

## **Human Rights Under Pressure – Promoting Human Rights Through Cultural Traditions?**

A Conference of the German Commission of  
Justice and Peace, Dec. 9-10, 2016

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## Introduction: Human Rights under Pressure – Promoting Human Rights through Cultural Traditions?

*Dr Daniel Legutke, German Commission of Justice and Peace, Bonn*

The present publication is a documentation of an international conference on the human right to health and cultural traditions, organized by the working group on “Human Rights and Cultural Traditions: Test case the Human Right to Health” of the German Commission of Justice and Peace. The conference convened in Berlin December 9<sup>th</sup> to 10<sup>th</sup> 2016.

In his opening speech Bishop Stephan Ackermann, President of the German Commission of Justice and Peace, situated the conference in the context of previous meetings of the Justice and Peace Working Group on “Human Rights and Cultural Traditions”. During these exchanges it had become obvious that there is no abstract dichotomy between human rights and traditional culture, although there always will be tensions in concrete situations. Instead, through human rights people on the margins of society can be encouraged and empowered to speak up for a better life; for human rights provide people with a certain framework and language to pronounce their grievances. Usually the argument of tradition is invoked by those who live well with imbalances of power and human rights obligations are recalled by those who are deprived of basic entitlements. Fr Rigobert Minani SJ, who participated in many of the previous meetings, shed light on the perceptions of human rights in many African countries as an expression of a certain European tradition. To take account of such perceptions is of great importance when entering into dialogue.

The next articles analyse the right to health as a test case for the relation between human rights and traditional or religious convictions more specifically. In his introductory contribution Prof Stephan Rixen not only explains what the right to health entails, but also identifies some misunderstandings. Human rights are not intended to replace culture, even if sometimes they are misunderstood in this way. Instead they give a legal framework that should enable and empower people to live in accordance with their own beliefs and convictions – within due restrictions, of course. Rixen furthermore gives examples of religiously sensitive implementations of the right to health. He stated that this perspective might also contribute to health programs of the United Nations because such an approach could help to overcome some of the tensions between UN and religious institutions. Azza Karam then shows from the perspective of UN institutions a variety of issues on which religious and international or-

ganizations cooperate have been cooperating for a long time. She supports the view that FBOs have an important social capital that international players should take into account more systematically. And lastly, Karam depicts some of the contentious issues where cooperation still is very difficult and full of misunderstandings, prejudices and also real differences. She invites FBOs to enter into dialogue, looking closely at the UN positions to overcome misunderstandings and to engage in dialogue where religious organizations reject some of the policy options. Marlies Reulecke, who had worked in Tanzanian hospitals for several years, demands to focus on problems and violations of human dignity, especially of girls and young women who often suffer most from violations of the right to health. To take a perspective of vulnerable groups might help to ease communication between FBOs and other (international) organizations working on the right to health.

The following chapters deal with some concrete problems. The first example focuses on measures necessary to stop care drain and brain drain in the health sector from Africa to countries abroad. More Tanzanian doctors work outside than inside the country. Prof. Eva Senghaas-Knobloch started the session by explaining that from a rights perspective people – health personnel included – are free to move and to work wherever they find career opportunities. Therefore to address the problems of educated health personnel, both sides – receiving countries and Tanzania as well – have to adjust their policies. Maria Kipele demands countries in the south to allocate enough financial resources to the health sector so that all educated health workers could find jobs and prospects of a career within their country. Archbishop Thaddeus Ruwa'ichi pointed out that Northern countries should create opportunities for circular migration, to encourage medical staff to migrate for a certain time without cutting all options of going back. Addressing Tanzania, the government should open better working conditions for health workers in the countryside. The overall ratio of doctors per inhabitants does not show the total picture since many doctors are located in the bigger cities; this worsens the situation in the rural areas. On the other hand, in all parts of the world states have the obligation to install a health system that works in itself without relying on cheap work or charity work and workers from abroad.

Chapter IV is dedicated to the role of so called 'traditional medicine'. Both speakers pointed out that traditional medicine can unfold its potential when it is recognized as addressing questions of life style and spiritual health. Walter Bruchhausen exemplified this by sketching the role of many traditional healers in Africa as care takers for spiritual health. Seen in this perspective nonconventional medicine could play a more important role, also in international health debates.

The concluding chapter V takes up some of the questions touched upon during the days. Referring to health care delivered by FBOs Archbishop Ruwa'ichi called for more quality in research and management of services. Research should focus on a better understanding of the problems within health systems and present methods to address them properly. The Ebola crises have shown that it is necessary to be prepared for many challenges – quality research is a precondition for quality care. Prof Anand Grover touched some fault lines between the freedoms and entitlements of human rights and traditional cultural or religious convictions. He explained that in many societies unbalanced power relations are hidden behind the evocation of tradition. They can be overcome by a human rights-based approach which calls for the participation of those affected in the decision-making process. Taking this seriously would strengthen the acceptability not only of medical treatment but also of preventive behaviour. The claim for acceptability also demands an ethical stance which respects the needs of minorities, which is culturally and gender sensitive and conducive to confidence-building.

The participants perceived the conference as a good example of how religions could establish platforms for dialogue. It brought together experts from different countries, institutions and religions. Their exchange, which reflected various backgrounds and experiences, was helpful not only for the sake of a better understanding of the human right to health. Moreover it was also as a contribution to the debate on the implementation of human rights: Human rights will have a greater impact if all persons involved – with their cultural and religious convictions – are invited to contribute to the implementation of human rights.

## Zur Einführung: Menschenrechte unter Druck – kulturelle Traditionen als Brücken zu einer menschenrechtskonformen Politik

*Dr. Daniel Legutke, Deutsche Kommission Justitia et Pax*

Wir freuen uns, mit dieser Publikation Beiträge einer internationalen Konferenz zum Menschenrechte auf Gesundheit und kulturellen Traditionen vorlegen zu können, die von der Arbeitsgruppe "Menschenrechte und kulturelle Traditionen: Testfall Recht auf Gesundheit" der Deutschen Kommission Justitia et Pax am 9. und 10. Dezember 2016 in Berlin ausgerichtet worden war.

Der Beitrag von Bischof Stephan Ackermann, dem Vorsitzenden der Deutschen Kommission Justitia et Pax, verortet die Konferenz in den Kontext vorangegangener Konferenzen und Workshops der Arbeitsgruppe, die sich in den letzten Jahren immer wieder mit dem Verhältnis des Universalitätsanspruchs der Menschenrechte zu lokalen und religiösen Traditionen befasst hatte. In der bisherigen Arbeit war deutlich geworden, dass es keine abstrakte Dichotomie zwischen Menschenrechten und traditioneller Kultur gibt, wenngleich in konkreten Situationen immer Spannungen auftreten. Sie können Menschen am Rande der Gesellschaft ermutigen und befähigen, sich für ein besseres Leben einzusetzen, indem sie ein Vokabular und einen Rechtsrahmen anbieten, in dem sie ihre Erfahrungen zu Wort bringen können. Gewöhnlich werden Argumente von Tradition durch diejenigen angeführt, die gut mit den Ungleichgewichten der Macht leben. Menschenrechtsverpflichtungen werden hingegen zumeist von denjenigen, denen die Grundrechte vorenthalten werden, in Erinnerung gerufen. P. Rigobert Minani SJ, der seit langem an Konferenzen der Justitia et Pax Arbeitsgruppe mitwirkt, weist in seinem Beitrag darauf hin, wie stark jedoch Menschenrechte etwa in Afrika als Ausdruck spezifisch westlich-europäischer Kultur wahrgenommen werden. Dies zumindest immer mit im Blick zu behalten sei eine wichtige Voraussetzung für gelingenden Dialog zwischen europäischen und afrikanischen Akteuren.

Die Beiträge des zweiten Kapitels befassen sich mit dem Recht auf Gesundheit und beleuchten es hinsichtlich seiner Aussagekraft als „Testfall“ für das Verhältnis von Recht einerseits und Kultur und Religion andererseits. Prof. Stephan Rixen stellt im einleitenden Beitrag nicht nur die Inhalte des Rechts dar, sondern benennt auch einige geradezu klassische Missverständnisse. Menschenrechte intendieren nicht, Kulturen zu ersetzen, auch wenn sie vielfach in diesem Sinn missverstanden werden. Vielmehr bieten sie ein rechtliches Rahmenwerk, innerhalb dessen Menschen entspre-

chend ihren je eigenen Überzeugungen und religiösen Traditionen selbstbestimmt leben können – natürlich unter Beachtung jeweils angemessener Grenzen. Darüber hinaus benennt Rixen Beispiele für religiös sensible Umsetzungen des Rechts auf Gesundheit. Eine kultursensible Haltung, so sein Resümee, kann zum Erfolg und zur Akzeptanz von Gesundheitsprogrammen der Vereinten Nationen beitragen, da sie helfen könnte, einige der Spannungen zwischen der UNO und religiösen Institutionen zu überwinden. Azza Karam zeigt in ihrem daran anschließenden Beitrag die Bandbreite aktueller Kooperationen religiöser Akteure und internationaler Organisationen auf, die besonders auf lokaler Ebene seit langem sehr fruchtbar sind. Hinausgehend über die wichtigen Dienstleistungen religiöser Akteure im Gesundheitsbereich sieht Karam jedoch noch große ungenutzte Potentiale für die Verbesserung der Gesundheitssituation, wenn alle Akteure, insbesondere jedoch die internationalen Organisationen, das enorme Sozialkapital religiöser Akteure stärker und systematisch wahrnehmen und fruchtbar machen. Schließlich weist sie auch auf die Themenfelder hin, in denen Zusammenarbeit schwierig ist, sei es wegen Missverständnissen oder ernsthaften inhaltlichen Differenzen. Sie erwartet von einem intensivierten Dialog ein genaueres Wahrnehmen der je anderen Positionen, um solche Missverständnisse zu überwinden, aber auch um nach Wegen zu suchen, mit schwierigeren Differenzen umzugehen. Marlies Reulecke, die dritte Autorin dieses Kapitels, hat als Ärztin viele Jahre in Tansania gearbeitet. Sie plädiert vor dem Hintergrund ihrer langjährigen Arbeit dafür, bei den Erfahrungen von Leid und verletzter Menschenwürde besonders von Mädchen und jungen Frauen anzusetzen. Menschenrechte aus der Perspektive verletzter Menschenwürde zu sehen, kann so ihre Überzeugung, den Austausch und Dialog zwischen religiösen Akteuren und (internationalen) säkularen Organisationen unterstützen und auf die Lösung gemeinsamer Fragen und Aufgaben richten.

Die Beiträge des dritten und vierten Kapitels wenden sich konkreten Problemen zu. Das erste Beispiel (Kapitel III) konzentriert sich auf Maßnahmen, die notwendig sind, um die Abwanderung von hochqualifizierten Fach- und Pflegekräften von Afrika in Länder des Globalen Nordens zu stoppen. Prof. Senghaas weist einleitend auf das menschenrechtliche Gebot hin, nach dem allen Menschen, auch medizinisch ausgebildeten Fachkräften, zunächst grundsätzlich zugestanden werden muss, sich dort um Arbeit zu bewerben, wo sie bessere Entfaltungs- und Karrieremöglichkeiten für sich sehen. Darauf politisch angemessen und menschenrechtskonform zu reagieren ist eine gemeinsame Aufgabe beider Seiten, sowohl der Empfängerländer als auch von Tansania. So sollten, darauf weist Maria Kipele in ihrem Beitrag hin, die südlichen Staaten dem Gesundheitssektor genügend finanzielle Mittel zur Verfügung stellen, damit ausgebildete Fachkräfte im Gesundheitswesen in ihren Ländern Arbeitsplätze

und Karriereaussichten finden können. Darüber hinaus, so Erzbischof Ruwa'ichi in seinem Beitrag, sollten die Länder des Nordens Möglichkeiten zirkulärer Migration eröffnen, um das medizinische Personal zu ermutigen, für eine gewisse Zeit zu migrieren, ohne die Möglichkeit zur Rückkehr einzuschränken. Ruwa'ichi fordert die tansanischen Regierungsbehörden auf, bessere Arbeitsbedingungen für Gesundheitspersonal auch innerhalb Tansanias, insbesondere auf dem Land, zu schaffen. Die durchschnittliche Anzahl von Ärzten pro Einwohner lasse nicht die Konzentration des Gesundheitspersonals in den größeren Städten erkennen – und vor allem nicht die schlechte Situation auf dem Land. In globaler Perspektive haben alle Staaten die Pflicht, Gesundheitssysteme einzurichten, die sich selber tragen – und nicht auf Billig- oder Wohltätigkeitsarbeit und Arbeitskräfte von außen gebaut sind.

Kapitel IV befasst sich mit der Rolle sogenannter „traditioneller Medizin“. Die traditionelle Medizin könne Potentiale entfalten, wenn sie als Spezialistin für Fragen des Lifestyles und für spirituelle Gesundheit anerkannt und berücksichtigt werde, wie Prof. Anand Grover ausführt. Und PD Walter Bruchhausen unterlegte dies mit seinen Forschungen, nach denen traditionelle Heiler im Sinn religiöser Akteure insbesondere mentale und spirituelle Gesundheitsbedürfnisse befriedigten. So gesehen könnten sie auch in internationalen Gesundheitsdebatten eine stärkere Rolle spielen.

Im abschließenden Kapitel V werden noch einmal einige Fragen aufgegriffen und vertieft, die zu Beginn angesprochen worden waren. Erzbischof Ruwa'ichi richtet an die Adresse religiöser Träger im Gesundheitsbereich den Appell, bessere Daten zu Gesundheitsfragen zu sammeln sowie die Managementstrukturen zu verbessern. Die Datenlage könnte dazu beitragen, die Probleme und Herausforderungen des Gesundheitssystems in Tansania klarer zu erkennen und passende Maßnahmen zu ergreifen. Die Ebolaepidemie hat gezeigt, wie wichtig es ist, auf Krisen vorbereitet zu sein. Daten guter Qualität sind eine Voraussetzung für qualitativ hochwertige Sorgearbeit. Anand Grover berührte einige der besonders sensiblen Themen zwischen Ansprüchen der Menschenrechte und traditionellen oder religiösen Überzeugungen. Um Machtungleichheiten in allen Gesellschaften zu überwinden – die oftmals mit einer Anrufung von Traditionen kaschiert werden – rief er den Menschenrechtsansatz in Erinnerung, demzufolge Maßnahmen immer unter Einbeziehung der von ihnen Betroffenen beschlossen werden müssen. Diesen Grundsatz ernst zu nehmen und in politische Praxis zu übersetzen würde nicht nur die Akzeptanz medizinischer Behandlungen sondern auch präventives Verhalten massiv erhöhen können. Die menschenrechtliche Forderung ‚kultureller Akzeptierbarkeit‘ erfordert eine ethische Haltung, die

respektvoll ist gegenüber den Ansprüchen von Minderheiten, gender- und kultursensibel sowie vertrauensbildend ist.

Die Konferenz, die hier dokumentiert wird, wurde von vielen Teilnehmern als gutes Beispiel dafür angesehen, wie Religionen Dialogplattformen einrichten können. Sie brachte Experten aus verschiedenen Ländern, Institutionen und Religionen zusammen. Ihr Austausch, der die unterschiedlichen Hintergründe und Erfahrungen reflektierte, ist nicht nur im Hinblick auf ein besseres Verständnis des Menschenrechtes auf Gesundheit hilfreich. Darüber hinaus kann er als Beitrag zur Debatte über die Umsetzung der Menschenrechte verstanden werden: Die Menschenrechte werden eine größere Wirkung entfalten, wenn alle Beteiligten mit ihren kulturellen und religiösen Überzeugungen eingeladen werden, zur Umsetzung der Menschenrechte beizutragen.

# I. Human Rights in Christian Perspective

## Commitment to Human Rights – Challenge for Christian Traditions

*Bishop Dr Stephan Ackermann, President of the German Commission for Justice and Peace, Bishop of Treves*

The theme of the Justice and Peace et Pax Congress is: "Human rights under pressure - cultural traditions as bridges to a policy that respects human rights". Today and tomorrow, Justitia et Pax wants to present some of the findings from the process that has been initiated and intensively supported in recent years, especially by the Human Rights Department. On the one hand, this means that the congress stands in continuity with our long-standing concern with human rights and their relationship to culture — on the other hand, it opens up new doors when we discuss the human right to health in concrete terms.

When we started discussing human rights and culture at Justitia et Pax, the working group looked particularly to Africa. In the Commission too, we have discussed with partners from Africa. The starting point was the observation that, especially in discussions with African partners, it was often criticised that human rights were an expression of an exaggerated individualism in Europe. On the other hand, the partners went on to say that African mentality is more focused on the "we". This is above all a cultural difference.

Following up on this criticism was the reason for Justitia et Pax to set up a working group on "human rights and human dignity", which worked from 2009 to 2014. Similar questions are now once again — albeit modified — at the centre of the department's current work.

In the past few years, we had repeatedly invited people to discuss these and similar theories. We have presented publications, the most recent of which has just been published in November. It combines the experiences of an Exposure and Dialogue Programme on human rights with the help of which we were able to invite people to come to Zambia in 2015. With the support of Caritas Zambia and other organisations, we have invited the participants to accompany human rights defenders in their small towns or villages far away from the capital.

Let me present to you some of the key findings, which are documented in more detail in the above-mentioned publications.

*1. First of all, there is no general contrast in the sense of "great significance of traditions for Africa" and an influence through a 'traditionless' modernity for Europe.*

The worldviews are as diverse as the people. Culture is important for everyone. It is expressed differently for each individual person. Essentialist attributions are not helpful, they create more problems than they solve. In different workshops and meetings, it became clear that a strong consensus among those who are committed to improving living conditions in the North and South was achieved by focusing on the protection of human dignity. The reference to traditions plays a role now and then. More important, however, is a focus on human dignity. This applies both here "in the West" and in other regions of the world.

