimacy and reasonableness.

When viewed from the perspective of how health systems serve the purpose of fulfilling the right to health the State's obligations to invest in human resources development for health is emphasised. The health rights perspective further serves to shape the manner in which human resources for health (HRH) are allocated and governed. The prime health rights obligation which impacts on the State's regulation of health education is that the State has an obligation to ensure that it provides acceptable and quality health care services to its population.[5] The Committee on Economic, Social and Cultural Rights (CESCR) has defined quality health care services as scientifically and medically appropriate and those of good quality, which includes skilled medical personnel.[6]

[5] It must be considered that the concern with appropriate and quality education and training is also mandated by the right to education. In this regard the two elements of acceptability and adaptability that are part of the right to education have particular implications to the concern with the nature of health education for HCPs. In respect of adaptability of education the CESCR has said that "education has to be flexible so it can adapt to the needs of changing societies and communities and respond to the needs of students within their diverse social and cultural settings. [Para. 6(c) and (d) of General Comment No. 13 of the Committee on Economic and Social Rights (CESCR) entitled *Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to Education (Article 13 of the Covenant)*].

[6] See para. 12(d) of General Comment No. 14 of the Committee on Economic, Social and Cultural Rights entitled *Substantive Issues Arising In The Implementation of the International Covenant on Economic, Social and Cultural Rights: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)* E/C.12/2000/4 [hereinafter referred to the "CESCR General Comment No. 14"].

III THE NORMATIVE FRAMEWORK FOR SAFETY AND JUSTICE IN HEALTH CARE SERVICES TRAINING AND DELIVERY

The South African Bill of Rights, various legislation and the common law provide a normative framework that mandates the concern with safety and justice in the context of health care services training and delivery. Below I deal briefly with each of these normative frameworks in turn as they pertain to safety and justice in the health services provision and delivery context.

Some of the questions to consider in understanding the nature and content of the legal obligations pertaining to safety and justice borne by health care professionals can only be properly understood by reference to the status of HCPs in the current constitutional framework. In general it can be said that HCPs can occupy one or more of the following status in the constitutional framework:

- Functionaries of State who exercise public power;
- Members of the executive branch of government;
- Members of the public service;

It must also be considered that they can bear obligations in terms of the Bill of Rights if the Bill of Rights must/should/can be applied horizontally.

III-1 The Constitutional Normative Framework Mandating Safety and Justice in Health Care Services Provision

(a) Human Rights Norms

The following is a list of human rights provisions from the Bill of Rights which mandate the concern with safety and justice in the provision of health care services:

(i) the right to equality before the law and equality of treatment; and the prohibition of unfair discrimination on any of the listed grounds or other status [Section 9];

(ii) the right of everyone to have their dignity respected and protected [Section 10];

(iii) the right to life [Section 11];

(iv) the right to security of the person, which comprises of the following elements:

- the right to be free from all forms of violence from either public or private sources [Section 12(1)(c)];
- the right not to be tortured in any way [Section 12(1)(d)];

- the right not be treated or punished in a cruel, inhuman or degrading way [Section 12(1)(e)];

(v) the right to bodily and psychological integrity, which comprises of the following elements:

- the right to make decisions concerning reproduction [Section 12(2)(a)];
- the right to security in and control over their body [Section 12(2)(b)];
- the right not to be subjected to medical or scientific experiments without their informed consent [Section 12(2)(c)];

(vi) the right to privacy [Section 14];

(vii) the right to freedom of conscience, religion, thought, belief and opinion [Section 15(1)];

(viii) the right to academic freedom and freedom of scientific research [Section 16(1)(c)];

(ix) freedom of trade, occupation and profession [Section 22];

(x) the right to fair labour practices [Section 23(1)];

(xi) the right to an environment that is not harmful to their health or well-being [Section 24(a)];

(xii) the right of everyone to have access to health care services, including reproductive health care services [Section 27(1)(a)];

(xii) the right not to be refused emergency medical treatment [Section 27(3)];

(xiii) every child's right to basic health care services [Section 28(1)(c)];

(xiv) every child's right to be protected from maltreatment, neglect, abuse or degradation [Section 28(1)(d)];

(xv) the child's right to best interests consideration in every matter concerning the child [Section 28(2)];

(xvi) the right to further education [Section 29(1)(b)];

(xvii) the right of persons belonging to cultural, religious and linguistic communities not to be denied the right to enjoy their culture, practice their religion or use their language [Section 31(1)(a)];

(xviii) the right of access to information [Section 32];

(xix) the right to administrative justice that is fair, lawful and reasonable [Section 33];

(xx) the right of every detained person to conditions of detention that are consistent with human dignity, including the provision at State expense of medical treatment [Section 35(2)(e)].

The above list of rights affects the manner in which health care services are delivered. And as I argue here should inform the nature and content of the knowledge, methods and approaches generated and applied in the health context. Of prime importance for our purposes is how these rights impose obligations on HCPs, the State, individuals and society generally, and thus the manner in which they pursue the provision of health care services. The above listed rights operate in an intersectional manner in that they impose corresponding rights and obligations on actors in the health context and they govern varying aspects of the health care services provision context. Some clearly address concerns with safety, others are concerned with attaining just and equitable outcomes.

(b) Principles Applicable to Public Administration

Chapter 10 of the Constitution deals with the manner in which the public administration should be conducted, including those components of the public administration which have responsibility for health care services delivery and administration. Importantly section 195 provides a list of basic values and principles that govern the public administration. The text of section 195 provides as follows:

Basic values and principles governing public administration

195. (1) Public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles:

(a) A high standard of professional ethics must be promoted and maintained.