The discussions of the working group, including the launch conference for the current working group in 2015 in Lusaka, have clearly shown that a general comparison of modernity here and tradition there is simply wrong. Orientation towards human dignity directs a critical view to traditions—all over the world. These can help strengthen identities. But traditions can also restrict people and hinder their development. We, too, are currently experiencing very intensively that we (in the West) are called upon to take a critical look at our traditions.

*2. Dealing with culture and tradition in African countries is extremely productive in many places.*

In particular, the Exposure on human rights and cultural issues in Zambia has shown that also in the South human rights are used as an argument when it comes to defending human dignity. Activists on the spot do not see them as Western imports, but for them they rather offer a conceptual pattern to express what many people experience as unworthy living conditions. Their basis—at least in the case of our partners in Zambia—is the deep faith in the dignity of man, created as an image of God and endowed with inalienable human dignity.

The rich treasure of different traditions is not static, but cultural practices, attitudes and values are subject to constant change. This flexibility of traditions makes it possi-

ble to integrate aspects and experiences of human rights work. Traditions do not necessarily have to be thrown overboard. They can develop and adapt to new needs.

After all, however, there are cultural practices that are offensive in themselves. To press for the abolition of such traditions does not come from a "Western view from the outside", if those affected by them demand the abolition themselves. The human rights approach encourages people to address what is offensive. In the best sense, the commitment to human rights serves empowerment, i. e. the ability of people to discover and use their dignity and their potential given by God.

*3. To understand human rights as an expression of a Western individualism or egoism of individuals means to misunderstand human rights as a whole.*

The Universal Declaration of Human Rights (UDHR) begins its preamble with the "recognition of inherent dignity and of the equal and inalienable rights of all members of the human family" as a reason for human rights in general. Human beings have dignity because they are part of the human family. It is no coincidence that this understanding of the human being resonates with an understanding of the person as derived from the personalism of Catholic thinkers.

The perception of the human being as a person is not limited to the preamble of the UDHR, but is consistently reflected in the Declaration of Human Rights as a whole, and also in the civil-political rights, the community dimension of which is often ignored: E.g. in the right to freedom of religion it is stated that the collective witness to faith is also part of religious freedom. Freedom of assembly is also only conceivable as a right in community with others.

The question therefore remains why the accusation that human rights are an expression of Western individualistic thinking still persists. The fact that human rights are often used as an argument politically does contribute a great deal to this. This leads to the fourth thesis.

*4. Political interests can discredit the human rights agenda in some cases.*

Discreditations are encouraged by politically incorrect tactics and actions. Western states protest loudly (and rightly) when the rights of individual groups are at risk, for example when a country wants to introduce the death penalty for homosexuals.

However, the same Western states cannot agree on rules that make their companies liable if they take part in the violation of economic or social rights in the states where they are entrepreneurially active. The responsibilities of companies are concealed deliberately or due to lack of willingness. In Germany they often have nothing to fear for the violation of human rights elsewhere.

The National Action Plan for Business and Human Rights, which the Federal Government has promised to the United Nations, was intended to remedy this situation. But—as one hears—the good drafts from the Federal Foreign Office and the Ministry of Social Affairs were first watered down, and now the plan threatens to fail completely.

Our governments are quick when they can point to others, but they act indecisively and half-heartedly if the interests of our large and small businesses could be disturbed by human rights obligations. This is an ambivalent policy that is damaging to the cause of human rights as a whole.

In the international arena, human rights are in danger of degenerating completely into a meaningless phrase. The UN Security Council is paralyzed; Syria's ruler can count on Russian support to assert his interests. The International Criminal Court, established to prosecute the most serious human rights crimes and crimes against humanity, is increasingly losing international support. States are withdrawing.

##### *5. Also our culture shapes our understanding of human rights.*

Tradition is increasingly being used in Germany to justify a wide variety of political objectives. The political propaganda of the German right-wing political party AfD, in its main motion for the basic programme of spring 2016, speaks of "the established tradition of German culture", of the protection of "regional traditions" and of the model "traditional family". By reverting to these traditions, this populists are agitating for a state that relies on exclusivity, i. e. the use of individual rights reserved exclusively for certain groups, which it wants to withhold from others, non-nationals, and which does not have equal opportunities as its goal. Human rights claims come under pressure. Once again, they need to be publicly justified against such tendencies.

Our response to this is a Christian tradition which sees in the other first a creature of God, endowed with the same dignity. It is the goal and mission of Christian tradition as we understand it to enable every human being to live in dignity.

This tradition is increasingly coming under pressure, not only in our country but also in many European countries, which especially in the European Union wanted to create an "area of freedom and human dignity".

*6. Human rights claims can be honoured in a culturally sensitive way without giving up the universality of human rights.*

The issue of human rights is not a question between North and South or East and West. Different priorities as far as commitment is concerned will remain. Those who do not have clean drinking water, or who do not have enough to eat, will be particularly concerned about the right to water or the right to food. Anyone who experiences restrictions on religious practice will be more likely to advocate religious freedom. Human rights do not give detailed instructions for action. They shall ensure that human dignity is respected as much as possible. Priorities will differ in the long term.

However, individual rights can come into conflict with each other. Then it is necessary to look for a compromise. Where possible, solutions should be sought in public debates and discussions. Court orders will often remain the second best option. Laws can provide clarity. But sometimes it is a clarity that is at the expense of individuals or groups—and that raises new human rights problems. We saw this here in Germany during the debate on the circumcision of boys for religious reasons.

Religious actors in the health sector are taking enormous efforts to enforce human rights. Their actions and attitudes, however, are by no means taken on by large parts of society. Tensions and arguments with other actors arise time and again when it comes to the right to health. How can it be possible, in view of a dwindling understanding of inherent religious logic in Germany, to contribute to better health care by taking greater account of religious factors and attitudes? For *Justitia et Pax*, this is a test case of how in concrete issues religious communities as actors can be integrated more systematically to the benefit of people and human dignity.

## Cultural Motivation and Human Rights in Africa

*Rigobert Minani S.J., Social Apostolate Coordinator and Jesuit Africa Social Centers Network (JASCNET) Director, Nairobi, Kenya*

### *African culture*

African societies, like many others, are dynamic. Indigenous processes of change were disrupted and some places accelerated by four centuries of slavery and colonial rule. Christianity, capitalism, industrialization and urbanization have all had a corrosive effect on ties of African culture. It is not possible to find a "pure" African culture. Africans who wrote about African culture were already hybrid because of the Western curriculum in school. But it is also true that even for the Africans who live in Westernized African cities it is far from true that their worldview is now Western (see marriage rites, funerals etc.). For these people the communal lifestyle with its responsibilities and entitlements has great meaning and value.

### *Human rights and culture*

Despite an increase in the discussion of human rights and culture very little exists in the form of literature that approaches the idea of human rights from an African perspective. A survey of the literature leaves one with the impression that scholars proceed on the assumption that although traditional concepts on the enhancement of human dignity are present in African culture. African societies have become modernized to a point where a discussion of these traditional concepts has become exotic.

### *The spread of human right liberal approach*

Through colonialism, Western concepts of individual rights and law have found a place in many non-Western parts of the World. In December 1948, at a time when most of the population in Africa south of the Sahara was still under colonial domination, a General Assembly dominated by the Western world adopted a Universal Declaration of Human Rights at the United Nations. This today is a customary international law that binds people of all cultures.

### *Values and cultural motivation for human rights*

For the African, a philosophy of existence can be summed up as: "I am because we are, and because we are therefore I am." The cohesiveness of African society and the importance of kinship to the African lifestyle is more important than in western societies. African families operate within a broader arena of the extended family. The Afri-

can worldview is tempered with the general guiding principle of the survival of the entire community and a sense of cooperation, interdependence, and collective responsibility. The extended family unit assigns each family member a social role that permits the family to operate as a reproductive, economic, and socialization unit.

#### *Human rights and African Values*

The African sense of community obligation that goes beyond charity may be necessary to foster economic rights. More pressing is the fact that with increasing immigration from the Third World to the Western world, no one can expect that non-Western peoples will always simply forget or throw away their traditional worldviews and take on the predominant worldview. In Africa society rights and duties are organized around principle of respect, restraint, responsibility, and reciprocity. Respect governs the behavior of family members toward the elders in the family. It is manifested in greetings, curtsies, and other gestures that signal recognition of seniority. Restraint does simply mean that a person does not have complete freedom. He is responsible for the life of community. And responsibility is a much broader concept for African families than Western families, given their larger size. Another difference between African and Western cultures is that of the ownership of land. While private ownership of land is considered an inalienable right within Western society, land in African society is communally held. The questions that we should seek to link culture and human right in Africa are whether Africans need to "modernize" to become individuals in the Western sense and whether the modern liberal state with its Western traditions should be allowed to break up African traditional value systems.

#### *Way forward: Toward a mutual learning experience*

To facilitate cross-cultural discussion and understanding of the ways by which different societies guarantee the dignity of their members we need to abandon conceptualizations that have as their starting point a view that Western culture is indisputably more important when it comes to human rights.

#### *Conclusion: The possibilities for cross-cultural understanding*

Today the perspective of Western scholars are increasingly analyzing the human rights abuses of the African woman, the African child etc. in that frame. To correct injustices within different cultural systems of the world it is not necessary to turn all people into Westerners. The problem today is that the discussion is still Western and the African voices are still those of the Western educated political and academic elites who are trapped in their unquestioning acceptance of the Western concept in the name of modernization and images of a global. The debate should be on whether

Western and African cultural values provide to human beings with human dignity. We should pose the problem in this light. If we do this then we can really begin to formulate authentic international human rights norms.

## II. The Human Right to Health

### The Right to Health – Contours of a Little-Known Human Right

*Prof Dr Stephan Rixen, University of Bayreuth*

#### *1. Introduction*

There are terms such as the “right to health” which are open for misunderstanding. Depending on one’s personal perspective, the “right to health” suggests associations which are deceptive. The “right to health” is not a right to be healthy, as this would be conditional on it being possible to enforce health, which we all know to be impossible. The “right to health” is not a promise to heal someone, it is not a Utopia of health, and it is not a guarantee that diseases can be avoided. So what is it? I would like to outline the contours of this human right which is indeed relatively unknown, and in fact misunderstood. I will be doing so in three steps: First of all, I would like to go into a little more detail as to how the right to health fits within the system of positive law. We will see for instance that German constitutional law does have guarantees in the shape of fundamental rights focussing on health. Having said that, no explicit right to health can be found in the German Basic Law. It is however worth taking a closer look, since this allows us to follow a trail to a right to health at national level, and this trail in turn leads us to international law.

The correct forum in which to speak of a “right to health” is international law. The interesting question is whether this international law understanding only amounts to well-meant rhetoric, or whether it has consequences for dealing with provisions of national law and for shaping the corresponding policy areas. I will illustrate this in a second step using the provisions on healthcare for migrants under the German Act on Benefits for Asylum Seekers (*Asylbewerberleistungsgesetz*). This also suggests itself because migrants’ right to health plays a major role in the international debate on human rights. Thirdly, I intend to explore the issue of whether, and if so to what degree, the right to health is amenable to cultural and religious motivations; if fundamental rights stand as guarantors for plurality, the right to health must also be conceived in a manner that is sensitive to plurality. But how can this actually be achieved?

#### *2. The forum for the “right to health” in positive law*

a) The “right to health” in national constitutional law, taking Germany as an example  
 Let us approach the first point, that is the forum for the “right to health” within positive law. Despite all talk of globalisation, positive law remains largely tied to states, and we currently have as many as about 200 of these. Many states enshrine a right to health in their constitutions. The Italian Constitution for instance reads as follows: “The Republic safeguards health as a fundamental right of the individual [...]”<sup>1</sup> Or in the Indonesian Constitution: “Each person [...] is entitled to receive medical treatment.”<sup>2</sup> We read in the Kenyan Constitution: “Every person has the right [...] to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.”<sup>3</sup> The Spanish Constitution acknowledges the right to protection of health, but explicitly only includes it in the guiding principles of social policy.<sup>4</sup> It is similar in the Constitution of Brazil, which explicitly lists the right to health among the “social rights” (at the beginning of the Constitution),<sup>5</sup> but which then states further back in the Constitution (in the small print, so to speak) that this right is guaranteed by social and economic policy.<sup>6</sup> The Constitution of Portugal states: “Everyone has the right to the protection of health”, but then also: “and the duty to defend and promote health.”<sup>7</sup> As is made clear by the Portuguese Constitution, this right to the protection of health is particularly to be fulfilled by means of a universal and general national health service, which is to be provided by the State.<sup>8</sup> The Slovak Constitution stresses the fact that the right to health depends on social and health policy efforts taken by the State: “Everyone has a right to the protection of his health. Based on public insurance, citizens have the right to free health care and to medical supplies under conditions defined by law.”<sup>9</sup> Evidently the legislature is in charge of defining the content of the right in operable terms.

The founding fathers and mothers of the German Basic Law were highly sceptical with regard to such social fundamental rights – so-called “second-generation” human rights. Their thinking was defined by an understanding related to “first-generation

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<sup>1</sup> Art. 32 para. 1 of the Constitution of Italy, which goes on to say: “[...] and as a collective interest, [...].”

<sup>2</sup> Art. 28H para. 1 of the Constitution of Indonesia

<sup>3</sup> Art. 43 para. 1 (a) of the Constitution of Kenya

<sup>4</sup> Art. 43 para. 1 of the Constitution of Spain. – The chapter to which the provision belongs is entitled: “De los principios rectores de la política social y económica” (Of the guiding principles of social and economic policy)

<sup>5</sup> Art. 6 of the Constitution of Brazil

<sup>6</sup> Art. 196 of the Constitution of Brazil: “A saúde é direito de todos e dever do Estado, garantido mediante políticas sociais e econômicas [...]” (Health is a right of all and a duty of the State, guaranteed by means of social and economic policies [...].)

<sup>7</sup> Art. 64 para. 1 of the Constitution of Portugal

<sup>8</sup> Art. 64 para. 2 (a) of the Constitution of Portugal

<sup>9</sup> Art. 40 of the Constitution of Slovakia

human rights”: Human and fundamental rights were considered as rights of defence vis-à-vis the State. They form a protective mechanism with which the individual defends himself or herself against attacks on the part of the State and defends his or her freedom. This remains an important function to the present day, perhaps playing the pivotal role in freedom rights. That social rights – rights to benefits – were to be defined as fundamental rights was rejected when the Basic Law came into being: Were the content of such a fundamental right to be fundamentally defined by the legislature, there could be no question of an effective tie to fundamental rights. Flagging such legal positions as fundamental rights was ultimately considered to be a false designation, so that the German Basic Law ultimately did without social fundamental rights such as a right to health.

The effect of a text over time frequently goes beyond its genesis. The significance of a constitutional provision does not end in what was thought at the time when the Constitution was handed down, and it is not written in stone for all time. Constitutional courts are a practical response to the fundamental problem regarding how social change can be accompanied by legal standards. The job of these courts is to act as an intermediary between genesis and application by means of a stream of new acts following on from one another, each providing a kind of provisional finality. They thus continually ensure in some way the semantic “*aggiornamento*” (updating) of a constitutional text. There are difficult questions of method and democratic theory underlying this process, given that the preliminary understandings lending direction to the interpretation are naturally the decisive point. A bonmot which is well known among lawyers goes as follows: A law can be smarter than the legislature – and this simply means that those who interpret the law are smarter than those who enacted it. Be that as it may, the German Federal Constitutional Court was smart enough to recognise that fundamental rights are not only freedom rights or equality rights, but that they may also constitute rights to benefits in certain cases. The word “social fundamental rights” is carefully avoided in order not to spoil the appearance that nothing has actually changed. This is an expression of respect for the fundamental decisions of the founding fathers and mothers handing down the Constitution, which definitely did not wish to have any social fundamental rights. At the same time, it is a matter of discretely developing on the understanding of fundamental rights in such a way as to not un hinge the traditional historical conception of the Constitution.

Accordingly, the Federal Constitutional Court found at an early date, and repeatedly stresses, that “the protection of the population against the risk of becoming ill [...] is a

core task of the State in the social welfare state system under the Basic Law".<sup>10</sup> This relates to a task incumbent on the State which in particular the legislature needs to permanently fulfil. As is made clear by the Federal Constitutional Court, this follows from the principle of the social welfare state (*Sozialstaatsprinzip*). This principle constitutes a permanent obligation to pursue the goal of making someone an associate, companion or ally, given that this is the meaning of the Latin term "*socius*", from which we derive the word "social". A "*socius*" is someone who belongs, in other words a member.<sup>11</sup> The social welfare state is a state which may not renounce its efforts to provide people with conditions in which there is a real possibility of personality development in order to enable them to feel that they belong. And this also includes healthcare. This means that the principle of the social welfare state as such necessitates the existence of a healthcare system, but without its design being defined in detail by the Constitution.

The Federal Constitutional Court has however departed from this point of view, which starts with the principle of the social welfare state. It has gradually orientated this point of view towards fundamental rights, particularly in the last ten years.<sup>12</sup> What this means is that, in the light of the principle of the social welfare state, it has refined some of the freedom rights – in particular the right to life and physical integrity – in such a way that one might interpret them as an item-by-item invention of a right to health, albeit it is not explicitly designated as such. True, the Federal Constitutional Court unambiguously stresses – in concrete terms: with a view to transplantation medicine – that the right to life and physical integrity is brought into play "if state regulations cause a sick person to be denied treatment which is available as a matter of principle according to the state-of-the-art of medical research entailing a prolongation of life, but at least a not inconsiderable reduction in suffering."<sup>13</sup> This is a problem of distributive justice: If the State blocks off access to a treatment option which is medically available as such, then this constitutes an encroachment which requires justification and with regard to which the burden of justification is considerable. What appears here as a right of defence (to put it figuratively: A sick person de-

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<sup>10</sup> Decisions of the Federal Constitutional Court (BVerfGE) 123, 186 (242).

<sup>11</sup> Stephan Rixen, Gestaltung des demographischen Wandels als Verwaltungsaufgabe, in: VVDStRL (Veröffentlichungen der Vereinigung der Deutschen Staatsrechtslehrer) Vol. 74 (2015), pp. 293 (304 et seq.).