(b) Efficient, economic and effective use of resources must be promoted.

(c) Public administration must be development-oriented.

(d) Services must be provided impartially, fairly, equitably and without bias.

(e) People's needs must be responded to, and the public must be encouraged to participate in policy-making.

(f) Public administration must be accountable.

(g) Transparency must be fostered by providing the public with timely, accessible and accurate information.

(h) Good human-resource management and career-development practices, to maximise human potential, must be cultivated.

(i) Public administration must be broadly representative of the South African people, with employment and personnel management practices based on ability, objectivity, fairness, and the need to redress the imbalances of the past to achieve broad representation.
(2) The above principles apply to-
(a) administration in every sphere of government;
(b) organs of state; and
(c) public enterprises.

In similar vein to the human rights provisions these basic values and principles affect the manner in which HCPs pursue the provision of health care services. Thus HCPs must be conscious of these values and principles when pursuing their official activities. Below I deal with the question of how curricula can be designed in a manner that facilitates for HCPs to acquire the necessary knowledge, skills and mentality to comply with and fulfil these basic values and principles.

III-2 Statutory Provisions Concerned with Safety and Justice in Health Care Services Provision

The primary statutes governing the health care profession are:

- Medicines and Related Substance Act, 1965;
- Health Professions Act, 1974;
- National Health Act, 2003;
- Nursing Act, 2005;
- Traditional Health Practitioners Act, 2007.

Various regulations, rules, proclamations and notices have also been passed in terms of these statutes. Important aspects concerned with the nature of HCP training, safety and justice in the health care context, which are governed by legislation include the following:

- Ethical rules of conduct for HCPs;
- The minimum requirements entitling persons to be registered and practice as HCPs;
- Conditions for the keeping, sale and administration of medicines and related substances;
- Guidelines on adverse drug reactions;

- Regulations on community service;
- Procedures for dealing with involuntary health care and treatment.

Consider that in terms of legislation procedures have also been laid down for the processing of complaints against HCPs by patients and members of the public. The statutes and legislation that are concerned with education services also have some application to the provision of health education and training.

III-3 Delictual Liability

At common law health care practitioners can be held liable for delictual damages in respect of their professional actions. Generally the common law delictual action imposes an obligation on HCPs to act with due or reasonable skill, care and diligence in the performance of their duties. The failure to do so resulting in death or injury to a patient can result in delictual liability. In some cases this liability has been extended to instances where the HCP fails to warn the patient of the risks attendant in the medical procedure or treatment.

III-4 The National Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17

The current framework regulating the provision of nurse training is in part governed by *The National Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17* (hereinafter the "Nursing ECT Plan"). The stated purpose of the Nursing ECT Plan is to "develop, reconstruct and revitalise the profession to ensure that nursing and midwivery practitioners are equipped to address the disease burden and population needs within a revitalised healthcare system in South Africa".[7] To this effect the Nursing ECT Plan sets a set of strategic objectives in relation to the nursing profession generally, some of which are of specific relevance to the subject of this paper *viz:*

- nursing education and training;
- professional ethics within the nursing profession;
- governance, leadership, legislation and policy;
- positive practice environments;

[7] *The Strategic Plan for Nurse Education, Training and Practice 2012/13 – 2016/17* at p. 17.

- compensation, benefits and conditions of service.

I have presumed that the University of Pretoria's Faculty of Health Sciences colloquium on "Exploring A Research Agenda for the Co-production of Knowledge Regarding Health, Safety and Justice in Africa", for which this paper is prepared, is in part a reaction to the Nursing ECT Plan and other policy developments concerned with the nature of HCP education in South Africa. The most significant objective outlined in the Nursing ECT Plan pertains to introduction of a component on professional ethics, which must include human rights, into the nursing profession training curriculum. Thus I have also considered the health rights perspective proposed in this paper in light of how it will impact on these policy initiatives by the National Department of Health.

IV KEY PRINCIPLES OF THE HEALTH RIGHTS PERSPECTIVE

The manner in which I have approached the subject is through the policy statements of the World Health Organisation (WHO), particularly on health care professional training and public health education; and the interpretative statements of the Committee on Economic, Social and Cultural Rights (CESCR) in interpreting Article 12 of the ICESCR. Other treaty bodies tasked with the interpretation of other rights with relevance to the health context have not been consulted for the research on this paper, except where these sources were already known to the author.

It is clear that because the WHO approaches health matters from the perspective that they should result in fulfilment of the right to health, the concern with the right to health should reflect in the policies that the WHO recommends for health. In this respect it is important to highlight the resolutions, policy documents and manuals adopted by the WHO, either through the Executive Board, the World Health Assembly, Expert Committees and other researchers in the area of health education. Annex A hereto provides an index of these documents.

Generally the WHO has focused on two particular aspects of significance to the subject. The first is generally the subject of health education of the public and then the issue of health care professional education, both of which are to a large extent

related. Of particular significance here is that HCPs are the prime agents for the implementation of public health education programmes.

From an overview study of the WHO's work in this area and by general deduction from the normative content of the right to health I have extracted a set of principles which comprise the "health rights perspective". These principles to me affect and impact on the manner in which HCPs are trained and the manner in which they carry out the provision of health care services, particularly their role as public health educators.