<sup>12</sup> This is outlined in Christian Pestalozza, Das Recht auf Gesundheit Verfassungsrechtliche Dimensionen, in: Bundesgesundheitsblatt 2007, 1113 et seqq.; on the current point of view, which tends to be more sceptical towards a right to health, Paul Kirchhof, Ein Recht auf Gesundheit?, in: Volker Schumpe-lick/Bernhard Vogel (eds.), Volkskrankheiten – Volkskrankheiten – Gesundheitliche Herausforderungen in der Wohlstandsgesellschaft, 2009, pp. 33 et seqq.

<sup>13</sup> BVerfG, NJW (Neue Juristische Wochenschrift) 1999, 3399 (3400).

fends himself or herself against the State, which has obstructed his or her search for medical assistance) is, in structural terms, a right to benefits, given that the State must enable equitable participation – that is participation that is guided by convincing reasons and free of arbitrariness – in a healthcare system and access to medical assistance; it is ultimately handing out chances of survival.

The Federal Constitutional Court further acknowledged – as an aspect of human dignity in conjunction with the principle of the social welfare state – a right to a physical minimum existence; this fundamental right also includes a minimum of healthcare.<sup>14</sup> It demands reasoning that is transparent and factually viable when it comes to establishing the minimum level of healthcare. In de facto terms, it is a matter of a right to health in the sense that there is a human right to the legislature enacting comprehensible, transparent arrangements for such minimum healthcare. This too is a measure materially aiming to facilitate access to adequate healthcare.

The Federal Constitutional Court, finally, derived from the right to life a right to access to alternative medical treatment when it comes to averting life-threatening diseases and those which are generally fatal, in those cases where no effective means are offered by classical medicine.<sup>15</sup> Here too, the Federal Constitutional Court puts forward as an argument the obligation to protect, entrenched in the fundamental rights, which it derives from the right to life and physical health. This is ultimately no other than a right to benefits with regard to which the State is obliged to guarantee that access to potential treatment options is handled comparatively generously in the face of serious life-threatening diseases.

We can see behind the façade on which someone has written that “The Basic Law does not provide for social fundamental rights” that there is a dynamic of change which – at least in some places – makes freedom rights, intended as they are to defend against the State, into rights to benefits – social fundamental rights – forcing the State to act, to do something, that is to provide effective access to and fair distribution of the opportunities to become healthy. As it is read today, the Basic Law therefore comes closer to international law’s understanding of the right to health. It is probably no coincidence that the Federal Constitutional Court refers at least in a supplementary fashion to provisions of international law, in some cases also in the rulings which interest us here.

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<sup>14</sup> BVerfGE 125, 175; 132, 134; 137, 34.

<sup>15</sup> BVerfGE 115, 25; 140, 229.

## b) The “right to health” under international law

There are many international documents relating to the right to health. The most prominent text is the “International Covenant on Economic, Social and Cultural Rights”, known as the UN Social Covenant, which has so far been ratified by 164 countries.<sup>16</sup> The Covenant guarantees the “enjoyment of the highest attainable standard of physical and mental health”. The text can be understood such that the highest standard of healthcare attainable in the respective reference country forms the point of reference.<sup>17</sup>

There is however another aspect that is of more fundamental significance: Talk of a “right to health” under international law is in fact unfortunately somewhat deceptive, since to be precise it is an obligation that is incumbent on the State, in other words the States Parties acknowledge this right, and undertake to implement it in their legal systems. This means that, in the prevailing view, the UN Social Covenant with its right to health is not a “proper” human rights agreement granting direct rights to individuals that they can assert in a court of law. (As they however can, for instance, in Europe with the European Convention on Human Rights.) The effect of the “right to health” is to place the States Parties under an international obligation that is incumbent on each country’s legislature. Were one to associate an individual right to enforce rights in court with the term “human right”, the right to health would not be a human right. If it is not regarded as being imperative, but accepts that such agreements that are incumbent on the states are a form of enforcement of human rights, then these are definitely human rights. This regulatory mechanism is not unusual with regard to social human rights; Europe for instance also has the Council of Europe’s European Social Charter, which imposes a duty on the states only, at least according to the prevailing view.

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<sup>16</sup> Summing up for instance Gabriel Alexander Baumstark, *The Human Right to Health and its Relation to the WTO*, 2016, pp. 21 et seqq.

<sup>17</sup> Stephan Rixen, *Zwischen Hilfe, Abschreckung und Pragmatismus: Gesundheitsrecht der Flüchtlingskrise – Zu den Änderungen durch das Asylverfahrensbeschleunigungsgesetz vom 20.10.2015*, in: *NVwZ (Neue Zeitschrift für Verwaltungsrecht)* 2015, 1640 (1643); same author, *Gestaltungsspielräume bei der Gewährung von Leistungen an Geflüchtete – Verfassungsrecht, EU-Recht, Völkerrecht –*, in: *Der Landkreis – Zeitschrift für kommunale Selbstverwaltung* 2016, 268 (272).

In the view of the UN High Commissioner for Human Rights and the World Health Organization (WHO), the right to health is an umbrella term for rights of defence (“freedoms”) and individual “entitlements”.<sup>18</sup> The “freedoms” serve to safeguard informed consent, that is consent to medical procedures. The “entitlements” largely include the right to access to a healthcare system operating at as high a standard as possible, providing both basic care and “essential medicine”, and accompanied by general rights to information and participation. The UN High Commissioner for Human Rights and the World Health Organization consider the right to health to include the “underlying determinants of health” such as safe food and adequate nutrition, safe drinking water and adequate sanitation and a healthcare infrastructure (including competent medical staff); this infrastructure also includes counselling on “health-related issues”, such as HIV/AIDS, domestic violence or the abuse of drugs. The “right to health” becomes a complex of stipulations as to the respective health and even social security system which also takes up sub-aspects of “third generation” human rights, that is rights to development. The States Parties are to effectively realise all this particularly by adopting suitable laws on this subject and implementing administrative routines. This sounds like a political manifesto, but admittedly with the difference that this manifesto has been transferred to the modus operandi of an obligation under international law. This does not go quite as far as an individually-enforceable right, but nonetheless constitutes more than a random political agenda. What is more, the UN Social Covenant provides for a specific commission which has a monitoring function, that is one that verifies the implementation of the right to health too, in a relatively “soft” way, but one which is nonetheless binding. The States Parties are obliged to report to the commission at regular intervals, and the commission gives critical feedback and recommendations, all subject to the scrutiny of the public.

### *3. The relationship between the international “right to health” and national law – Example: the German Act on Benefits for Asylum Seekers*<sup>19</sup>

Even though the international right to health is not a “strong” enforceable individual fundamental right, it may nonetheless be put into effect in a manner which considers the individual. In fact, the right to health must be taken into account when interpreting national legal provisions where individuals are seeking rights in accordance with national law. It is not only in Germany that for instance the principle of an interpretation that is friendly to international law applies. It obliges the State to interpret do-

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<sup>18</sup> On the information below: Office of the United Nations High Commissioner for Human Rights/ World Health Organization, The Right to Health, Fact Sheet No. 31, 2008, [www.ohchr.org/Documents/Publications/Factsheet31.pdf](http://www.ohchr.org/Documents/Publications/Factsheet31.pdf)

<sup>19</sup> See the articles by Stephan Rixen mentioned in footnote 17 with regard to the following.

mestic legal provisions in accord with stipulations of international law as far as possible. This is highly relevant in Germany at present, for instance with regard to the UN Convention on the Rights of Persons with Disabilities, but the principle of interpretation in accord with international law naturally also applies to the UN Social Covenant.

The competent UN Commission understands the right to health such that access to health facilities must be ensured “on a non-discriminatory basis, especially for vulnerable or marginalized groups”. There is therefore a need for instance to largely bring the healthcare received by asylum applicants into line with that of the remainder of the population. The law of the European Union (UN) is also dedicated to this approach, which contains a great deal of directives on the topic of “migration/displacement and health”. EU law no longer requires – as it used to do – merely “emergency care and essential treatment of illnesses and of serious mental disorders”, but requires healthcare going far beyond this. The absolutely necessary treatment of serious mental disorders must therefore be ensured, as must the treatment of people with special treatment needs (e.g. children and persons who have been subjected to torture or rape), as well as of “persons with serious illnesses”, that is people with chronic diseases.

Studying for instance the German Act on Benefits for Asylum Seekers confuses one: The only care entitlements refer to “acute illnesses and pain”. This leads in practice to highly-divergent views of what exactly an acute illness is – quite apart from the fact that limiting to such acute treatment situations is in breach of the principle enshrined in international law of ensuring a level of healthcare that covers all health problems, and not only acute ones. The Act on Benefits for Asylum Seekers furthermore does not contain the general stipulation which it rightly should, namely that special treatment is to be provided to the designated groups of vulnerable individuals. This is in breach of international law and of the stipulations of EU law. What is more, the provisions on healthcare contained in the Act on Benefits for Asylum Seekers are vague, i.e. they are undetermined. The Federal Constitutional Court however requires that minimum existence (physical and in terms of health) be “ensured by a statutory right”. A legal text with an almost lottery-like lack of determinedness fails to do justice to this. The violation of the Constitution lies in the fact that the Act on Benefits for Asylum Seekers fails to define the level of healthcare by means of sufficiently precisely-worded entitlements and legal consequences lending the level of healthcare particularly required under EU and international law a reliable legal wording that is operable in everyday legal life.

#### 4. *The “right to health” under international law – open to plurality*

A quick look at the law of the European Union, which is influenced in turn by international law, shows that the particularities of migrants need to be taken into consideration, especially those particularities that result from the fact of their displacement. This means that the right to health must be designed around the individual whose health is affected by it. Such individuals have biographical, cultural, religious and moral particularities. They are what makes up their personalities, and the question is whether it is possible to adequately reflect the individuality of each person, that is (as Hannah Arendt put it) the “fact of human plurality”<sup>20</sup> in the right to health?

This question is so important because, in the practice of some UN agencies such as the WHO, it appears that only one particular understanding of the “right to health” is recognised. When it comes for instance to participation in programmes, a specific understanding of the “right to health” must be accepted in order to be able to take part in the programme; this means in concrete terms in order to obtain the hoped for funding for projects. The problem at the moment is likely to be greatest when it comes to “reproductive rights”, and the question arises of whether or not these should include a right to access to medically-controlled abortion. It might be helpful at this juncture to take a look at another human right, namely freedom of faith and conscience.

The UN High Commissioner for Human Rights and the WHO themselves stress that human rights are interdependent, indivisible and interrelated. This must also be taken into consideration when studying the right to health. Numerous examples can be put forward all over the world that and how it is possible to also accommodate plurality in health-related issues, and to what degree freedom of faith and conscience acts as a catalyst in this regard.<sup>21</sup> Specific treatments may for instance be rejected for reasons of faith or conscience (such as the rejection of blood transfusions among the Jehovah’s Witnesses). One might also think of a refusal by medical staff to take part in specific procedures, for instance when it comes to reproductive medicine or abortions; many legal systems provide for a conscience clause, as they are referred to in US law, in this regard. Such clauses are naturally not without their boundaries, but need to be weighed up against opposing interests which are protected by human rights. The right to refuse to take part in an abortion naturally does not apply if the

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<sup>20</sup> Hannah Arendt, *Vita activa oder Vom tätigen Leben*, 9th ed., 2010, p. 213.

<sup>21</sup> See on the following Stephan Rixen, *Die Gewissensfreiheit der Gesundheitsberufe aus verfassungsrechtlicher Sicht*. In: Franz-Josef Bormann/Verena Wetzstein (eds.), *Gewissen. Dimensionen eines Grundbegriffs medizinischer Ethik*, 2014, pp. 65 et seqq.

woman's life would be placed in danger, as German law explicitly states. The cessation of life-maintaining medical treatment also brings up many difficult issues, for instance whether the care staff have a right to refuse to participate that is protected by freedom of faith and conscience.

There is no scope here to explore this in detail, and indeed this is not my intention. I merely wish to point out here that a discussion of human rights has already broached the question of how to do justice to cultural, religious and moral plurality. As is for instance shown by corresponding legal provisions in the US States of New York and New Jersey, this may go so far as the law as it stands accepting two parallel definitions of death, and permitting specific groups (specifically Orthodox Jews), who for religious reasons reject irreversible brain death as a concept of death, to select a concept of death in line with their religious ideas. Plurality in the interpretation of human rights is possible with such controversial questions in particular, and can be coordinated in such a way that it is possible for concurring understandings to coexist simultaneously.

We should understand this discussion, which is engaged in from the point of view of freedom of faith and conscience, as a motivation and impetus to also re-accentuate the right to health of individuals and their cultural, religious and moral preferences. Let there be no misunderstanding: This is not an invitation to fundamentalistically re-interpret the right to health, and certainly not to restrict it, in a manner that might for instance serve to disenfranchise women. It is however an appeal to pay close attention to the question of whether it is possible to also make a distinction within the topic of "reproductive rights", and to define a hierarchy of importance, so to speak. I do not for instance believe that the right to reproductive health imperatively needs to be understood in such a way that it includes the option of "abortion" without exception. Reproductive health is known to include much, much more, and it is always decisive that the self-determination of women in particular is respected. With all respect for whatever the religious and moral views of the women in question may be, if "faith-based organisations" do not wish to exhaust the entire spectrum of options of reproductive health, i.e. are critical of the option of abortion, I do not consider this to be in contradiction of any "right to health", as long as it is conceived in such a way that it is open to religious and moral diversity. It is however right that the debate to date is dominated by a view which makes the right to health an all-or-nothing right, demanding that all aspects of reproductive health be recognised, including abortion. The international "right to health" should do more to reflect the plurality-safeguarding function of "first-generation human rights" (freedom of faith and con-

science), and should afford more scope than has previously been the case to cultural, religious and moral diversity.

### 5. Summary

Modern law operates on several levels, known as multi-level regulation or multi-level governance. This means that several levels of the law work together: national law, supranational law (in Europe: EU law), and international law. Human rights such as the “right to health” are also enforced in such a multi-tiered system of mutual influence between the levels of the law. The constitutions of many countries do contain an individual right to health, similar to the international “right to health”, with the difference that national rights to health are generally understood as individual entitlements. This is also true of the German constitutional system. As such, at least an inkling of a right to health can be recognised in German constitutional law. Having said that, such fundamental rights as are entrenched in national constitutions ultimately only require action on the part of the respective national legislature. Similarly, the international “right to health” contains multifarious stipulations which are incumbent on the individual states which have signed the UN Social Covenant. The international right to health does not entail an individual right to lodge a complaint. The international “right to health” can be interpreted in such a way as to leave space especially for religiously-motivated positions, unless these question the foundations of the right to health – including the freedom of every woman to decide on reproductive health. In this respect, the right to health plays a role in ensuring fundamental and human rights in very general terms, i.e. to coordinate cultural plurality, religious diversity and moral diversity in a manner that is mutually acceptable.<sup>22</sup> This will not be possible without responsible compromises, without weighing up and without a hierarchy of importance.

I have attempted above to shed some more light on the contours of the right to health. There is still a need to couple the right to health in conceptual terms even more closely with other human rights, in particular freedom of faith and conscience. This linking in particular will help to ensure that for instance religious points of view are incorporated into the right to health. Religious difference and a definitive stance with regard to human rights are not mutually exclusive – also not when it comes to the right to health.

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<sup>22</sup> See on this Stephan Rixen, *Diffusion der Grundrechte in der Biopolitik: Die Wiedergewinnung des Menschen als demokratisches Projekt*, in: Stephan Rixen (ed.), *Die Wiedergewinnung des Menschen als demokratisches Projekt*, Vol. 1: *Neue Demokratietheorie als Bedingung demokratischer Grundrechtskonkretisierung in der Biopolitik*, 2015, pp. 1 (17 et seq.).

## On Faith, Health and Tensions. An Overview from an Inter-Governmental Perspective

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Faith groups are major providers of health care and health-related services around the world. Faith-based providers of healthcare will often maintain that their approach to health is built on a holistic perspective, employs holistic approaches, and that the care extended to patients is also provided in order to offer a support system to help the family cope during the patient's illness and in their bereavement. In so doing, many faith-based and faith-inspired health care givers will reference an approach intended to address the needs of patients, their families, and their communities, which is carried out with a view of the whole of the person: body, mind and spirit; individual, familial and communal.

In line with the World Health Organization's definition of palliative care,<sup>1</sup> faith-based or faith-inspired health care tends to be built on approaches which blend different forms of care and intervention – including the spiritual – while also seeking to make use of available community resources. Faith communities can exert powerful leverage to reduce vulnerability to ill-health, since the major world religions express a commitment to respecting the dignity of every person, regardless of age, gender, sexual identity, ethnicity, social position, or political affiliation. Areas of convergence exist, therefore, between the core values informing faithbased responses to health and the rights-based understanding of health that now dominates the health policies employed at governmental and inter-governmental level. The rights-based approach to health, as the name implies, is founded upon respect for and promotion of the fundamental human rights of persons as they are expressed in the Universal Declaration of Human Rights. A rights-based approach to health would therefore seek to promote respect for persons, gender equality, informed consent, confidentiality and so on.

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<sup>1</sup> World Health Organization, 'WHO Definition of Palliative Care' <http://www.who.int/cancer/palliative/definition/en/> accessed 1 July 2014.

In an article published in *The Seattle Times* in February 2012, Monica Harrington, Deborah Oyer and Kathy Reim write that 'nearly 18 percent of all hospitals and 20 percent of all hospital beds in health systems nationwide are owned or controlled by the Catholic Church'. 'In some isolated areas' they continue, 'the only hospitals available are Catholic-run'. This is a reality in the United States of America, a country whose total net Overseas Development Assistance disbursements (aid provided overseas) was \$30.7 billion in 2012.<sup>2</sup> In other words, this is a donor country, not classified as least developed, underdeveloped, or poor.

A growing body of evidence points to the significant role of faith communities in health delivery world-wide. It is estimated that faith-based organizations (FBOs)<sup>3</sup> provide an average of 30 to 40 percent of basic health care in the world.<sup>4</sup> This figure tends to be much higher in contexts of conflict and humanitarian emergencies (e.g., Sierra Leone, the Democratic Republic of Congo and Syria) where organizations such as IMA World Health inform us that almost 70 per cent of the basic health care can be provided by FBOs (particularly Christian ones, which are relatively more numerous and have a history of service delivery which, in some instances, extends back into colonial and missionary times).<sup>5</sup>

Religious institutions manage significant health infrastructure (hospitals, clinics). More broadly, health assets such as home based and community care capacity in most parts of the world have strong links to faith communities. In some cases (for example, Catholic-run hospitals) they are owned by religious bodies, while in others religious communities and principles are important in less direct ways. This is of special concern in the world's poorest communities where religiously owned and operated

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<sup>2</sup> Monica Harrington, Deborah Oyer and Kathy Reim, 'The role of faith in health-care delivery', *The Seattle Times*, February 10, 2012 [http://seattletimes.com/html/opinion/2017478449\\_guest12harrington.html](http://seattletimes.com/html/opinion/2017478449_guest12harrington.html) accessed 1 July 2014.

<sup>3</sup> There is a great deal of discussion and debate around the definition of an FBO. It is used herein to reference faith-based or faith-inspired non-governmental organizations (NGOs), with legal standing, which are working to advocate for and/or deliver development and humanitarian services whether nationally, regionally or internationally (or indeed at all those levels). In this article, FBOs are distinguished from individual religious leaders or local faith communities, which operate in diverse contexts without being legally registered or established as a non-governmental entity.

<sup>4</sup> See, for example, Lynn Alyward, *Global Health and Africa: Assessing Faith Work and Research Priorities*, Tony Blair Faith Foundation & World Faiths Development Dialogue, April 2012, pp. 37–41 <http://berkleycenter.georgetown.edu/wfdd/publications/global-health-and-africa-assessing-faith-work-and-research-priorities> accessed 1 July 2014.

<sup>5</sup> Hafner, Craig, 'Strengthening the Role of Faith-Based Organizations in Human Resources for Health Initiatives', *The Capacity Project, Legacy Series 8*, September 2009, Washington, DC: USAID [http://www.imaworldhealth.org/images/stories/technical-publications/strengthening\\_fbos.pdf](http://www.imaworldhealth.org/images/stories/technical-publications/strengthening_fbos.pdf) accessed June 30, 2014.

health facilities play particularly important roles as service providers.<sup>6</sup> These range from small-scale clinics and dispensaries to major teaching hospitals, such as the Aga Khan University Hospital in Nairobi. The Catholic Church, for instance, has over 120,000 social and healthcare institutions world-wide in many developing countries, and considers itself 'one of the key partners of the State in healthcare delivery, providing services in remote areas to rural low-income populations, enabling them to access services that would otherwise be out of their reach'.<sup>7</sup>

Broadly, the benefits of faith-based health care include wide-reaching and continued community presence which often leads to intimate knowledge of local community contexts, and qualities of compassion, spiritual nourishment and/or culturally consonant forms of faith-inspired nurture. Disadvantages are perceived as including inadequate financing, which undercuts the quality of care; and lack of inclusion with government strategies and/or government-run health facilities and systems. Given that there are increasing efforts to integrate the provision of health services – as part of overall strengthening of the national health systems – having faith-based health providers outside of the acknowledged national health 'grid' renders them more vulnerable to fragmentation, and may increase the burden of efficient management.

Moreover, there are numerous instances where faith leaders and faith communities may lag behind evolving understandings of the more universal application of human rights standards. Notably, such instances can involve: girls' health (e.g. religious leaders may sanction early marriage when girls' mental and physical health ill-prepares them for the responsibilities thereof); women's reproductive roles (e.g. religious voices can be among the loudest proclaiming that reproduction and high fertility are women's only duties); approaches to domestic violence and rape as a weapon of war (where not all faith leaders or communities have taken a proactive and/or clear stance in opposing sexual and gender-based violence); approaches to lesbian, gay, bisexual and transgender (LGBT) people (against whom faith-inspired and faith-based discrimination is rife in many communities); and approaches to mental health (where some faith-based voices may at best disregard and at worst discriminate against mental ill-health).

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<sup>6</sup> See Gary Bandy, Alan Crouch, Claudine Haenni, Paul Holley, Carole Jane Larsen, Sian Penlington, Nicholas Price, Carolyn Wilkins. 'Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare'(Geneva: World Health Organization, 2008) [http://www.ccih.org/bulletin/0608files/BuildingFromCommonFoundations\\_WHO\\_and\\_FBOs.pdf](http://www.ccih.org/bulletin/0608files/BuildingFromCommonFoundations_WHO_and_FBOs.pdf) accessed June 30, 2014.

<sup>7</sup> Archbishop Zygmunt Zimowski, 'Address to 65th World Health Assembly', Geneva, 23 May 2012 <http://www.zenit.org/en/articles/holy-see-at-world-health-assembly> accessed June 30, 2014.

As will be elaborated later, the bulk of the contentious issues in the relationship between faith and health involve reproductive health, including approaches to HIV and AIDS as a largely sexually transmitted pandemic. Secular public health actors and institutions and human rights activists often blame religious leaders and religiously-inspired proclamations for faithbased resistance to and ignorance of family planning (especially the use of modern contraceptives), and for faith-based opposition to women's empowerment and attention to women's health needs. Issues involving adolescent sexuality (e.g. access to comprehensive sexuality education and access to contraception) and abortion continue to generate significant tension at the community, national and intergovernmental levels.

Nevertheless, numerous publications point to how the HIV and AIDS pandemic, which initially sparked tensions with religious communities (writ large) around approaches to condom use as a necessary part of prevention strategies, has in fact been catalytic to changes in perception, rhetoric, and engagement by and of faith communities. Many point to enhanced appreciation by more secular health actors of the significance of faith-linked roles at community levels, and of faith-based actors' appreciation of scientific developments in this field, both of which have prompted changes in public health strategies.<sup>8</sup>

### *The Social Capital of the Faith and Health Nexus*

Amartya Sen, winner of the 1998 Nobel Prize for Economics, set in motion a paradigmatic shift which moved international development from being all too often regarded as no more than a matter of hard core economics. His efforts were part of a wider movement within the international development world to broaden understandings of the multiple dimensions involved in modernization and approaches to development work. Among other changes, this shift has encouraged greater focus on so-

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<sup>8</sup> For more on this, see Ted Karpf, 'Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa', Geneva: World Health Organization, 8 February 2007 <http://www.who.int/mediacentre/news/notes/2007/np05/en/>; NAM Aids Map, 'Faith' <http://www.aidsmap.com/Faith/page/1693440/>; RAND Corporation, 'How Can Faith-Based Organizations Help Address the HIV/AIDS Epidemic in Central America?', RAND's Research Highlights, 2010 [http://www.rand.org/pubs/research\\_briefs/RB9512/index1.html](http://www.rand.org/pubs/research_briefs/RB9512/index1.html); Michael Schuenemeyer, 'Faith and HIV/AIDS: Engaging a renewed solidarity to save millions of lives', July 27, 2012 <http://www.faithstreet.com/onfaith/2012/07/27/faith-and-hiv-aids-engaging-a-renewed-solidarity-to-savemillions-of-lives/10987> [all accessed June 30, 2014].

cial, cultural, and (to a lesser degree) religious dimensions, including a broader understanding of what is involved in 'social capital'. Sen argued that domains of identity and behavior, and freedom from want and fear were essential parts of what human development aims to achieve, in order to generate the social capital which enables sustainability.<sup>9</sup>

What I argue here is that where and when faith both forms and informs values and praxis especially ensuring access to and affordability of holistic and comprehensive health care, i.e. ensuring a rights-based approach which secures the dignity of the human being and her/his community, then that faith contributes significantly to social capital. In turn, when secular development processes engage with faith-inspired and faith-based mechanisms to enhance the advocacy of and build national capacities which realize the range of human rights relevant to health, this is a form of investment in social capital. And this is part of the business of international development partners, particularly the United Nations.

Investments in this form of social capital have long term – and often difficult to quantify – returns, which can also be non-linear. There can be setbacks too, created, for instance, by the confluence of religion and politics (discussed in more detail below). Such setbacks may occasion their own challenges for governments, societies and economies. Yet, whatever the outcomes, this form of investment in social capital, which is dependent upon relationships and issues which touch the very core of our humanity, has often received little systematic attention in international development praxis, and less attention still in the domain of health.

In a scoping report on the role of faith-inspired institutions and initiatives in the areas of maternal health and HIV, authors Anne Smith and Jo Kaybryn note that such faith community institutions are diverse in their size, forms, structures, outreach and sense of identity. Echoing what many earlier extensive reports have noted, the report affirms that 'faith groups often have extensive reach and access throughout many countries, through the services and infrastructure they provide, although estimates of the extent of faith-related involvement in health care vary considerably'.<sup>10</sup> The report was commissioned by the Joint Learning Initiative on Faith and Local Communities, which is an international network of practitioners, policy advisors and academics that

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<sup>9</sup> See Amartya Sen, *Development As Freedom* (New York: Oxford University Press, 1999).

<sup>10</sup> Smith, Ann and Kaybryn, Jo, 'HIV and Maternal Health: Faith Groups' Activities, Contributions and Impact', A Report by the Joint Learning Initiative on Faith and Local Communities, August 2013. <http://www.jliflc.com/~media/Files/Joint%20Learning/LHHIVMH/Microsoft%20Word%20-%20JLI%20-%20HIV%20and%20MH%20Report%20-%20Final.pdf> accessed June 30, 2014.

gathers evidence and makes policy recommendations concerning the impact and effectiveness of faith-based activities in the field of health and development.<sup>11</sup>

There is an increasing mutual recognition of the need for constructive engagement between and by faith-based and secular organizations around health care. This is driven by many factors, including the increasing visibility, investment and policy engagement of major international development organizations (e.g., World Vision International, Caritas Internationalis, Catholic Relief Services) in international platforms such as those provided through the United Nations and the World Economic Forum, among others. The increasing focus given to the nexus between faith and health care is driven by considerations of effectiveness and efficiency of health care provision in general, and is rooted in considerations of religion as a critical component of social and cultural dynamics of community mobilization, attitude and behaviors in particular. Elena Fiddian-Qasmiyeh (from the University of Oxford's Refugee Studies Centre), and Alastair Ager (Columbia University) note that 'faith groups are often central to strengthening resilience and reinforcing the local processes of identity and connection that comprise the social fabric of communities disrupted by disaster or conflict', including through the latter's capacities to be 'first responders' when disaster strikes, as well as through the psychosocial support, or 'psychological first aid'.<sup>12</sup>

### *Criticisms and Concerns*

As noted above, criticisms of the nexus between faith and health often center around the lack of recognition of the serious social, political, cultural and economic considerations that exacerbate gender inequalities and thereby prevent women accessing health services. The areas of contention focus particularly – albeit not only – around the continuum of sexual and reproductive health.

The ways in which faith groups have responded to HIV and AIDS over the last three decades is an important area of study in its own right, and it also provides a lens to analyze the broader dimensions of the faith and health nexus. The response to HIV and AIDS constitutes the largest and most challenging health undertaking by the faith sector to date. It is also the most extensively researched area of faith-based engagement. In various ways, the response to HIV has provided a learning opportunity for the faith community, informing its ongoing response to HIV and approaches to

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<sup>11</sup> See the website of the Joint Learning Initiative: [www.jliflc.com](http://www.jliflc.com) accessed 1 July 2014.

<sup>12</sup> Fiddian-Qasmiyeh, Elena and Ager, Alastair (Eds.), 2013. 'Local faith communities and the promotion of resilience in humanitarian situations: A scoping study'. The Joint Learning Initiative and Oxford University Refugee Studies Center, Working Paper Series, No. 90, pp. 4–5. [http://www.jliflc.com/en/learning\\_hubs/resilience\\_in\\_humanitarian\\_situations/](http://www.jliflc.com/en/learning_hubs/resilience_in_humanitarian_situations/) accessed June 30, 2014.

other health challenges. It has highlighted areas of best and worst practice in tackling the disease and helped faith leaders and communities to reflect on their key strengths and weaknesses. In many respects faith groups have been found wanting: in their approach to sexual and reproductive health and HIV prevention; in their stigmatization of affected populations; in their harmful use of religious rhetoric, among other areas.

More positively, the faith response to HIV has accelerated the professionalization of FBOs, improved monitoring and evaluation practices, strengthened FBO and inter-faith cooperation, and fostered partnerships with secular agencies. Furthermore, the global response to HIV has confirmed the need for an inclusive, comprehensive, multi-pronged public health strategy that involves a wider body of stakeholders than the medical community alone. It has reinforced the importance of involving faith groups, as civil society actors, in tackling health emergencies at community as well as governance levels; and it has provided pointers of the effectiveness of the holistic and community-based care approaches that faith groups typically deploy.

Whether we speak of the intergovernmental arena which is populated by actors such as the World Health Organization or other UN or EU counterparts dealing with health matters, or we view the bilateral development world, the actors tend to be largely secular entities, with an ethos based, in most cases, on relatively secular human rights principles. This may explain some of the ongoing tensions inherent in the outreach between secular and faith-inspired health entities. Many of these tensions inform the broader development dynamics and are not limited to health matters alone. These include concerns about understanding the motivations behind the work undertaken in the name of 'the divine', 'God', 'faith' or 'religion' and the religious.

In some cases this is framed as a deep-seated suspicion on the part of secular development entities, particularly inter-governmental ones, about the dangers of proselytization. This involves both a perception that the primary motivation of faith-linked actors is conversion, and worries that proselytizing can undermine traditional societies and provoke intercommunal tensions. Such concerns can translate into an unwillingness and unease in any action that might be perceived as favoring or even pushing a particular faith or religion – especially transnationally. Thus, from the secular health providers' points of view, engaging with faith-inspired or faith-based actors must be undertaken only after careful vetting of the true motivations behind all such initiatives.

It is interesting to note that these same secular entities have relatively less concern about active measures to advance human rights, for those are assumed by most secular development partners to be universal and indivisible, and are backed by international conventions which governments are signatories to. As to the latter fact, some faith-based actors take serious issue with this and point to the reality that some governments have signed onto such Conventions with reservations precisely based on religious and cultural considerations. Other faith groups will also point out that reinforcing international treaties and declarations is not the priority of a faith entity. It is important not to dismiss the concerns about the potential for religious exploitation of vulnerabilities, just as it is important to appreciate that the strength of faith-based and faith-inspired health providers is precisely in their rootedness to their faith, and thereby to their communities' very core essence and values. It is also important to stress that these concerns should be addressed in a more studied fashion and should not be allowed to stand in the way of important partnerships needed to address critical matters of health and human dignity.

An elephant in the room of any conversation or initiative which brings together the secular and the faith-based or faith-inspired, is the particular intersection of religion with politics. Religion can be the motivation, or the rationale or the instigator behind many forms of political activism, political parties, and general dynamics of governance. Civic, military and government tensions rise and fall within and between nation-states, based in some ways, in some parts of the world, on religious arguments and interpretations. In other words, religion is very much part of the public space in many countries, with consequences which can impact strongly – and diversely – on considerations of peace and stability.

This geo-political reality informs some of the concerns around religious and faith-based actors, including in health care contexts. Some of the most challenging recent instances involve health care workers –including in contexts of humanitarian crisis – who were unable to provide necessary services to extremist religious actors. In some cases, health care workers have found themselves targeted in contexts of political and economic tensions in which religion plays a role. For example, in Muslim-dominated northern Nigeria in 2003, the political and religious leaders of Kano, Zamfara, and Kaduna states brought the immunization campaign to a halt by calling on parents not to allow their children to be immunized. These leaders argued that the vaccine could be contaminated with anti-fertility agents, cancerous agents and HIV. In analyzing the context, Ayodele Samuel Jegede notes:

Embarrassed by the political undertone of the boycott, the prominent Islamic scholar Sheikh Yusuf Al-Qaradawi, President of the International Fiqh Council, said: 'In fact, I was completely astonished about the attitude of our fellow scholars of Kano towards polio vaccine. I disapprove of their opinion, for the lawfulness of such vaccine in the point of view of Islam is as clear as sunlight'. Sheikh Qaradawi said that the same polio vaccine has been effective in over 50 Muslim countries, and blamed [them] for creating a negative image of Islam: 'They distort the image of Islam and make it appear as if it contradicts science and medical progress'.<sup>13</sup>

Another emerging concern centers around competition over resources. This is most keenly felt among more secular NGOs who perceive the increasing number and range of partnerships with faith-based and faith-inspired actors to be another factor in conditioning and determining the allocation and distribution of foreign aid. The argument often is that the pool of international development aid is already diminishing, and the pie is cut, so to speak, already among so many. The counter to this argument however, is the fact that not all faith-based actors are lacking in resources, and indeed, in many cases, their entrenchment within and service to communities enables some form of 'greater return' on the investments made. Moreover, some would argue that certain international faith-based organizations today, are among the most resource-rich – not only financially but also in terms of human and labor wealth, enhanced by volunteer and in-kind contributions. So, far from taking away from the available financial resources, these actors may indeed be expanding the available resource pool, and/or contributing to maximal outreach of the limited resources, given their centuriesold extensive community base.

Yet another area of contention revolves around gender equality issues. For many of the health activists and researchers working on gender rights, gender equality and the entire spectrum of reproductive health and reproductive rights (including sexuality education, sexually transmitted diseases, HIV, maternal health, family planning), this is fertile ground for contention and boundary setting between secular and faith-based health engagements. A common understanding among many gender equality activists is that religious practices and related cultural norms are often opposed to gender equality and to related human rights discourse.<sup>14</sup>

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<sup>13</sup> Jegede, Ayodele Samuel , 2007. 'What Led to the Nigerian Boycott of the Polio Vaccination Campaign?' Public Library of Science Medicine 4 (3) March 2007  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/> accessed April 25, 2014.