The right to health generally imposes obligations on States to ensure the availability, accessibility, acceptability and provision of quality health care services to their populations. Thus the principles outlined seek to concretise the elements of availability, accessibility, acceptability and quality of health care services (into a health care professionals' perspective).

Availability entails that the State take measures to ensure that there are sufficient health care facilities, goods, services and programmes within the State's territory.[8] And importantly for our purposes it entails that the State ensure that the human resources necessary for an effective health system are available. This includes both that there be HCPs of a sufficient quantity and that they possess the necessary knowledge and skills (trained medical and professional personnel).

The right to health's accessibility element entails that health facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions – non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility.[9] The acceptability element entails that health facilities, goods and services must be respectful of medical ethics and be culturally appropriate, which implies that they be designed to respect confidentiality and improve the health status of those concerned.[10]

[8] Para. 12(a) of the CESCR's General Comment No. 14.
[9] Para. 12(b) of the CESCR's General Comment No. 14.
[10] Para. 12(c) of the CESCR's General Comment No. 14.

The CESCR states that the quality element of the right to health implies that: "…, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[11] It is primarily this quality dimension to the right to health which impacts on the nature and content of the health education of HCPs.

The CESCR has also specifically articulated the following legal obligations on States having significance to the concern with HCP training and manner of service; and public health education:

- The duty to respect the right to health implies that States must refrain from withholding or intentionally misrepresenting health-related information (or information vital to health protection or treatment), including sexual education and information[12];
- The States' duty to protect the right to health also entails the obligation to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct[13];
- The States' obligations to fulfil include the obligation to ensure the appropriate training of doctors and other medical personnel. And also the promotion of medical research and health education.[14] The State must also ensure that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups. The State must also ensure the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services. The State must also support people in making informed choices about their health.[15]

[11] Para. 12(d) of the CESCR's General Comment No. 14.
[12] Para. 9 and 50 of the CESCR's General Comment No. 14.
[13] Para. 35 of the CESCR's General Comment No. 14.
[14] Para. 36 of the CESCR's General Comment No. 14.
[15] Para. 37 of the CESCR's General Comment No. 14.

Importantly the CESCR has emphasised that though States are ultimately accountable for compliance with the obligations stemming from Article 12 of the ICESCR HCPs are among the groups and individuals who have "responsibilities" regarding the realization of the right to health. The States Parties must ensure an environment which facilitates for the discharge of these responsibilities.[16]

Among the key principles of the health rights perspective are the following:

(i) Respect for the rights of the patient

The most important rights that are often implicated or come into conflict with other interests and imperatives in the health context are the physical security and privacy rights of the patient. In general this principle requires that HCPs practice in such a manner that they respect the patient's rights to dignity, bodily integrity and privacy (confidentiality). Of particular significance is how HCPs relate to these rights in the context of administration of medicinal and related substances and involuntary medical treatment such as mental health detention and quarantine. Privacy interests are implicated in which HCPs deal with patients' health records or information in their possession.

The nature of the legislative framework is such that in certain instances within the health care service delivery context HCPs are called upon to make assessments of whether particular actions by them in fact show the due respect for the rights of patients. The health rights perspective will facilitate for HCPs to be able to make correct judgments. It should be considered that most of these actions will seldom be subjected to further scrutiny by the courts or other authorities. A most immediate example of this is when HCPs are called upon to determine whether they have provided the patient with sufficient information in order for the patient to give informed consent for the performance of a medical procedure.

(ii) Integration of principles concerned with fair labour practices and safe conditions of service for HCPs

The essential nature of health care services can often create the possibility that the labour rights of HCPs are placed in jeopardy, in order to advance the population's

[16] Para. 42 of the CESCR's General Comment No. 14.

health care needs. The concern is with ensuring HCPs their right to fair labour practices. To me the issue is that HCP training must facilitate for self and group advocacy by HCPs of their rights, thus they need to be made aware of their rights in order to protect and enforce them. But they must also do so in a conscientious manner, having regard to the essential nature of health care services.

(iii) Practical, scientifically sound and socially acceptable methods and technology

During the 1970s the UN identified that drastic advances in science and technology pose a significant threat to the life, health and human rights of man, and particularly in the health context. Even to present times rapid advances in technology pose a danger to man. This danger operates alongside the vast advantages that scientific and technological advances offer to man and society. Thus the concern is with mediating these tensions through striking a perfect balance. The nature of medical methods and technology is one of the prime reasons for enforcing a human rights-based engagement within the health context. Consider that in respect of the right to health this aspect is covered by the element of the right which is concerned with the quality and acceptability of health care facilities, goods and services.

The WHO has emphasised the "extensive application in every country of the results of progress in world medical research and public health practice, with a view to ensuring conditions that will make it possible to obtain maximum effectiveness from all health measures taken".[17]

(iv) Duties on the State and HCPs to uphold the status, integrity and independence of the health care profession

This principle must be considered particularly in light of how the public's perception of HCPs impacts on their ability to fulfil their role as public health educators. This role indicates the need for both integrity on the part of HCPs and their ability to command the attention of their target audiences.

[17] WHO Executive Board *Health Aspects of Human Rights In The Light of Scientific and Technological Developments* EB55/41 (Fifty-Fifth Session – 5 December 1974) at p. 5.

This principle also has the effect of causing concern with the traditional bases for the ethical pursuit of the health care profession, such as those contained in the Hippocratic Oath and the ethical principles outlined by the World Medical Association and the International Council of Nurses.