<sup>14</sup> For more on this see the website of the International Planned Parenthood Federation, 'The cost of gender inequality' <http://www.ippf.org/our-work/what-we-do/gender/cost-gender-inequality> Accessed April 25, 2014.

When UN agencies and faith-related groups engage around health, there are many areas of shared concern. These include but are not limited to, maternal and neo-natal or child health, malaria, tuberculosis, polio, HIV treatment and care, disability-related health issues, many aspects of gender-based violence, and engaging men and boys around family health matters. However, as the spectrum of health issues moves closer to issues of gender identity, gender equality, comprehensive sexuality education, domestic violence, some aspects of family planning such as modern contraception, and access to safe, legal abortion, we find the domain of interaction far more contentious.

*Intergovernmental and Global Dynamics Post 2015 and twenty years after the ICPD*<sup>15</sup>

The United Nations has varied records of partnership and engagement with FBOs and religious leaders. Indeed, some, like the United Nations Population Fund (UNFPA), have a legacy which goes back to the 1970s involving research aimed at ensuring that the language of UN advocacy – in this case around health – is strengthened by the teachings of religion. Others, like the World Bank, UNAIDS and UNICEF, cultivated these partnerships largely around advocacy, care and service delivery respectively, more towards the late 1990s and into the new millennium. Yet others, such as UNHCR and the Department of Political Affairs, are relatively recent entrants into this awareness of the potential of and actual outreach to the faith-based world and keep the engagement around uncontroversial areas such as protection of displaced peoples and refugees, as well as mediation efforts.

An important nuance here is that the experience of outreach to and with faith-based actors can differ within the one Office/entity/body/agency. The headquarters office of one agency (invariably based in New York, Geneva, Vienna, Rome etc.) will often harbor a greater degree of concern and hesitancy about engaging with faith actors than their national office in a developing country. The latter often appreciates the value of such partnerships as intrinsic to community engagement and efficacy of delivery. Headquarter offices often have to grapple more with broader geo-political concerns, given they are more directly connected to their Executive Boards, which are com-

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<sup>15</sup> ICPD is the International Conference on Population and Development, which was held in Cairo in 1994 and developed a Programme of Action (PoA) signed by 174 governments. This PoA continues to inform all reproductive and population dynamic initiatives at governmental and non-governmental levels and has been extensively reviewed through a process which involved more than 180 governments. For more on this 20 year global review, including a detailed report, please see: <http://icpdbeyond2014.org/about/view/29-global-review-report> accessed 1 June 2014.

posed of the multiple countries/governments which form the United Nations. Headquarters offices are, therefore, directly engaged in intergovernmental dynamics, whereas national/country offices of the UN tend to deal with the one government and the local communities more immediately.

Consequently, the overall approaches towards such partnerships vary widely. Most UN development agencies and humanitarian relief actors are relatively more cognizant of the potential and value of such partnerships. Indeed, it is safe to say that the more openly 'political' the mandate of the UN body, the more the acknowledgement or 'fuss' made about partnerships with faith-based and faith-inspired actors. It is also fair to argue that, in general, the overall norm concerning such engagements tends to err on the side of suspicion at worst, and caution at best.

What is irrefutable, however, is that no matter what the level of experience, transparency of the track record, or even acceptability of the discourse of partnership, there is little dispute that the UN Population Fund (UNFPA) has raised the visibility of this conversation with faith influenced actors within the UN system. UNFPA has been a driving force behind convening the UN system to call for a collective platform within the broader organization to reflect critically and in a studied manner on the purpose, objectives, methods, lessons learned and pros and cons of such engagements. These efforts are visible in a myriad of ways and were enabled from the very outset thanks to support of one donor government – Switzerland; and are now continuing with support from the Norwegian Agency for Development Cooperation (Norad). UNFPA was the first UN agency to undertake a systematic mapping of its own historical engagement with FBOs (which was published in 2008). This inspired other UN sister agencies to undertake similar – and even better – initiatives documenting their respective outreach with FBOs and religious communities. UNFPA also launched the UN's first Global Interfaith Network and database for population and development issues.

In 2008, UNFPA's Principal invited the United Nations Development Group peers to formalize the UN Inter-Agency Task Force on Engaging with FBOs for Development (IATFFBO), which brings together several UN agencies at least twice a year, and hosts many consultations with FBOs, academia and think tanks, around issues common to the development/religion nexus. Many of these consultations are documented in print by UNFPA. In addition, UNFPA, together with UNAIDS, convenes UNICEF, UNDP, UN-HCR (on a rotating basis), under the auspices of the UN Staff College for a yearly Strategic Learning Exchange in which both UN staff as well as FBOs meet to share

and critically assess concrete case studies of partnership and lessons learned, with a view to enhancing the delivery towards common goals and seeking to identify and overcome challenges.

The outreach to faith actors around the 'Post 2015' process (2015 being the date in which 'new' international development objectives following from the millennium development goals will be agreed to at the intergovernmental level) can only be described as very varied, given the huge diversity of FBOs themselves. At the global level, the engagement of FBOs tends to be informed by the following dynamics:

(a) The size of the organization:

The bigger the FBO in question, the more likely it is that they have been active in UN-related outreach with civil society. Of particular note are organizations which have long partnered with diverse UN agencies on specific issues, such as World Vision on child rights and maternal health, and Islamic Relief on humanitarian relief and emergency support in countries.

(b) Heavily dominated by Christian NGOs:

Christian NGOs have a relatively longer history of centralized organization and presence at the international level and, some would argue, a longer track record of providing social services in countries other than their own, preceding colonial presence. They are thus the most visible at the international 'policy tables', conferences and meetings, including at the United Nations.

(c) Dependent on the responsiveness of the FBOs themselves:

This feature also reflects the extent to which some FBOs consider the global agendas on health, such as those spelled out by the Millennium Development Goals (MDGs), to be relevant to their own agenda setting and responsibilities. Some have been more willing to be engaged, and have articulated the MDGs or reference thereto, in their own strategic and policy frameworks. It is noteworthy, and possibly not a coincidence, that those FBOs are also the ones likely to be headquartered in the western hemisphere, and also relatively more comfortable in adopting human rights language and issues. But many FBOs – and religious leaders – while serving large segments of the local populations at the most micro community levels have no interest in and no resources for a sustained presence in western headquarters. These religious actors will rarely feel the need to accommodate MDG or related discourse in their own agendas or outreach. Yet they are critically important development agents. In some ways, as is the case with many other NGOs, FBO engagement with the global development agenda to date is, arguably, almost class-based. The 'elite' and most powerful NGOs and FBOs are the ones at the table.

(d) Dependent on the outreach done by the different UN agencies and offices themselves:

Some UN agencies have sought FBO input, deliberately organized outreach to their FBO partners, included FBOs in programme roll-outs, and developed some sort of guidelines for such engagement. Notable in this regard are more operational agencies such as UNICEF, UNAIDS, UNEP and UNFPA. Other UN offices have, at different moments, selectively reached out to some religious leaders and engaged them in certain advocacy efforts and/or in certain mediation initiatives when deemed advisable.

### *Tensions around sexual and reproductive health*

... sexual and reproductive questions ... have been bitterly contentious. Whenever touchstone issues like abortion or homosexuality have been discussed, conservative alliances have sprung up, cutting bizarrely across denominations and faiths. Campaigns at the UN in pursuit of 'family values' bring together Christian actors – Mormons, Catholics, Protestants and the Russian Orthodox Church – as well as conservative Muslims. Moves by Brazil to introduce resolutions in favour of gay rights ran into a wall of opposition ranging from conservative American groups to the governments of Egypt and Pakistan. But liberal religious lobby groups also exist, and they team up with secular liberals.<sup>16</sup>

When it comes specifically to sexual and reproductive health and reproductive rights issues, there is no coordinated global faith-based engagement. Indeed, this continues to remain the single-most contentious area of rights in the entire development agenda. Both because of this, and indeed adding to it at the same time, is the reality that governments themselves (which are the main actors in intergovernmental negotiation spaces and who ultimately decide on what the Post MDG 2015 framework will look like) have very different positions on these contentious issues.

The difference in positions and many of the divisions between faith-based and faith-inspired organizations and groups – including around contentious issues – is not dependent on the faith itself (e.g. it is not Muslim-Christian or Christian-Buddhist). Nor are these differences uniformly along national lines (west-east, north-south). Instead, they are within each faith and within countries, which is important to realize for na-

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<sup>16</sup> Erasmus, 'Religion and the UN: Visions of a New World', Erasmus Religion and Public Policy blog, The Economist, October 8, 2013 <http://www.economist.com/blogs/erasmus/2013/10/religion-and-unaccessed> on February 25, 2014.

tional advocacy purposes. In other words, within one country, the position that a government will adopt in intergovernmental negotiations is dependent on the strength of the advocacy by and for human rights' actors within that country.

As framed by Berit Austveg for a report to the Norwegian Ministry of Foreign Affairs (May 2013):

The SRHR controversies tend to come up not just when they are expected, such as at the Commission on Population and Development (CPD), at the Commission on the Status of Women (CSW) and in WHO's work on health in general and sexual and reproductive health more specifically. More unexpectedly they can be brought up during negotiations on issues such as disability, refugee situations and housing, and delegations can be caught unaware.<sup>17</sup>

The specificities of faith-based operations are such that it is relatively rare to find one FBO focused exclusively on only SRH issues. This feature differs markedly from more secular dynamics where there are a plethora of international organizations and institutions and groups who work exclusively on and around SRHR mobilization and related issues. This means that the FBOs are often working simultaneously on women's empowerment issues, on broader health issues, on climate change, on immigration, on sanitation, among others.

Identifying partners and common language around the sexual and reproductive health agenda specifically becomes much more complicated, less frequent, and remains relatively less publically celebrated and advertised. Indeed, around these kinds of issues, it is most often the case that ongoing dialogue and individual trust building consultations undertaken over a period of time remain critical keys to success behind joint health endeavors.

*In lieu of a Conclusion: Reflections on continued engagement between intergovernmental fora and faith-based entities around SRH*

A noteworthy lesson learned is that if these most contentious issues are placed on the agenda of discussions between secular and faith-based actors without prior work having been undertaken on the other common areas of concern, it is mostly likely to result in failure to see eye-to-eye on many matters, and it is unlikely to lead to a developing consensus. More often than not, some of the same faith-based partners with whom this relationship of trust, and a template of common steps and strategic ap-

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<sup>17</sup> Austveg, Berit. 'Perpetuating Power: Why Maternal Mortality Continues to be High Despite Good Intentions', Oslo: Report presented to the Norwegian Ministry of Foreign Affairs, 2013.

proaches has been developed, can become critical interlocutors in paving the way to identify, invite or bring to the table, their faith-based counterparts with whom these kinds of discussions can unfold, until a common syntax and joint programme can be reached.

While concerns about instrumentalization are articulated on all sides, some religious leaders and FBOs have vocalized the fear of being used somewhat more openly than their intergovernmental counterparts. Some representatives of the faith-based world have questioned why the UN and larger international community have, as it were, suddenly woken up to the importance of faith in the promotion of health. Some have even voiced their unease that this may be another passing fad which would seek to maximize the strengths of faithbased actors, or that it may even be a covert attempt to change the way faith-based actors operate and, as it were, to secularize the religious.

Nevertheless, given the realities of service provision, resource capacity and political presence, not to mention the potential of faith leaders and organizations to mitigate or aggravate a variety of health-impacting behaviors at the community level, being knowledgeable of the work of FBOs is necessary, if only to benefit from the social capital available for sustainable human development, human rights, and peace and security. Thus, an informed and systematic outreach to key partners in the world of religion, where community service provision has been a reality for centuries, is essential.

#### *Calls for a 'Safe Space'*

Mutual suspicions between intergovernmental and faith-based actors, especially around sensitive sexuality-related issues, remain a feature of a large part of the reproductive health and gender equality developmental agenda. This to be expected after so many years of sometimes tepid and often ad hoc acknowledgement of each other. Sustained dialogues and partnerships remain necessary, where a common narrative can emerge that identifies what can be agreed upon, and what areas remain to be discussed. This can provide a context for a sharing of lessons learned resulting from the experience of witnessing mutual interventions. It can also offer opportunities for the acknowledgement of mutual strengths and achievements. This space for dialogue, not only to assess statistical data and evidence, but also to assess strengths and weaknesses with honesty, and to stand in witness to one another, can create a sense of trust and respect over time. The formula of trial and error based on actual engagement, especially around service delivery in the field, with a transparency of

purpose, together with respect for respective modus operandi and accountability to joint agreements, appears to be the only winning formula available thus far.

## Religious Motivations and Potentials of Interreligious Co-operation for the Human Right to Health

*Dr Marlies Reulecke, Medical Mission Institute, Würzburg*

It is obvious that it is a huge challenge to achieve the Sustainable Development Goals including the SDG 3 on health and well-being. Therefore, all international, national, public, civil society and also faith based stakeholders have to work together.

Over the last decades, various conventions on human rights have been devised and been signed by most countries of the world. These agreements include women's rights and the right to health, also containing the right to reproductive health. This is certainly a big achievement, but what share is actually respected in reality?

In many countries, and particular in sub-Saharan Africa, the main area that I am working in, these rights are still denied to many girls and women. Since 2000, over 67 million girls have been forced into marriage, sometimes before the age of 15. An estimated 30 million girls are at risk of female genital mutilation within the next decade and only 28 % of women in sub-Saharan Africa use modern methods of family planning, in West Africa even only 14 %.

In working toward these goals, appropriate and sufficient health care services have to be put in place and have to be made accessible to the population. But at the same time, certain attitudes and behavior patterns have to change as well.

Also behavior patterns and attitudes towards health and, particularly with regards to reproductive health and gender roles, are very much influenced by culture and religious believes.

Religious leaders have a great potential to influence people's behavior which can help in achieving the SDGs but it could also hinder their attainment.

At the same time, faith-based organizations provide health care services all over the world.

The magnitude of their contribution is not very well known and varies from country to country. According to the Lancet series on Faith Based Health Care, faith-based

health providers play an important part in many countries in Africa, particularly in fragile or weakened health systems. In countries like the Democratic Republic of Congo, the Catholic Church alone provides more than half of the health care services, particularly in rural areas where no other providers can be found.

Now talking about the church, it provides a wide variety of health care services from hospital care to community based approaches. This includes the treatment of diseases like malaria and tuberculosis, mother and child care, including vaccinations, ante and post-natal care and assuring safe deliveries, providing care for people living with HIV and other chronic diseases and so on.

Thus the Church contributes to the attainment of the universal health care coverage in many ways.

Talking about religious motivation and potentials of Interreligious Cooperation for the human right of health, I see a clear difference between the motivation of the Church and the human-rights- based approach of secular organizations.

The self-concept of the Church includes taking care of the neediest, the most vulnerable people, such as the poor, the sick, the disabled etc. The healing ministry of the Church dates back to its beginning, to Jesus himself.

Thus, the motivation of the Church to provide health care isn't based on the human rights' approach, yet it is rather rooted in the core values of Christian believes like compassion and mercy.

Christian health care, which is usually comprehensive and includes the poor and marginalized, expresses the theological concept of human dignity and justice, the irreducible value of human life.

This isn't at all controversial to the human rights' approach and, therefore, offers a unique opportunity to improve health outcomes to use the extensive experience, strength and capacities of faith-based organizations to achieve this goal. Fortunately over the last years, there are more and more examples for partnerships between churches and other actors like governments or international donors.

These partnerships are not always easy, but, nevertheless, should more actively be looked for by both sides.

It is particularly challenging when it comes to some very controversial aspects concerning health care and development, like reproductive health rights and gender equality.

There are some more aspects which sometimes create differences, like violence against women and child protection concerning child marriage or female genital mutilation. These are practices which, in theory, are condemned by the Church and I came across priests, who are actively fighting against these violations of human rights of women and children. On the other hand, still many Church members and leaders believe that these practices are part of culture and religion and can be accepted.

The most difficult terms are reproductive health and gender equality as many Church members are linking negative associations with these terms.

Reproductive health is quickly associated with the attempt to force the Church to provide family planning and abortion services to women and even adolescent girls. The term gender equality is associated with choices of sexual orientation and the questioning of cultural and biblical norms which are frequently based on different roles of men and women in society. This often entails submission of women to men which stands in contrast to gender equality.

On the other hand, representatives of secular organizations can be found looking only at the Church's objection to provide abortion services and, therefore, they refuse their cooperation.

Looking at the goals ahead, it is certainly more helpful to study each other's approaches in searching the good that the other side is doing for the population. International donors don't just promote family planning and abortion services and Churches provide many aspects of reproductive health services, like ante and post-natal care, assisted deliveries and to a certain extent, they also provide access to or at least information on family planning.

There is certainly much more common ground!

Mutual respect seems essential, and a certain degree of openness for the others believes and their fears.

The focus on yet another aspect might help to learn from one another. Taking the example of access to family planning services, it is a fact that the Church could take much more responsibility. Yet in order to convince their leaders, who are usually men, it is necessary to use a language they understand and that they will accept. In my experience, it isn't very helpful to start a conversation with an African bishop on family planning by talking about reproductive health and the right of every woman to decide when and how often to get pregnant. It might be more sensitive to point out the health risks of early or too many pregnancies. Instead of talking about gender equality, it might be possible to point out the suffering of women and girls, who are abused in various ways and the Church's role of protecting them. As long as the dialogue is open, Church leaders will listen, and thus they have the chance to learn from the secular approach. Instead of insisting on abortion services, one could start talking about family planning also as a mean to avoid abortion. Even though many Church health centers won't provide modern methods of contraception they could be convinced to provide information about all methods available. On the other hand, the government could benefit from the expertise of Catholic health care centers on how to provide attractive health care to pregnant women.

A good example for this type of cooperation between Catholic health care and public health care can be found in one diocese in the East of the Democratic Republic of Congo, where the Ministry of Health has asked the Catholic Church to manage several of their health districts. As a result of this collaboration, the quality of care has increased not just in the Catholic but also in public health facilities. This collaboration also concerns family planning, as the catholic health care providers are training the staff of the public health facilities on family planning including natural methods. At the same time the catholic facilities agreed on passing on information on all methods of family planning and referring those women who decide for modern methods.

As long as the dialogue is open, there is a chance for mutual enrichment.

As I am representing the Catholic side on this panel, in ending my input, I would like to point out opportunities I see for the Catholic Church.

Particularly in Sub Saharan Africa, I see a great chance that this dialogue with human right activists could open the eyes of some Church leaders for the lived reality of women and girls. Sometimes religious teaching on sexual behavior and marriage is so idealized that contact to a different point of view might help to shift the focus from

particular issues like the right to choose abortion or ones sexual orientation, to the reality of many people's life.

They could start to realize that many women and girls don't even have a choice as to when, where and with whom they have sexual relations or get married and they have no chance to protect themselves from HIV or other sexually transmitted diseases let alone to decide on when and how often to get pregnant.

### III. Brain Drain and Care Drain: Responsibility of the North?

#### Framing Mobility in a Human Rights Perspective

*Prof Dr Eva Senghaas-Knobloch, Sustainability Research Center (artec), University of Bremen, Bremen*

##### *Human Rights are interrelated*

Liberal freedom rights, social and political rights are interrelated and indivisible which affects the discussion of Brain Drain and Care Drain. Article 13 describes the right to leave any country including his own. Article 23 describes the right to work, to free choice of employment and to just conditions of work. Article 25 describes the right to a standard of living that is adequate for the health and wellbeing and finally Article 28 describes an entitlement to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

In this context there are some further developments done by the European Social Charter, the WHO, the International Labour Organization and the UN-Agenda for Sustainable Development.

##### *The crisis-laden social situation on global scale underscores the significance of social human rights and corresponding policies*

The deepened gap of income in the relation of the 20 poorest countries and the 20 richest countries increased from 1963 with 1:54 to 2003 with 1:121. A reduced public spending may affect the quality of national healthcare service by reducing the personal and weakening the institutions. Statistics show that the numbers of foreign medical staff in Germany has increased substantially in the last 20 years. In 2002 there were 789 people from Africa working as medical staff in Germany. This number increased to 2584 people in 2015. In addition we also need to have in mind the cases of domestic workers as carers in private households. The ILO-Estimation in 2013 of migrant domestic workers worldwide is 11.5 Million, with  $\frac{3}{4}$  of them are women. And most vulnerable are the 24h-careworkers who are living in private households. The ILO response in 2011, the Convention 189 on decent work for domestic workers, is an attempt to formalize informal work. Decent work is serving the right to health – for

the recipients for care and for the givers of care in the countries of the Global North and in the countries of the Global South.

Therefore exists the need for public investment in public health. The ILO-concept of a social protection floor includes 'universal access to essential health care'. Goal 3 of the 2030 Agenda for Sustainable Development requires: "Ensure healthy lives and promote well-being for all at all ages" by "substantially increasing health financing and the recruitment, development, training and retention of the health workforce in developing countries".

According to this the states all have a responsibility, because public health is a public good and needs public financing. Externalizing problems from one region to another creates problems and deficits in the other region. Such policy backfires. Policies for preventive public health, occupational health, medical and care work is indispensable for any sustainable development, for social cohesion and for human development. So the Global North has to adopt a coherent policy fostering sustainable development everywhere.

## Adequat Work Environment and Payment: Preconditions to Fight Brain Drain

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Nowadays we live in capitalist and competitive economies and because of this it is legal to find the best people in order to be the best. Thus, each country needs top skilled labor, to keep up with this system. A result of this is a major challenge to almost all southern countries. In particular it means retaining the skilled labor and stop the global movement of skilled women and men from the Global South to the Global North, which, for instance, deprives patients from health care and also leaves many children behind without parental care.

In this context my basic argument is, to recruit, train and retain skilled labor through adequate payment and proper work environment is the solution to fight brain drain from the Global South. It is the core responsibility of the Governments of the countries in the Global South, in the first place, where such labor is to be trained properly and to be employed properly!

There are different reasons for skilled labor to migrate to the Global North, for example to reduce poverty or seek a better future, but this has also impacts on the families, as migrating parents leave their children behind at the cost of neglected care, affection and love. But is it wrong if people do so? Is the North responsible for that? What are the pulling and what are the pushing factors? And another important question: Why is there a coexistence of shortage of skilled labor on the one hand, and unemployed skilled labor roaming the streets, on the other? In the following I will present the different sides of this problem with the example of Human Resource in the Health Care System in Tanzania and I will also try to give some solutions.

Since 2014/2015 the Government in Tanzania has not employed any medical doctor, which leads to the fact that more than 600 medical doctors are unemployed. And this is what fuels Brain Drain. The graduates of the following year who just finished their internship are also waiting to be employed. Are they going to wait until the Governments decides to employ them? Yet Tanzania is one amongst 57 countries with critical shortage of health workers, but the health minister claims that there is no shortage.

But this deployment is facing many challenges. First there are budgetary constraints, because the health care sector budget competes with the budget from other sectors. And this is fueling Brain Drain. Second one can name a governmental bureaucracy, which in this case means that the decisions on deployment are handled by another ministry than the ministry of health and social welfare. And third we have to deal with a poor human resource management and planning.

To get a perspective on a way forward for the Global South a multi-sectoral involvement is necessary for the realization of retaining skilled labor in the countries of origin. Norway and Ireland the two recent European winners of the Health Worker Migration Policy Council Award are two good examples for that. Also it is necessary to deliberate efforts on recruitment of academic staffs and to provide more opportunity for further training. This is followed by the implementation of the available policies like motivation and improvement of the working environment.

But there are also perspectives for the Global North that have to be kept in mind. The core responsibility of the North is fighting Brain Drain from the Global South. This can be realized in different ways. It is important to make very transparent arrangements with Southern partner countries on high-level training schemes for skilled labor. Also it has to involve local professional associations, labor organizations and religious institutions when negotiating with Southern Partner Governments. Additionally the investments in both vocational training and business or sector development have to go hand in hand. Continuing it is necessary to help Governments to truly track record of their human resource development and employability of skilled labor beyond celebrating output figures only. Mechanisms of incentive may also be a part of the solution so that Southern trainees want to return to their countries of origin. Furthermore one should assist southern partner countries to absorb those people that are trained exactly where there is critical shortage by prior arrangements and adequate guidelines. The Global North also has to incentivize their "native" specialists to remain in Northern countries or return after overseas assignments so as to narrow the gap in which Southern skilled labor would seek & find employment. To reduce the negative impacts of Brain Drain the migration policies in the European Union should be checked. Circular migration should be allowed, thus skilled labor of Southern (or Eastern) countries can work for some years in the EU. But these circular labor migrants should also get incentives to return to their country of origin. This way circular labor migrants will have gained a lot of job experience and professional skills, which is useful for their original labor markets, especially in the health sector. And finally one has to reverse "brain gain" to make much called-for "Triple Win-Win" a reality!

## Care Drain as a Multilevel Phenomenon

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### *Abstract*

The migration of educated, skilled and professional workers from countries of their origin in the developing world to more developed countries in search of better standards of living and quality life, higher salaries, access to advanced technology and more stable political conditions termed as brain drain is a well known phenomenon for decades.

Now, a trend that is less well known, but which is becoming increasingly visible and equally troubling, is the "care drain"—the migration of women from developing countries, where they perform the bulk of care work unpaid, to the developed world, where they can do the same work for pay. The care for children, frail elders, the disabled and chronically ill has emerged as a key policy challenge around the globe. Rising rates of female labor force participation, combined with declining birth rates and rapidly aging societies, have disrupted conventional divisions of labor that assigned care work primarily to women.

Care drain, involves hands-on physical ministrations. It often requires workers to live in the homes of their employers and tends to be conflated with domestic service. Widely regarded as unskilled (though many in the field would dispute this), it is usually low-paid and often, because it is performed in isolation, can become a site for the exploitation and abuse of workers. Care work is also perceived as a dirty, difficult and dangerous work that is widely avoided by native-born workers in developed societies. But women from developing countries where local employment is scarce see it as an opportunity. It is also associated with human trafficking, sex slaves and consequently is a form of modern exploitation.

This migration of professionals seeking for better opportunities is of great concern today worldwide, both from within countries and across international borders due to its impacts on developing countries. The number of professionals and women joining brain drain and care drain respectively has reached a peak in recent years in apparent response to huge demands emanating from developed countries. These demands were associated with demographic changes, aging populations as well as reduction in recruits. Why do professionals leave their countries or place of work and go else-

where searching for better opportunities? What are the consequences of such migration with regard to care delivery? Why is Visa affecting the developing countries? What policies can be adopted to stop such movements from developing countries to developed countries?

It is now estimated that the proportion of foreign born people in developed countries has tripled since 1960, and the emigration of high skilled people from developing countries has accelerated. Many developed countries tend to attract and retain foreign students which in turn increase the risks of brain drain in the sending countries. On the one hand, brain drain causes labour shortages, and affects fiscal policy, but on the other hand it can also generate remittances and other benefits from expatriates and returnees! Generally, brain drain is a curse for developing countries as it has been claimed!

The impact of brain drain and care drain on a source country's welfare and development can be beneficial or harmful. But evidence shows that many developing countries are more losing than gaining through this phenomenon.

### *Introduction*

#### *Brain Drain Explained*

The term "brain drain" refers to international transfer of human capital resources, and it mainly applies to the migration of highly educated personnel from developing countries to developed ones. Brain drain can also mean the exodus of skilled and qualified professionals out of certain areas in search of better working conditions, salaries, and quality of life. In a narrow sense the term is used to denote the migration of engineers, physicians, scientists and other highly skilled professionals with university training to developed countries. Comparative data show that by 2000 there were 20 million high skilled immigrants (foreign born workers highly educated) living in members countries of the organisation for Economic Cooperation and Development (OECD), a 70% increase in ten years. Two thirds of these immigrants came from developing and transitional countries (Docquier, F. 2014). These are people who were supposed to provide quality health care to the community and now they are doing this in developed countries (care drain).

In the 1970s, the World Health Organisation (WHO) (2004; 82:624-5), published a detailed 40 country study on the magnitude and flow of the health professionals. According to this report, close to 90% of all migrating physicians, were moving to just

five countries: Australia, Canada, Germany, UK and USA. Is the scenario today different? Have health professionals stopped moving to developed countries searching for better living life, high salaries and access to advanced technology and more stable political conditions from developing countries? It is said that the main donor countries for brain drain reflect colonial and linguistic ties! But also evidence shows that highly skilled health professionals migrate from rural areas to urban areas within a given country.

The world economic recession in the 1980s left many African countries destitute as they experienced large drops in national incomes. As a result in order to finance the provision of social services, most countries turned to external borrowing (World Bank 1991). The external borrowing led to increased debt which resulted in preventing countries from allocating a large part of their budgets to health education, and infrastructure development. Many Nongovernmental organisations (NGO) rose as alternative means of providing social services to the public (World Bank 1998). Development aid was channelled through these NGOs which offered better pay and working conditions that lured professionals from the declining public sector.

In Tanzania, the health system suffered from lack of training and poor motivation of doctors and health workers, shortage of supplies, and inadequate management. The quality of hospital care declined and clinics became crowded.

#### *Types of Brain Drain*

- i. Global level: Migration of skilled and qualified medical professionals from developing countries to developed countries.
- ii. National level: migration of skilled and qualified medical professionals within the country from rural areas to urban areas to work and from public sectors to private sectors because of high pay and vice versa.
- iii. Brain waste: refers to the migration of skilled and qualified medical professionals from the health sector to other sectors of work

NB: all three types of brain drain contribute to shortages of skilled and qualified medical professionals in certain areas worldwide and thus affecting the quality of health care delivered to the population. This migration of skilled and qualified health professionals has contributed to the fragile African health system.

## Global situation

In 2006 there was a global shortage of 4.25 million doctors, midwives, nurses and support workers (WHO 2006a). 57 countries reported acute shortages, and 36 out of the 57 were in Sub-Saharan Africa (United Nations 2010). The United States and Canada have 37% of global skilled and qualified health professionals whereas Sub-Saharan Africa has only 3% of skilled and qualified health professionals worldwide but carries 24% of the global burden of disease (Mmbando 2009). In order to decrease this burden of disease, health professionals must be available to give care. The United Kingdom, United States and France have the highest number of doctors from abroad.

Table 1: Native African Physicians working domestically and abroad

Sending Country	Domestic	Receiving Country									Total Abroad	%
		UK	US	France	Canada	Australia	Portugal	Spain	Belgium	South Africa		
Tanzania	1'264	743	270	4	240	54	1	1	3	40	1'356	52
Kenya	3'855	2'733	865	0	180	110	1	4	1	81	3'975	51
South Africa	27'551	3'509	1'950	16	1'545	1'111	61	5	0	-834 <sup>a</sup>	7'363	21
Malawi	200	191	40	0	0	10	2	1	1	48	293	59
Botswana	530	28	10	0	0	3	0	0	1	26	68	11
Somalia	310	53	70	0	25	3	0	0	0	0	151	33
Mozambique	433	16	20	0	10	3	1'218	4	2	61	1'334	75
Ethiopia	1'310	65	420	16	30	9	1	1	2	9	553	30
Algeria	13'639	45	50	10,594	10	0	2	60	99	0	10'860	44
Egypt	14'555	1'465	3'830	471	750	535	1	17	31	19	7'119	5
Africa <sup>b</sup>	280'808	15'258	12'813	23'494	3'715	2'140	3'859	1'096	1'107	1'459	64'941	19
Sub-Saharan Africa	96'405	13'350	8'558	4'199	2'800	1'596	3'847	173	696	1'434	36'653	28

Source: Clemens and Petterson (2008, 8).

Note: The table shows the number of physicians in some African countries who are working within the country and those who have moved to work outside their country of birth. Data for France are from 1999; data from the United States are from 2000; data from the rest of the countries are from 2001.

## Situation in Africa

It is difficult to estimate the number and effects of migrating skilled and qualified health professionals because there is no reliable data from the sending countries. Brain drain jeopardises the delivery of health care in many ways, with doctors and nurses making up a majority of the 20'000 health professionals that leave Africa annually (Barka and Ofori Spong n.d).

According to the WHO 2006a the minimum standard to ensure basic health care services is 20 physicians per 100'000 people. Developed countries enjoy 222 physicians per 100'000 while Sub-Saharan Africa falls short of the minimum standard, and 13 of these countries have 5 or fewer physicians per 100'000 people. Tanzania and Malawi have the lowest doctor patient ratio, with only 2 doctors per 100'000 people. What is the current situation with increased production of doctors and nurses in recent years!

Countries receiving skilled and qualified health professionals seem to save money by not having to train their professionals. According to Mmbando (2009), 130'000 international medical graduates have saved the US more than US\$26 billion in training. However, these savings come at the expense of countries that trained them. Tanzania, for example, pays for some of its medical students to attend college in two different ways. First, those who excelled in their advanced level education can receive full scholarships. Second, some students receive no interest loans of various amounts, depending on need. These investments become economic losses if the students decide to leave the country to work elsewhere. The loss is, however, more than economic. Coming on top of Africa's high burden of disease and initial low production of health professionals, the transfer of personnel leaves the health system ill equipped to handle its patient burden and hinders the continent's development.

#### *The situation in Tanzania*

In 2006 the WHO identified Tanzania as experiencing a critical shortage of health workers (United Nations 2010). Medical professionals in Tanzania are both moving out of the country and moving from rural areas to urban areas. As of 2000, about 52 percent of Tanzania's native-born doctors were working abroad (Clemens and Pettersson 2008). Tanzania has 1'264 native-born doctors working in the country and 1'356 working abroad. In contrast, only 4 percent of Tanzania's nurses are working abroad, a much lower percentage than many of its Sub-Saharan African neighbors (Clemens and Pettersson 2008). Still, Tanzania is greatly affected by the migration of its health professionals, especially doctors, out of the country.

The economic loss to the country is also significant. The Tanzanian government spends US\$27'256 to train each medical student from primary school through medical school. It is estimated that Tanzania has spent US\$3.49 million to train Tanzanian-born doctors who are currently practicing in Australia, Canada, the United Kingdom, and the United States (Mills et al. 2011). Migration of health workers from rural to urban areas is a growing concern, and the shortage of workers in rural areas is severe. In Tanzania, "the capital city of Dar es Salaam alone has nearly 30 times as many

medical officers and medical specialists as any of the rural districts” (Anyangwe and Mtonga 2007, 95). A study conducted in Tanzania showed how this understaffing in rural areas increased the work burden on health workers in these areas. One female auxiliary nurse explained, “Say at every centre you have got one nurse and one doctor. If it happens that the doctor faces a problem the nurse will be alone. Now she will do the cleaning and dispense drugs and deal with patients....You often find that work to be done by two or three people is performed by a single person” (Manongi , Marchant, and Bygbjerg 2006, 4; Muula 2005). This poor quality of care contributes to Tanzania’s burden of disease and disability, which are disproportionately found in rural areas.

#### *The Causes of the Brain Drain and Care Drain*

The exodus of health professionals depends on their personal values as well as an interplay of complex social, political, and economic forces both in the sending and receiving countries. The underlying driving force is the weak health system with poor infrastructure and minimal equipment in the sending countries.

#### *Push factors*

We identify as “Push” those factors that occur within the sending country, motivating skilled and qualified health professionals to leave. Push factors in developing countries like Tanzania are low salaries (low remuneration), poor working conditions, including lack of incentives, political and ethnic problems as well as civil strife and poor security. Poor governance (or perceived poor governance) is an important issue for professionals to work elsewhere. The lack of adequate technology and equipment to perform professional tasks for which staff are trained will automatically reduce job satisfaction.

#### *Pull factors*

Pull factors are the deliberate and/or unintended actions that attract skilled and qualified health professionals originating from the recipient country policies and actions. Thus pull factors in developed countries, that is countries that receive health professionals are higher salaries, better living standards and facilities. They may arise because of increased demand for health professionals in developed countries (e.g aging populations requiring more care) and economic.