Emphasis on the independence of the health profession is relevant to the manner in which the State treats them. Of particular importance is that HCPs should be able to exercise their professional discretion in carrying out their duties without regard to the State's views or opinion, but rather based on medical criteria. Independence is particularly important to circumstances where HCPs have the role and responsibility of protecting the rights of patients, in contexts such as treatment of prisoners of war and other persons subject to any form of detention, particularly in monitoring norms aimed at prohibiting torture and other forms of cruel, inhuman or degrading treatment or punishment.

(v) A commitment to patient safety

The concern with patient safety arises because of the occurrence of harm and adverse reactions for patients in the course of medical treatment, which is in part attributable to the quality of the knowledge and skills of medical practitioners, the existence of safeguards and the evolving nature of medical knowledge and technology. In this regard the WHO has compiled a *Patient Safety Curriculum for Medical Schools* in order to integrate patient safety principles into HCP training and thus practice.

(vi) Promotion and furtherance of equitable provision health care services

Inequities in levels of enjoyment of the highest standard of health has been identified as a world problem in need of resolution. In general the right to health's non-discrimination and equality of treatment elements mandate the concern with equitable provision of health care services. In respect of the State this principle impacts on the manner in which the State regulates the curricula that is taught in HCP training institutions. In respect of HCPs the principle impacts on the attitude with which they engage in the process of health care service delivery. My libertarian instincts forbid me adopting the position taken by the South African government to mandate compulsory community service for HCPs. But seemingly the concern with

equitable provision of health care services may justify such measures once States decide to implement them.

However I believe that the HCPs' interaction with humanist philosophy, and its human rights concretisation, will incline the HCP to an appreciation of the ills of inequities in health status. This principle is enshrined in documents that advocate for "health for all" and "universal health coverage for all" such as the Alma-Ata Declaration, 1978 and the Millennium Declaration. A related subject is how the concern with civic responsibility impacts on the HCPs perception of his role in health care service delivery. The hope is that an understanding and appreciation of the right to health and its implications by HCPs will incline them towards a voluntary concern with eradication of health problems and the attainment of equal enjoyment of the highest standard of mental and physical health.

(vii) Promotion and furtherance of health education of the public

The right to health also has as an element the duty of the State to promote and further health education for the public.[18] In this regard the most important factor is that HCPs must be considered to be critical agents, if not the primary agents, in the implementation of public health education and information programmes. Thus their education and training must include components which facilitate for their ability to render public health information and education services. The general objective of public health education should be to gain the confidence of the population covered and the people's skills in planning action at the local level. The emphasis is on their provision of public health information and education which facilitates for the prevention of diseases or the deterioration of the health of the population.

There are also concerns with ensuring the integrity of the health information and education which the State transmits and disseminates. In this regard the CESCR has emphasised that it is a violation of the right to health for States to "withhold or intentionally misrepresent health-related information, including sexual education and

[18] Health education is recognized as an essential element of primary health care (PHC). Article 7(3) of the *Declaration of Alma-Ata on Primary Health Care* provides that: "Primary health care: (3) includes at least: education concerning the prevailing health problems and the methods of preventing and controlling them; …".

information.[19] Furthermore there is caution about the manner in which public health education is carried out, that it should not take a moralizing or sermonizing approach, but rather should be aimed at enabling people to make informed choices about their health-impacting behaviour.[20]

Public health education also emphasises the role of the individual in promoting and fulfilling his right to health. It should also be considered that health education is part of the education which is guaranteed by the right to basic education in section 29(1)(a) of the Bill of Rights. And it is indeed recommended practice that health education is integrated into primary and secondary school curricula.

(viii) The practice of preventive medicine

This principle is specifically referred to in Article 12(2) of the ICESCR[21] as one of the measures aimed at fulfilment of the right to health. In terms of this principle States must ensure that health education for HCPs and the public facilitates for the capacity to prevent diseases or the deterioration of health status. In this regard it is important to consider some of the theoretical discussions that have taken place at the WHO concerning the manner in which the concern with the practice of preventive medicine should be achieved through the medical curricula.

As this has is an old debate, which has been dealt with at the WHO since the 1950s, it is likely that this aspect is already significantly integrated in medical curricula. However as health is an evolving science there is always need for reconceptualization of the nature of preventive medicine. Of particular significance is the proliferation of popular literature on health, and the increasing availability of information through advanced information technology mediums. These have to be considered in light of their potential to facilitate the dissemination of both the correct and wrong information.

[19] Para. 34 of the CESCR's General Comment No. 14.
[20] WHO *Reports of Discussion Groups on New Policies for Health Education in Primary Health Care* A36/Technical Discussions/3 (06 May 1983) at p. 2.
[21] Article 12(1)(c) of the ICESCR provides that: "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: (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases."

The WHO policy documents suggest that preventive medicine should be an approach to the teaching of medicine, and it should be taught through the teaching of the preventive aspects of all the subjects in the curriculum.[22]

(ix) The practice of social medicine

Social medicine has been defined as "… the study of the relation of peoples' health and sickness to social conditions and forms of social organisations. It is the medicine of groups, societies, or larger populations. Its goal is to discover ways of living together in a society that will promote the health and development of individuals and groups and also how these ways can be attained".[23]

The practice of social medicine attunes the HCP to being able to not only address the isolated manifestation of disease but to also consider how the underlying determinants of health impact on the individual and society's state of health. This should impact on the manner in which HCPs are trained as well as the content of the medical curriculum.