#### *Six gradients*

It is a combination of both “push” and “pull” factors that lead to a threshold decision to migrate. The combined “push-pull” ingredients is described in terms of the gradi-

ents between situations in the country of origin of the health worker and in the receiving country:

The Income Gradient: the differential in salaries and living conditions between the home and recipient countries.

The Job Satisfaction Gradient: the perception of good professional working environment, skills utilisation and technical proficiency that allows international recognition.

The Organisation Environment / Career Opportunity Gradient: Health professionals see opportunities for advancement in careers and in specialisation that are fair and accessible. A fair well governed environment for human resource management will help to attract and retain staff.

Governance Gradient: it is linked to organisational environment as discussed above and to the level of administrative bureaucracy and the differences in efficiency with which services are managed.

The Protection/Risk Gradient: there is some indication that the lack of protective gear and a perceived increased occupational risk from HIV/AIDS when working in Africa, compared to that receiving countries, plays a great role in the decision to leave and work abroad.

Social Security and Benefits Gradient: health professionals are concerned with basic comforts during their working life and with security after retirement. Retirement and pension benefits are important motivating factors.

In a nut shell, the following are the contributing factors for Brain Drain in Tanzania:

Push: Socioeconomic factors and professional opportunities

Pull: demand in the receiving countries, networking and good living conditions

#### *Effects of the Brain Drain and Care Drain*

In Tanzania for example brain drain and care drain have severely affected the distribution of skilled and qualified health professionals and consequently contributing to the weakening of the fragile health system. On the other hand, the flow of remittances has helped some families cope with the increasing cost of living. However, the balance between benefits and burdens is unequal, with developed countries benefiting at the expense of tax payers in Tanzania.

#### *i. Benefits to sending countries*

- Financial remittances from workers that have migrated. However, it is difficult to estimate as the transfer of money to Tanzania is done through informal channels.

- Professionals who practice in developed countries receive training and experience that may be unavailable in their home countries and may return to their home countries with these new skills. This migration and exchange of knowledge allows professional networks to form between developed and developing countries (Hooper 2008, 685).

#### *ii. Burdens to sending countries*

- The migration of medical professionals results in a lack of personnel in the abandoned areas. Rural areas house half of the world's population but less than 25 percent of doctors and only 38 percent of nurses (United Nations 2010).
- The low doctor-to-patient ratio in developing countries, as discussed previously, shows the unequal global distribution of medical personnel, creating a severe deficiency in care in developing countries.
- Potential loss of tax revenues.
- The government loses its return on an investment made, given the high percentage of government spending on education. Every time Tanzania loses a health professional, it costs the country about US\$27,256 that was invested in education, while the developed country saves on education spending.

#### *iii. Effects on Medical Professionals*

- Brain drain affects medical professionals themselves. Those who stay behind often are overworked and overburdened because of the large case load and worker shortage.

#### *Coping Strategies*

In a nut shell brain drain in Tanzania has the following effects:

- Increased burden of disease
- Poor quality of health care services
- Economic loss e.g. tax revenue
- remittances

Countries have attempted to cope with these problems through:

- i. International recruitment and inter-country arrangements: Many countries in Africa such as Botswana and South Africa have recruited from other countries within and without the continent. Tanzania also recruits expatriates from within and outside the continent.
- ii. Extended Retirement age: Tanzania formerly compulsory retirement age was 55 but it was extended to 60 years. But after 60 years health professionals are allowed to extend their employment through contractual arrangements up to 65 (of two years,

then two year and lastly one year). But still it can go beyond depending on the local institution where the health professional works.

iii. Bonding or Compulsory Service Schemes: but this has not worked very well due to poor administrative efficiency of HR management systems in public service.

iv. Skills substitution and Delegation: a variety of locally designed health professionals can be found in Africa. For example, the cadre of Clinical Officers – in Malawi, Zambia and Tanzania; Surgical and Medical technicians in Mozambique; Assistant Medical Officers in Tanzania. In general terms the traditional health professionals do not easily acknowledge the efforts done by these groups.

v. Incentives and Motivation Systems: salary levels as the basic factor to retention; then topping up and responsibility allowances; and provision of housing facilities, transport and airtimes.

vi. Return Management: The International Organisation for Migration and some countries have tried encouraging professionals in diaspora to return to their home countries.

### *Policy Options*

Individuals' right to move (as they please) conflicts with the need to compensate sending country governments for the loss of professionals. Tanzania undeniably suffers from a severe lack of healthcare professionals, and therefore an increased burden of disease. However, an intertwined structure of pull and push factors, along with the professionals' own motivations, result in high emigration from Tanzania. Even within the country, rural areas disproportionately struggle with lack of staff and NGOs pull professionals to the private sector. Because this brain drain exists at so many levels, solutions are neither straightforward nor simple. In addition, the lack of data, especially from the sending countries, makes measuring the exact scope of brain drain difficult. Brain drain is also affected more broadly by the economic and structural changes in the country as a whole. Global and national policy options exist to ameliorate Tanzania's brain drain.

In Tanzania more health professionals need to move to rural areas to close the gap between rural and urban areas and improve rural health care. There is need of concerted efforts by all ministries to create conducive working and living environment in rural areas, affecting not only health professionals, but all rural residents. Additionally, in order to improve on the working conditions of health professionals, administration in the health sector needs to be decentralized. Instead of a centralized funding system, lower-tier health facilities should be in charge of their own procurement process, which would meet their own needs. Let there be incentives given to health profes-

sionals to work in rural areas. Put a system in the country to track doctors inside and outside the country.

### *Conclusions*

Skilled and qualified health professionals who have emigrated for several reasons are recoverable assets who can play a great role providing quality health care which was drained in developing countries. However, recovery requires the opening of diverse and creative conduits. The health services in developing countries must be supported to maintain their skilled personnel. Global and national policy recommendations should balance health professionals' right to move with the need to compensate sending countries for the money spent to train these professionals. A solution will require the cooperation of both sending and receiving countries' governments and, within the country, the public and private sectors.

There is need for various sectors within Tanzania to strive in order to improve the working environment, living conditions, and family ties to provide incentives for health professionals to remain in currently understaffed areas.

## IV. „Traditional Medicine“ – Indigenous Practices for Human Rights from `Bottom Up`?

### Necessity for Differentiation: Regaining Space for „Traditional Medicine“

*PD Dr Walter Bruchhausen, University Aachen*

*What is “traditional medicine”?*

Traditional medicine has a social function. It gives to marginalized or deprived groups and peoples a part of their desired identity, something to be proud of (as allegedly equal to Western medicine) and a culturally acceptable and proven means of dealing with affliction. The social reality of “traditional medicine” is found often outside the written traditions (e.g. China, India, Arab-speaking countries, Iran), where healing before colonialism was not “medicine” since. There were no full-time experts, the practice was mixed with non-medical tasks and the knowledge was not widely shared but often idiosyncratic.

*WHO and traditional medicine: Healers or treatments?*

Traditional practitioners are seen as additional staff, that should be integrated into the national health systems and get a short biomedical training. With regard to traditional healers as village health workers, there has been high desertion rates since villages did not pay them and they had the lowest rank in the governmental health care hierarchy instead of previous local authority.

“Traditional medicine” as medical treatment contains often medicinal herbs and e.g. Acupuncture in China or Ayurveda in India, but also other rituals.

*“Traditional medicine” and human rights*

In the context of “traditional medicine” and human rights there are three aspects that are important to notice. First the spiritual dimension of traditional medicine, second the aspect of anti-discrimination and third the attainment of the highest possible standard of health.

In the context of the spiritual dimension a proposal for the WHO constitution is: ‘Health is a dynamic state of complete physical, mental, spiritual and social well-being...’ (52<sup>nd</sup> World Health Assembly, April 1999, Official Records A52/24, ‘Amendments to the Constitution: Report by the Secretariat,’ p.4.).

The aspect of anti-discrimination leads to the General Comment No. 14 that says about the acceptability that 'all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities...'. Regarding to this healers can better reflect and express than ordinary people that local practices are not superstition, but potentially helpful and rational measures, also they can address political bodies in the case of discrimination for cultural reasons and identify 'black sheep' of fraudulent practitioners in their own circles.

In the context of the highest possible state of health one should take a look on what healers can contribute. Healers cannot cure children with severe pneumonia and extreme dehydration, save mothers with obstetric emergencies and prolong the survival with HIV/AIDS or TB. Also 'Traditional medicine' loses the importance in international health it had gained since the late 1970s because of its minor importance for infectious diseases and its minor impact on mortality of vulnerable groups (mothers, children, elderly). After the reports by World Bank (1993) and WHO (2001) on investment in health such vertical programs were favoured.

But 'Traditional medicine' may regain some importance with the acknowledgement of mental health as a major global health issue since this is a domain of traditional medicine and with the rise of attention to Non-communicable diseases (NCDs) caused by life-style factors as much traditional medicine concerns health nutrition (Ayurveda) and physical exercises (Yoga, Tai Chi). Healers can also spread biomedical knowledge, e.g. of oral rehydration therapy against high child mortality from diarrhoea and they can refer pregnant women and infants with life-threatening complications early. Also they can support the adherence of HIV/AIDS patients to ART and secure the psychosocial requirements of treatment which concern more than half of the doctor-patient-interactions. So healers send biomedical messages to the local population.

But for this it is necessary to differentiate which health problem needs which approach (biomedical vs. traditional, preventive vs. curative, vertical vs. horizontal). Also the advocacy by the local healers are necessary that pointing to neglected health issues of a community (endemic and epidemic diseases) as well as the salutogenesis that contains spiritual resources as factors of resilience. So healers send messages of the local population to political and medical bodies.

## Indigenous Medical Knowledge: Claiming fair Compensation and Recognition for Commercial Exploitation

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### *Distinction between traditional and indigenous medicine*

The term traditional is used interchangeably with indigenous, especially in the context of knowledge and medicinal uses for plants and other natural resources. However the two may be different. In India – indigenous people, referred to as Adivasis (“first settlers” or native Indian) have a set of beliefs and practices that make up indigenous knowledge, including medicinal uses for plants and natural remedies for many ailments. Traditional medicine in India on the other hand has its origin with the arrival of Hinduism, Islam and cross-border influences over time. Traditional medicine and indigenous medicine are by and large based on knowledge of naturally occurring substances.

### *Traditional Medicine Systems in India*

Ayurveda dates back as far as the Indus Valley Civilization. Hindu religious texts make references to Ayurveda. Practitioners believe that a balance ought to be struck between the mind, the body and one’s personality and treatment is in the form of diet, exercise and meditation as also the use of medicinal herbs and naturally occurring substances to cure illness.

Siddha is based on Dravidian culture and beliefs (indigenous people in the south of India) and it is referred to in Hindu texts. The core belief is that there ought to be a balance of humours in the body and an imbalance causes maladies that must then be cured by adjusting the patient’s diet and lifestyle.

Unani was first practiced in India during the Mughal empire but it is having its origins in Persia. Unani medicine is also based on humours and has parallels with ancient Greek medicine and beliefs. Plant and animal based oils that are commonly used in Unani treatment have entered mainstream traditional usage in Indian homes, especially Almond Oil.

While they are not strictly pertaining to any particular religious practice, some aspects of traditional medicine therefore borrow from religious beliefs and faith.

### *Non Conventional Medicine and Alternative therapies*

The phrase Non-Conventional Medicine (NCM) and alternative medicine or therapies have been put forward to refer to anything besides allopathic medicine. These NCMs are as diverse as the traditional medicine systems in India, like Traditional Chinese Medicine including Accupuncture, Homeopathy, Bach Flower Remedies, Reiki and Crystal therapy and many other similar forms of alternative medicine around the world. To many individuals, there is easy access to only these alternative medicines. Indeed, in many parts, there is no belief in or knowledge of allopathic remedies – be it medicine, surgery or standard treatment and care.

### *Right to Health considerations in NCMs*

There are mixed opinions on the reliability of NCMs, with several types labeled as merely pseudoscience and sustained only due to the placebo effect, experienced by those who believe in and regularly turn to them. The most important question that NCMs throw up is that of quality. The Right to Health, as defined in Article 12 of the International Covenant on Economic, Social and Cultural Rights – is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

### *Right to Health – Essential Medicine*

The General Comment 14 to the Article 12 'Right to Health' discusses the authoritative interpretation of the right to health under Article 12. General Comment 14 describes the entitlements that all human beings must have as a part of their Right to Health. This implies that an important aspect of the Right to Health is the right to access medicine that is not only easily available and accessible (physically accessible and economically affordable) but also that these medicines are good quality and efficacious. The main concern with NCMs is that their efficacy and quality is not always something which is easily verified.

### *Establishing the quality of NCMs*

With a large number of people turning to NCMs as their primary source of healthcare, there is a need to ensure that these NCMs are of the highest quality. Many traditional remedies relying on medicinal plants and herbs are scientifically proven to be efficacious and there have been many allopathic drugs that have medicinal plants based on the same core ingredients.

### *Colonial influences in criminalizing drug-use*

The use of substances like marijuana to suppress nausea, and as a painkiller is traditionally understood and recorded in many cultures and has gradually come to be accepted in modern drug enforcement laws around the world with exceptions carved out for medicinal use. Similarly, narcotic substances like opiates (itself a derivative of naturally occurring opium) such as morphine and ketamine have found use in end of life pain management. The use of coca leaves as a stimulant is also well documented as accepted and without any of the stigma attached today to drug use. The advent of colonialism brought in western or Christian morals and values impacting on traditional medicines, like marijuana and coca. This informed and influenced changed laws to reflect these sensibilities making local cultural mores immoral and illegal. Alcohol (a drug) became legal but coca and marijuana became illegal. This thinking impacted the framing of the three Drug Conventions which mandate criminalizing of possession of narcotic and psychotropic substances illegal. As a result in a number of countries not only are jails filled with persons with drug related offences but criminal war lords have taken over sections of diverse countries.

### *Safeguarding the use of NCMs for indigenous people*

Drug patenting is seen as a common practice to secure ownership rights over new drug inventions and also to ensure that profits can be drawn from such inventions. While Indian Patent Law grants patents to only novel and innovative inventions, countries with more relaxed patentability criteria such as the USA has caused controversy by granting patents to uses of plants that are widely known and understood as a traditional medicines in other parts of the world. The patenting of the use of turmeric in the USA was seen as profiting from what was commonly known and used in many millions of homes in the Indian Sub-Continent. Critics have come to view this as profiting from indigenous peoples' traditional knowledge and is as such unethical.

### *The impact of granting IP protection to traditional knowledge*

An IP maximalist approach excludes indigenous people from enjoying benefits of the commercial exploitation of traditional knowledge – such as the use of naturally occurring substances in allopathic medication. For example, Traditional Chinese Medicine was identified as offering the core ingredient of Tamiflu, used to treat the H1N1 Swine Flue outbreak. The drug was highly sought out in the epidemic in 2009 and was prohibitively priced despite containing a core of inexpensive star anise, which is traditionally known to cure the flu like symptoms of Swine Flu. Furthermore the recipient of the 2015 Nobel Prize for Medicine Dr. Youyou Tu is credited with inventing a

cure for malaria based on Traditional Chinese Medicine and the properties of a naturally occurring compound – Artemisinin.

### *Benefit sharing*

The Convention on Biological Diversity has as one of its goals fair and equitable sharing of benefits arising out of living genetic resources. As a result, Access and Benefit Sharing Agreements (ABSAs) have been considered to ensure that indigenous people receive fair compensation and recognition when genetic resources known by them is commercially exploited. The Nagoya Protocol solidified the modalities of these ABSAs under Article 5 which highlights the importance of recognizing the efforts taken by first settlers and indigenous people through agreements containing mutually agreed terms for sharing and benefit. It also covers procedures for compliance and obligations of each party as also the many tools and mechanisms available in order to facilitate mutual benefit and sharing. However with the complete dominance of profit making corporations in the economic sphere these treaties have largely remained on paper.

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## V. Religious Actors within Health Systems: Potentials and Challenges

### Between Crisis Management and the Strengthening of Health Structures – The Role of Religious and Cultural Sensitisation

*Archbishop Thaddaeus S. Ruwa'ichi OFMCap, Archbishop of Mwanza, Tanzania*

#### 1. Introduction

Health structures are designed and aimed at addressing situations which affect the human person especially in as far as caring for his or her well-being. Religious and cultural institutions have a significant role to play, and indeed, that has been true from time immemorial.

Recent global trends tend to indicate that:

- a. There is an increasing number of health related crises and disasters. These owe to a variety of causes, both natural as well as those that are provoked by human activity.
- b. There are growing social and economic losses.
- c. Health remains a major concern notwithstanding the great strides which have been registered in the field of science and technology.

Crisis situations require adequate preparedness in order to respond to them in a timely and adequate manner. Preparedness for crisis response is a matter of survival or perishing, closure or flourishing of an institution. Without denying the pain, loss and disorientation that may result from a crisis, it is also true that crises can provide challenges as well as opportunities for learning and welcome transformation. But this latter scenario will only come true if an institution or organisation is equipped with the right tools to handle the entailed challenge.

In any given scenario, there are basic modalities of managing a crisis:

#### i. Predictability and preparedness:

Organisations which invest in adequate data collection and analysis are better placed to anticipate the possibility of a crisis and are reasonably equipped to manage or prevent the possible crises in as far as such is humanly possible.

#### ii. Response:

It is desirable that crises be handled punctually and professionally. A crisis situation does not entertain procrastination or guesswork. Crises demand focused and timely responses.

### *2. Responding to Crises in the Health Sector:*

In modern times, man has had to grapple with a variety of cases which threatened human health and survival: malaria has been a major case especially in tropical countries. There have also been health threats which have caused great concern such as Ebola, and the recent outbreak of Zika fever in Brazil. The sheer thought that such ailments could spread out of control is extremely unsettling.

The WHO being the global organisation committed to monitoring and addressing human health challenges, stipulates that in dealing with challenging situations, the objective should be to reduce health consequences that may result from emergencies and disasters, crises and conflicts, and to mitigate their social and economic impact. To realize this objective, the following functions need to be attended to:

- a. Informed and adequate assessment and analysis of data. This task is part and parcel of health information management.
- b. Coordination of interventions and initiatives so as to remain focused.
- c. Identifying gaps in public health response and adequately filling them.
- d. Protecting and strengthening local capacities and systems.