(x) The attainment and maintenance of health systems' preparedness and responsiveness

This principle is concerned with ensuring that health systems are prepared to deal with the health challenges that face individuals and society. It also demands that health systems be able to respond to the population's health needs. The concern with attaining health system preparedness and responsiveness affects the type of medical knowledge and skills which HCPs must possess. It has been emphasised that medical practice should be "ahead" of, rather than "follow", social change.[24]

Because of the capacity of environmental processes to cause public health emergencies and the evolving nature of diseases the possibility arises of new types

[22] WHO *Education and Training of the Physician for the Preventive and Social Aspects of Clinical Practice* A16/Technical Discussions/6.Rev.1 (17 May 1963) at p. 13.
[23] A.T. Shousha *Education and Training of the Physician for the Preventive and Social Aspects of Clinical Practice* in A16/Technical Discussions/4 of 10 May 1963.
[24] World Health Organisation *Education and Training of the Physician for the Preventive and Social Aspects of Clinical Practice* Report of the Technical Discussions at the Sixteenth World Health Assembly A16/Technical Discussions/6.Rev.1, at p. 10.

of threats to health, thus there is also need for research into health questions in order to attain the greatest knowledge possible.

(xi) Consideration of special needs patients

Special needs patients include women, survivors of violent crimes, children, older persons and persons with disabilities. It has become an established norm of international human rights law that vulnerable and marginalized groups should enjoy special measures of protection from the State, and are also entitled to special measures of advancement.

In General Comment No. 14 the CESCR also emphasised particular principles applicable to the treatment of special needs patient in the context of health information and education. These can be summarised as follows:

- The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information[25];
- Children's access to child-friendly information about preventive and health-promoting behaviour and support to families and communities in implementing these practices[26];
- Adolescents should be provided an opportunity to acquire appropriate information in order to participate in decisions affecting their health and to build life-skills[27];

(xii) Accountability of HCPs

The concern here is with avoiding and penalising unlawful actions and acts violating human rights by HCPs in the process of health care service delivery. As I stated this is the first dimension of justice (corrective justice). As the nature of the context is that individuals are fallacious there is need for mechanisms and systems to be able to detect whether HCPs are performing their duties within the legal and ethical boundaries. The prime method for ensuring HCP accountability is through systems of record-keeping. Thus the administrative aspects of medical practice also have to be considered in medical curricula.

[25] Para. 21 of the CESCR's General Comment No. 14.
[26] Para. 22 of the CESCR's General Comment No. 14.
[27] Para. 23 of the CESCR's General Comment No. 14.

(xiii) Active participation of the community

The CESCR refers to the participation of the population in health-related decision-making at the community, national and international levels.[28] The CESCR emphasises that effective provision of health care services can only be assured if people's participation is secured by States.[29] Community participation also encompasses their participation in the provision of preventive and curative health care services, such as the organisation of the health sector.[30]

Knowledge on health matters should aim to empower the individual in order for him to be able to attain the highest attainable state of health, and thus to meaningfully engage in life and its purposes.

(xiv) Relevance of health knowledge and information

The knowledge transmitted to HCPs must be able to satisfy the health needs of the community. This principle also place emphasis on research by and continuing professional development of HCPs.

(xv) Development of a team work ethic in the provision of health care services

The nature of the public health delivery system is such that a wide variety of knowledge and skills is needed, which makes it unlikely, if not impossible, that an HCP can be possessed of all the necessary knowledge and skills to meet the health needs presented in a particular community, particularly in the public service. Thus inevitably there is need for HCPs to work in teams with diverse expertise. This requirement is also indicated by the nature of certain medical procedures which an individual HCP cannot perform alone.

V PRACTICAL APPLICATION OF THE HEALTH RIGHTS PERSPECTIVE IN HCP TRAINING AND SERVICE

In this section I consider how the health rights perspective can be practically integrated, applied and implemented in both health care services training and

[28] Para. 11 of the CESCR's General Comment No. 14, particularly in addressing the underlying determinants of health.
[29] Para. 55 of the CESCR's General Comment No. 14.
[30] Para. 17 of the CESCR's General Comment No. 14.

provision. I assume that to a large extent current medical practice and training reflects some of these principles. Despite this there arises concern with assessing to what extent current curricula reflects or fails to reflect these principles, in order to ensure equitable outcomes. That a professional ethics component is only being introduced now into nurse training is an indication that there is need for consideration of the question of integration of a health rights perspective into HCP training. Furthermore recent policy changes, indicated by situation analysis, cause the concern with reconsideration of curricula from the perspective of how they affect the concern with safety and justice in health care service delivery. Furthermore the Ebola crisis challenges the capacity of health care systems on the African continent to deal with public health emergencies.

Another important concern for practical implementation is that of the international character of the medical education that medical schools provide to medical students. Unlike disciplines such as law, which by their nature have predominantly a nationalist dimension, medicine is a universal science which implies that theoretically those who study it should be able to practice it everywhere without much adjustment. In discourse concerned with relevance of medical knowledge and health system responsiveness the question must be considered how medical training can attain this international character, in addition to addressing the local needs of the national population. Consideration of the State's international obligations to provide disaster relief and humanitarian assistance to other UN Member States impacts on the nature and content of health curricula.

V-1 HEALTH CARE PROFESSIONAL TRAINING

V-1.1 The Nature and Content of the Medical Curriculum

The most important point made by the WHO policy documents is that HCPs should be trained in order to prepare them for educating the public about health matters. This aspect reflects the ideological nature of medicine proposed by the WHO, that of social medicine, which primarily proposes a preventive form of medicine in which there is primary concern with the prevention of manifestation of health problems. Thus it is envisioned that medical practitioners will play a role in educating the public about health matters in order to further the prevention of diseases, or generally health problems.

The WHO also emphasises that medical education be capable of fulfilling the health needs of the population which the HCPs serve. This entails that medical education be relevant. It thus emphasises a practical engagement with the nature and type of health problems which affect the community which health care training is aimed at serving. Furthermore health education must facilitate for the health systems' preparedness and responsiveness in addressing the population's health needs, such as for e.g. the emergence of new diseases or public health emergencies.

The WHO approach to health emphasises the role that social factors play in causing health problems and in resolving them, or rather in fulfilling the right to health.[31] This is referred to as the "social determinants of health" or the "underlying determinants of health". The CESCR has specifically emphasised "access to health-related education and information, including on sexual and reproductive health" as some of the underlying determinants of health to be addressed.[32] Thus the suggestion is that medical education equip HCPs with the knowledge and skills to address the social determinants of health.

The WHO has also prepared a safety curriculum guide for medical schools. The aim of the guide is to ensure that patient safety principles are integrated into the medical curriculum.

The concern with justice in health probably entails that medical practitioners be made familiar with their ethical and legal obligations. This is an area of great complexity from the perspective that we don't mean that medical practitioners should study the full complement of legal studies. However it should be considered that legal aspects of medical practice are concerned with both the liability of medical practitioners and the enforcement of their rights and the protection of their interests.

[31] The Committee on Economic, Social and Cultural Rights in General Comment No. 14 states that: "… the express wording of Article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to underlying determinants of health, such as food and nutrition, housing, access to safe and portable water and adequate sanitation, safe and healthy working conditions, and a healthy environment." [para. 4]

[32] Para 11 of the CESCR's General Comment No. 14.

For instance medical practitioners inevitably become concerned with management of their private practices, which is a matter subject to highly technical regulation.

In the African context health care service delivery is fraught with the inequities and the underdevelopment problems and obstacles that afflict the continent. Thus questions of the social duty of medical practitioners arise. But more fundamentally the question is how medical practitioners are able to observe human rights standards in the provision of health care services, particularly the norm of non-discrimination. In General Comment No. 14 the CESCR emphasised equality of treatment in the implementation of the right to health and generally in respect of measures impacting on the enjoyment of the right to health.[33] Thus education and training of HCPs may have to be geared more towards the provision of primary and preventative health care which are aimed at benefitting a far larger part of the population rather than for e.g. expensive curative health services accessible to only a small, privileged section of the population.

Recent trends in public health discourse have also focused on the transformative nature of medical education and training. In a study by the Global Independent Commission in 2010 they make the recommendation that:

> "To advance third-generation reforms, the Commission puts forward a vision: all health professionals in all countries should be educated to mobilise knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams. The ultimate purpose is to assure universal coverage of the high-quality comprehensive services that are essential to advance opportunity for health equity within and between countries."[34]

V-1.2 Guidelines on the Technical Aspects of Curriculum Development, Implementation and Evaluation

In addition to addressing the nature and content of medical education the WHO documents also deal with the technical aspects of curriculum development, implementation and evaluation. It can be implied that the perspective through which

[33] Para. 19 of CESCR's General Comment No. 14.
[34] Julio Frenk *et al. Health Professionals for a New Century: Transforming Education to Strengthen Health Systems in an Interdependent World* The Lancet available online at Harvard University's DASH repository.

health care service is approached also implies something to the manner in which knowledge is produced/developed and transmitted. It seems locally medical training has to be aligned to the general outcomes based education policy, which includes the emphasis on critical reasoning and thinking skills.

Primarily emphasis is placed on evidence-based development of curriculum, which emphasises a research basis for the nature and content of the curriculum. This also emphasises that curricula be evaluated for whether they are achieving the outcomes which they are aimed to achieve. The CESCR referred to the value of compiling and analysing epidemiological evidence to the process of decision making and planning on health care.[35]

V-1.3 Application and Relevance of the Medical Curriculum to Specific Areas of Public Health

As in most societies, in South Africa the most immediate subject of any public health education programmes is sexual and reproductive health. With the prevalence of sexually transmitted diseases there is an ever increasing need for reliable and accurate public health information and education on the subject. However because of the intimate nature of sexual and reproductive activities this is an area in which tensions can arise in the demands and outcomes indicated by human rights principles.

Other problems in which individual choice and technical health knowledge can come into collision are:

- Alcohol, tobacco and drug use/abuse;
- Diet questions;
- (Harmful) traditional practices.

To me the existence of these tensions is a further argument in favour of consideration of a human rights-based engagement with health matters. A human rights reflex for thinking and approaching social and medical issues indicates in the direction of reasoning and the concern with legitimacy of values and principles.

[35] Para. 43(f) of the CESCR's General Comment No. 14.

V-2 HEALTH CARE PROFESSIONAL SERVICE

A health rights perspective is mandated to some extent by the norms and procedures which facilitate for the accountability of HCPs for the manner in which they provide medical services. The gist of what I have tried to say is that the legal obligations of HCPs should reflect in their training. But more importantly the State's obligations in terms of the right to health care services mandate a particular type of health care training framework.

The basic values and principles of the public administration also imply that the State put in place particular measures to ensure that health care services are provided in a manner compatible with the Constitution and in furtherance of the developmental objectives of the State. In respect of the private sector of the health care service it must be considered what impact the duty to protect has on the manner in which the State regulates this sector. Of prime importance is how the State ensures that medical education facilitates for medical practitioners to:

- be held accountable for the manner in which they render health care services in both the public and private sector;
- respond to national health needs, particularly public health emergencies and inequities;
- attain the broader socio-economic development objectives of the State;

An efficient health system also needs skilled and efficient administrators. Thus the concern with health services delivery also entails that HCP training focus on developing the administrative and management skills of HCPs. Thus there is also need for attention to ways of influencing the career choices of trainee HCPs to orient them towards filling not only roles of being practitioners, but the other roles that are essential to an efficient heath systems such as health educators (in the formal sector), researchers and academics, and administrators.[36]

[36] In para. 55 of the CESCR's General Comment No. 14 the CESCR emphasised that principles of good governance must be made applicable to the process of implementation of the right to health, particularly accountability and transparency.

V-3 SPECIAL APPLICATION TO CONCERN WITH RURAL AND REMOTE COMMUNITIES

This issue to me is primarily addressed by a consideration of the manner in which medical education is capable of fulfilling the population's health needs. Thus the identified special needs of rural and remote communities must be reflected in the knowledge and skills that medical curricula imparts to HCPs.

This issue further is related to how medical education addresses itself to preparing health care practitioners to deal with the social determinants of health. In itself the existence of such communities is a manifestation of the intersection between social determinants and the enjoyment of the right to health. The question to me arises how urbanization of rural areas, as a solution, will impact on the health standard of these communities, particularly their susceptibility to health problems which are intricately connected to the rudimentary nature of their living conditions e.g. increased exposure to cold weather, difficulties in accessing safe drinking water. The prevalence of cholera in Africa is probably a manifestation of this urbanization dynamic.

As a vulnerable, marginalised and/or underserved group rural and remote communities are entitled to both special measures of protection and advancement. It may be that the types of health problems they face may be too common for the medical curriculum and may thus not be given the due attention, as concern is with satisfying more urban communities. The right to health demands that HCPs recognise the special needs of this group and be responsive to it.

V-4 THE NEED FOR AND MANNER OF CO-PRODUCTION OF KNOWLEDGE ON HEALTH, SAFETY AND JUSTICE IN AFRICA

The colloquium conveners have already identified co-production of knowledge as the proper approach to the subject of the convergence of health, safety and justice, particularly on the African continent. The manner of co-production will be determined primarily by the form in which the knowledge is to be produced and its intended beneficiaries.

In these notes I have placed emphasis on the relevance of law generally, but particularly human rights, and more particularly health rights to the concern with health, safety and justice. The aspects I have emphasised are how a health rights perspective should inform the perspective with which HCPs engage in their professional activities, and thus their education and training.

More generally it is important to identify the partners who will participate in the co-production process are. To me this suggests a consideration of how other disciplines of knowledge impact on medical education. I have attempted to contribute a minor part of the discipline of law into the subject of health, safety and justice, particularly its educational aspects. I think the questions these subjects raise are broader and engage a wider variety of knowledge fields and disciplines.

The health rights perspective also emphasises the role that the communities for whose benefit the knowledge is developed should play in the process of developing health knowledge. There needs to be a clear delineation of their various roles. Communities as the intended beneficiaries of the knowledge are also the prime subjects of study in that they are the source of the knowledge that helps us to identify health needs. Research and experimentation are also vital in developing new knowledge, and there is no other area of medical science where human rights concerns are most seriously considered (in human experimentation).

VL MASHAVA
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12 June 2015
Hatfield, Pretoria

ANNEXURE A:

WHO POLICY DOCUMENTS ON HEALTH EDUCATION AND PUBLIC HEALTH EDUCATION

A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

ACTION ON THE SOCIAL DETERMINANTS OF HEALTH: LEARNING FROM PREVIOUS EXPERIENCES

FRAMEWORK FOR IMPLEMENTATION OF THE OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM

A STRATEGY FOR ADDRESSING THE KEY DETERMINANTS OF HEALTH IN THE AFRICAN REGION Report of the Regional Director

CBR A STRATEGY FOR REHABILITATION, EQUALIZATION OF OPPORTUNITIES, POVERTY REDUCTION AND SOCIAL INCLUSION OF PEOPLE WITH DISABILITIES - Joint Position Paper 2004

CLOSING THE GAP: POLICY INTO PRACTICE ON SOCIAL DETERMINANTS OF HEALTH | Discussion Paper |

CLOSING THE GAP IN A GENERATION HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

IMPROVING EQUITY IN HEALTH BY ADDRESSING SOCIAL DETERMINANTS

PROMOTION OF NATIONAL HEALTH SERVICES Report By The Director-General

EXPERT COMMITTEE ON TRAINING OF HEALTH PERSONNEL IN HEALTH EDUCATION OF THE PUBLIC Second Report

TRAINING OF NATIONAL HEALTH PERSONNEL Report of the Director-General

TRAINING OF NATIONAL HEALTH PERSONNEL Progress report by the Director-General

CHANGING MEDICAL EDUCATION AND MEDICAL PRACTICE FOR HEALTH FOR ALL

HEALTH WORKFORCE STRENGTHENING

SOCIAL DETERMINANTS OF HEALTH Report By The Secretariat

TRAINING IN HEALTH EDUCATION William Darity, WHO Visiting Lecturer in Health Education

EM/RC27/Tech.Disc.1 TECHNICAL DISCUSSIONS HEALTH EDUCATION

HEALTH EDUCATION: THEORETICAL CONCEPTS, EFFECTIVE STRATEGIES AND CORE COMPETENCIES

EB55.R65 HEALTH ASPECTS OF HUMAN RIGHTS IN THE LIGHT OF SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS

THE DOMAINS OF HEALTH RESPONSIVENESS – A HUMAN RIGHTS ANALYSIS

EDUCATIONAL HANDBOOK FOR HEALTH PERSONNEL - Sixth Edition

REALIST REVIEW AND SYNTHESIS OF RETENTION STUDIES FOR HEALTH WORKERS IN RURAL AND REMOTE AREAS

EFFECTIVE TEACHING: A GUIDE FOR EDUCATING HEALTHCARE PROVIDERS

OUAGADOUGOU DECLARATION ON PRIMARY HEALTH CARE AND HEALTH SYSTEMS IN AFRICA: ACHIEVING BETTER HEALTH FOR AFRICA IN THE NEW MILLENNIUM

PATIENT SAFETY CURRICULUM GUIDE: Multi-Professional Edition

PATIENT SAFETY RESEARCH A Guide For Developing Training Programmes

STRENGTHENING HEALTH SERVICES DELIVERY - STRENGTHENING HEALTH SYSTEMS IN DEVELOPING COUNTRIES - Report by the Secretariat

THE DECLARATION OFALMA-ATA

WHA RESOLUTION ON HEALTH IN THE POST-2015 DEVELOPMENT AGENDA

EDUCATION AND TRAINING OF THE PHYSICIAN FOR THE PREVENTIVE AND SOCIAL ASPECTS OF CLINICAL PRACTICE By A. T. Shousha, M.D. Supervisor, Health Affairs League Of Arab States

EDUCATION AND TRAINING OF THE PHYSICIAN FOR THE PREVENTIVE AND SOCIAL ASPECTS OF CLINICAL PRACTICE Bibliography On Preventive Medicine (Publications On Display In WHO Library)

EDUCATION AND TRAINING OF THE PHYSICIAN FOR THE PREVENTIVE AND SOCIAL ASPECTS OF CLINICAL PRACTICE - Report Of The Technical Discussions At The Sixteenth World Health Assembly -

"EDUCATION FOR THE HEALTH PROFESSIONS - REGIONAL ASPECTS OF A UNIVERSAL PROBLEM" Report Of The Technical Discussions At The Twenty -Third World Health Assembly

TRAINING OF NATIONAL HEALTH PERSONNEL Report of the Director –General

TRAINING OF NATIONAL HEALTH PERSONNEL Progress report by the Director-General

REPORTS OF DISCUSSION GROUPS ON NEW POLICIES FOR HEALTH EDUCATION PRIMARY HEALTH CARE

WHA RESOLUTION ON HEALTH PROMOTION, PUBLIC INFORMATION AND EDUCATION FOR HEALTH

HEALTH WORKFORCE STRENGTHENING

SOCIAL DETERMINANTS OF HEALTH Report By The Secretariat

TRANSFORMING HEALTH WORKFORCE EDUCATION IN SUPPORT OF UNIVERSAL HEALTH COVERAGE

HEALTH ASPECTS OF HUMAN RIGHTS IN THE LIGHT OF SCIENTIFIC AND TECHNOLOGICAL DEVELOPMENTS

EDUCATION FOR HEALTH – A Manual on Health Education in Primary Health Care

FRAMEWORK FOR ACTION ON INTERPROFESSIONAL EDUCATION & COLLABORATIVE PRACTICE

TRANSFORMING AND SCALING UP HEALTH PROFESSIONALS' EDUCATION AND TRAINING - WORLD HEALTH ORGANIZATION GUIDELINES 2013

INTERREGIONAL WORKSHOP ON STRENGTHENING TEACHING OF HEALTH EDUCATION/COMMUNICATION SCIENCES AT PROFESSIONAL LEVEL Wad Medani, Sudan. 6-11 December 1986

WHO PATIENT SAFETY CURRICULUM GUIDE FOR MEDICAL SCHOOLS

TRANSFORMATIVE SCALE-UP OF HEALTH PROFESSIONAL EDUCATION – An Effort to Increase the Number of Health Professionals and Strengthen Their Impact on Population Health

USING LAY HEALTH WORKERS TO IMPROVE ACCESS TO KEY MATERNAL AND NEWBORN HEALTH INTERVENTIONS IN SEXUAL AND REPRODUCTIVE HEALTH

TRADITIONAL HEALTH PRACTIONERS AS PRIMARY HEALTH CARE WORKERS

EXPERT COMMITTEE ON PROFESSIONAL AND TECHNICAL EDUCATION OF MEDICAL AND AUXILIARY PERSONNEL – Report on the First Session

EXPERT COMMITTEE ON SCHOOL HEALTH SERVCIES – Report on the First Session

EXPERT COMMITTEE ON PROFESSIONAL AND TECHNICAL EDUCATION OF MEDICAL AND AUXILIARY PERSONNEL – Second Report

EXPERT COMMITTEE ON HEALTH EDUCATION OF THE PUBLIC – First Report

WORLD HEALTH REPORT 2013 – RESEARCH FOR UNIVERSAL HEALTH COVERAGE