### *3. Crisis Management and Strengthening of Health Structures:*

To be able to respond to a crisis, health structures, personnel and contingencies need to be strengthened. To achieve this, it is important to raise and respond to key issues such as:

- a. What could go wrong? That which could go wrong constitutes a risk. In the health sector, a risk be any factor which may compromise the ability of an organisation in its quest to achieve its professed goals. As such, risks may relate to an organisation's programs, finances, management, infrastructure or even the organisation's susceptibility to natural disasters. By their nature and scope, health-care institutions are susceptible to crises. Inevitably health organisations differ in size, location, competence and resources. Institutions with fewer resources are prone to acute situations as opposed to their counterparts with rich and adequate resources. There is a broad range of things which could go wrong in a health organisation, especially in those which are precarious. It suffices to highlight the following examples: embezzlement, messed up software entailing loss of essential data, flooded premises or the withdrawal of a key

partner. These and other examples serve to demonstrate the close relationship that exists between risk and crisis. However, it should be stressed that normally there is a predictable link between a risk and a crisis; for example, lax financial management may result in embezzlement, while delayed maintenance and repairs of working space may lead to tear and wear such as necessitates the condemnation of a given building as an unsafe working space. Both instances are bound to ensue into a crisis. Besides the foregoing, it is important to bear in mind that by their nature, health organisations deal with tasks that are inherently risky. Therefore health facilities which deal with vulnerable populations or scenarios, must constantly strive to ensure that their clients are protected. Failure to foresee and prepare to handle inherent risks augment carelessness thus increasing the chances of the occurrence of crises. Moreover, even seemingly safe situations and positive endeavours may turn negative if left to poor or reckless planning.

b. What should one do in order to prevent things from going wrong? In short, to prevent things from going wrong, one should be proactive. This entails building a culture of close monitoring, systematic and sustained collection and careful analysis of data, networking with all relevant stakeholders, make some informed forecast and last but not least, to be prepared for prompt action if and when things go wrong. In short, the foregoing boils down to the strengthening of health systems and structures. For a health institution, this implies a diligent assessment of risks, the assessment of the significance of those risks, and treating those risks which are deemed significant in a measured and professional manner. Such an approach will enable an organisation or health facility to cope with scenarios of uncertainty by taking relevant steps aimed at safeguarding its vital assets and resources.

#### *4. The Role of Religious and Cultural Organisations*

It is an acknowledged fact that it is the prerogative of government to provide health and other social services to its citizenry. Moreover, it is also the duty of government to ensure:

- a. That there are adequate policies to guide the provision of social services.
- b. That adequate facilities, manpower, equipment and medicines and other consumables are sufficiently available.
- c. That security is in place to safeguard personnel, facilities, other equipments and finances.
- d. That funds are regularly made available to ensure smooth and sustained operations of health facilities.

e. That strategies and contingencies are put in place to avert or address risks and crises.

Without prejudice to the foregoing, it should be acknowledged that no government can shoulder this responsibility alone. Hence the need for a sound Public – Private Partnership. We are glad to confide that this has been adopted in Tanzania, albeit with challenges which require vigilance and constant advocacy. The following was the state of health provision facilities in Tanzania in 2014 (CSSC, 2015).

FACILITY	NUMBER	BED CAPACITY
National Hospitals	1	1362
Special National Hospitals	4	1497
Zonal Referral Hospitals	5	2327
Regional Referral Hospitals	15	3449
FBO Regional Referral Hospitals	12	4581
District Council Hospitals	63	7267
Council Designated Hospitals	37	6742
Voluntary Agency Hospitals	103	5595
Govnt Agencies Hospitals & Health Centres	29	1214
Health Centres	614	14959
Dispensaries	5987	00
Special Clinics	12	00

Nota Bene: Church or Faith Based health facilities figure predominantly among the highlighted sections.

In Tanzania, religious organisations and cultural entities are among the forefront collaborators with government in social services provision including health care provision. In this regard, religious organisations have and continue to play a key role in social services provision.

Churches have been involved in the provision of health services from the arrival of the Missionaries in the 1860's. To date, faith based organisations especially churches own and run over 40% of health service facilities mainly but not exclusively in rural areas. This caters for the greater part of the population. Therefore within the Tanzanian scenario, religious and cultural organisations shoulder a hefty responsibility. The government acknowledges this and appreciates the same, though not without hitches and inconsistencies.

Considering the role played by religious organisations and cultural entities in the provision of social services especial health care provision, it is inevitable that they are implicated in ensuring smooth functioning, adequate safeguards and preparedness to

address risks and if need be, respond to crises. Therefore, religious organisations should see to it that the following are in order:

i. Stewardship:

- Ensure the availability of adequate leadership and governance: In this regard, provision and cognisance of the following is imperative:

- National Health policy.
- The institution's (Church's, e.g. TEC, Archdiocese, etc.) policy.
- National health crisis management policy and legislation.
- Risk reduction initiatives.
- Crisis preparedness plan.
- Coordination and partnerships.
- Health education strategies.
- Public information and adequate communication.

ii. Resource Mobilization and Management:

- Ensure the availability of needed numbers and quality of human resource in church owned facilities:

- Strategic plan for the formation, employment, motivation and retention of human resources for optimal functioning as well as crisis management.
- Adequate capacity building for crisis management.
- Access to adequate essential pharmaceuticals as stipulated by national guidelines.
- Availability of disaster resistant health facilities.
- Appropriate logistics and infrastructure for service delivery and support functions.
- Continuous health risk assessment, surveillance and issuing of timely warning.
- Capacity to affect a rapid health needs assessment and adequate response.

iii. Financial Resources:

- Ensure that the financing of health care in church owned facilities is sound and sustainable:

\* Planning and budgeting: this calls for budgeting for normal functions as well as crisis management. Besides, it entails budgeting for vulnerability assessment as well as risk reduction measures.

- Contingency planning and funding: to take care of unforeseen eventualities. When things are going well, there is a temptation to neglect this component.

iv. Service Delivery:

- Health care facilities management:

- Ensuring the preparedness of health care facilities
- Securing health care / hospital crisis management capacity.

- Mass casualty management:

- Building up the capacity and ability to respond promptly and effectively.

- Ensuring the availability of adequate surgical capacity as an essential component of health system's response
- Availability of appropriate and effective medical evacuation facilities.
- Ensuring the availability of essential medical services:
- Having in place essential health programs including primary health care systems.
- The availability of health care services to marginalised or displaced populations.

#### *5. If things go wrong:*

The provision of social services especially health care provision takes place in human environment and by human persons. Therefore, even with the best of intentions and effort, things may still go wrong, risks will still be encountered and crises can ensue. Notwithstanding this fact, service providers, among which religious organisations should do everything humanly and professionally possible to ensure normal functioning and reliable, effective and sustained service provisions. In the event however that a crisis emerges, that should be met in a prepared manner. In a nutshell, any organisation involved in health service provision, and that includes religious organisations, should see to it that they are not caught unprepared due to negligence or poor management. Proper planning serves to address worst-case scenarios which can be very frustrating and disorienting. Therefore, it is needful to establish protocols to guide the following:

- Management in decision making.
- Employees' action and responsiveness.
- Awareness and responsiveness to client expectations.

#### *6. Conclusion:*

In matters of social services' provision particularly in the health sector, religious and cultural organisations as partners of the state are taxed to ensure that health systems are strengthened and enabled to address challenges such as those entailed in normal as well as crisis situations. Hence, it is needful to:

- Undertake adequate and periodic situational analysis: which entails making an informed assessment to ascertain the nature and scope of a challenge or a crisis and thereafter determine the most appropriate response.
- Undertake a consistent communication with all relevant parties. This is crucial especially during a crisis.
- Adopt an informed stance in order to lobby and advocate to the government and all relevant parties for the sake of putting in place mechanisms for adequately rendering normal service as well as ensuring promptness in case of crisis.

It is assumed that when persons are assured of the soundness of their environment and the reliability of expected services for their wellbeing, they live in peace and go about their duties more responsibly. For this we should strive and commit ourselves.

## Right to Health and Cultural Traditions: Typological Analysis of Emerging Fault Lines

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### *Right to health under international law*

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. The steps to be taken by the State Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child, the improvement of all aspects of environmental and industrial hygiene, the prevention, treatment and control of epidemic, endemic, occupational and other diseases and finally the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

### *General Comment 14*

The General Comment No. 14, which was adopted at the 22<sup>nd</sup> Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, gives an authoritative interpretation of the right to health under Article 12. It does not just deal with the right to be 'healthy', but with freedoms and entitlements that come along with this topic.

Freedoms are understood as bodily integrity, autonomy, the freedom from interference and the right to control one's health and body, including sexual and reproductive freedom. The entitlements include a functioning adequate healthcare system, an equitable distribution of health services, the access to essential medicines and special provisions for vulnerable groups.

### *General Obligations*

In this context there are three types of State obligation. First to respect: States must neither directly nor indirectly violate the right to health. For example States must refrain from interfering with the exercise by individuals of their right to SRH. It also requires States to repeal, and refrain from enacting laws and policies that create barriers to access SRH services. Second to protect: States must take measures to prevent third parties from interfering with the right to health. For example States must pre-

vent third parties, such as conscientious objectors, from preventing access to lawful abortion services. And third to fulfill: States are required to adopt appropriate legislative, judicial and administrative measures and a national plan and strategy for realizing the right to health. For example States must provide for a national plan to make available effective sexual and reproductive health services that are accessible and acceptable to the needs of women.

#### *Core obligations vis-à-vis SRH*

But there are also core obligations vis-à-vis the sexual and reproductive health. First to adopt a national strategy and action plan, that is reviewed and monitored periodically through a transparent and participatory process. Second the ensuring of privacy, confidentiality and free, informed and autonomous responsible decision-making. Third it includes to take decisions always with the participation of those effected. Fourth it has to guarantee universal, non discriminatory and equitable access to affordable, acceptable and quality goods, services and facilities, in particular for vulnerable and disadvantaged groups. Fifth it has to enact and enforce legal prohibition of harmful practices and gender-based violence, including female genital mutilation, child and forced marriage, domestic and sexual violence, including marital rape. And sixth there is the obligation to provide essential medicines, equipment and technologies essential to sexual and reproductive health, including those on the WHO Essential Medicines List.

#### General Comment 14 (CESCR)

Availability, accessibility, acceptability and good quality of healthcare facilities, goods, services and programs are interrelated and essential. By availability is meant that there is an adequate number of services for reproductive and sexual health. The non-availability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, cannot be a barrier to accessing services. Accessibility especially refers to non-discrimination, for example services that say only vulnerable groups like women and girls need access. Services must be physically accessible and financially accessible, with provision for those on no or low incomes, therefore the State must provide for affordable reproductive health services within the State. Women must also be able to seek, receive and impart information about sexual and reproductive health. The claim for acceptability contains medical ethics, that are respectful of requirements of minorities, gender-sensitive, culturally and respectful of confidentiality. Gender sensitivity requires health facilities, goods and services to respond to the particular needs of women and respect the capacity of each woman to make-decisions concerning her own reproduc-

tive health. Also it includes no denial of health facilities, goods and services goods on cultural differences. Quality refers to a scientifically and medically appropriate, skilled medical staff, safe medicines, equipment and adequate sanitation.

### *ICCPR and ICESCR*

With regard to international treaties there are differences in the application in civil law countries (applicable law on signing and ratification) and common law countries (have to domesticate the law). In some common law countries even in the absence of a contrary law the treaty becomes enforceable on signing and ratification (for example in India). Traditionally *rights under the International Covenant on Civil and Political Rights* (no arrest without furnishing grounds) are immediately realizable as against those under the *International Covenant on Economic, Social and Cultural Rights* (providing essential medicines) which are to be progressively realized except for core obligations. This came out from the difference in the perception of erstwhile western countries and the erstwhile soviet states. There is no intrinsic difference between ICCPR and ICESCR. They are interrelated and inextricable linked. The apparent difference is because of requirement of resources. They have turned out to be so because of historical accident of the existence of resources. In the right to due process in arrest, the conviction requires as much if not more resources than treating a patient in hospital. Both are now enforceable in the UN under the Optional Protocols and both are based on the inherent dignity of human beings.

### *Religion, culture and health*

Religion, culture and customs are legally distinct concepts but they are deeply intertwined, with religion often having a significant bearing on cultural practices and traditions. In many societies, religions, culture and custom constitutes a significant part of individual identity. It informs decisions about health as well as it provides coping mechanisms, social support, existential meaning, a sense of purpose, a coherent belief system and a clear moral code. Custom is what exists as local practices from time immemorial (30 years), it can be overridden by statute. International law and some Constitutions provide for the right to conserve culture and in particular language of a community (Article 29 of the Indian Constitution). In indigenous communities the relationship of the people, the land, the rivers, the animals and their ancestor is very important and nay sacred. Today's development paradigm of making all natural resources and the habitat, both flora and fauna subservient to human beings is contrary to many cultures.

### *Understanding religions as a human right*

Religion in the west assumes the 'existence' of a superior being: God (See *Nikulnikoff v. Archbishop, etc., of Russian Orthodox Greek Catholic Church*, 142 Misc. 894, 255 N.Y.S. 653,663). Amongst Hindus it is a way of life with existence of the divine being. Amongst Buddhists there is no divine being but the spiritual relationship with one self and others. The right to practice, profess and propagate religion is a recognized human right internationally and constitutional rights in many countries. However courts tend to protect the core of religious practices and not every aspect of it. Ritual sacrifices of animals is not a core of Hindu sects but the way animals are slaughtered amongst Muslims is protected.

#### *Freedom of religion in the international law*

Article 19 of the Universal Declaration of Human Rights (UDHR) establishes the freedom of opinion and expression stating: "everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers." Article 18 of the International Covenant on Civil and Political Rights (ICCPR) says "Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice..." Article 18 (3) continues: "Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."

#### *Freedom of religion under the Indian Constitution*

The freedom of religion in India is a fundamental right guaranteed by Article 15 and Article 25 of the Constitution of India. Freedom of conscience and free profession, practice and propagation of religion is a subject to public order, morality and health and to the other provisions of this Part (Part III – fundamental rights). All persons are equally entitled to freedom of conscience and the right freely to profess, practice and propagate religion.

#### *Freedom of religion is subject to other human rights*

The General Comment 22 of the Human Rights Council to Article 18 discusses the limitation on the right to religion. It should be established by law, directly related and proportional to the goal of public health and non-discriminatory. The Convention on the Elimination of All Forms of Discrimination against Women, and the Protocol of the African Charter of Human and Peoples' Rights on the Rights of Women in Africa

call for discriminatory customary and traditional practices that violate human rights to be removed. Where there is a conflict, international law and constitutional law has expressly preferred protection of the right to health by restricting the right to practice religion in order to further public health goals.

*Fallout with religion: The negative impact on the right to sexual and reproductive health*

Women and girls are often burdened with upholding religious, cultural or customary norms, values and practices. Religious and cultural tradition is often used to justify discrimination and crackdowns on rights – especially those of women. Religious and cultural preferences for male offspring perpetuate the practice of female infanticide in countries like India. Female Genital Mutilation is widespread in Egypt and some sects of the Islamic faith. And there are restrictions and criminalization on the use of birth control and abortion that exist particularly in Ireland, Poland, Portugal and the Philippines.

*Impact of criminal laws on women's right to reproductive and sexual health*

The Report on criminalization of sexual and reproductive health from 2010 from the UN Special Rapporteur on the Right to Health focuses the discriminatory in nature and effect. Legal restrictions are founded upon, and perpetuate wrongful gender stereotypes, discrimination and marginalization of women and girls. This negates the empowerment of women. The criminal regulation of health services that only women need, is antithetical to the empowerment of women, instead of isolating women and discouraging them from taking steps to protect their health due to fear of prosecution and stigmatization. Women almost exclusively bear the health burdens caused by restrictions on reproductive and sexual autonomy. This generates disproportionately poor health outcomes for women compared to men. Women have to resort to unsafe or expensive health services. Other means of accessing reproductive health facilities, goods and services can be prohibitively expensive, thereby discrimination is compounded for women from disadvantaged socio-economic backgrounds. Criminalization leads women to resort to unsafe abortions. States should “ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control” (CEDAW Committee General Recommendation 19 (1992) on violence against women).

In the context of Criminal laws and public morals public morality is not a legitimate justification for enacting or enforcing laws intended to regulate conduct or decision-

making on sexual and reproductive health matters. Laws that are based on public morality are not evidence-based. "Morals" tend to reflect a dominant social or cultural patterns, in which stereotyped roles for men and women typically prevail. Thus the CEDAW Committee requires States to modify such patterns (Article 5).

#### *International jurisprudence on abortion*

In 2005 the United Nations Human Rights Committee dealt with a case of a 17-year-old girl from Peru that was pregnant with a seriously ill baby. Although she wanted to have an abortion it was denied and she had to deliver the baby. The Human Rights Committee found a violation of the freedom from torture and cruel, inhuman and degrading treatment due to the significant psychological injury cause to the girl in giving birth to a child with a fatal foetal abnormality. The right to privacy includes protection of women from "interference in decisions which affect their bodies and lives, and offers them the opportunity to exercise their right to make independent decisions on their reproductive lives." (CCPR/C/85/D/1153/2003)

Another case took place also in Peru in 2011. A woman got pregnant as a result of a rape and an abortion was also denied. The decision of medical staff to delay spinal surgery after discovering that the woman was pregnant was based on the prescriptive sex-role stereotype that women should be mothers. Reliance on this stereotype had the effect of prioritising protection of the foetus over the life, health and dignity of the pregnant woman in this case. Consistent with jurisprudence relating to the right to privacy, the right to health under Article 12 of CEDAW requires effective and accessible procedures to establish entitlement to the medical services.

#### *European Court of Human Rights*

Three cases in Poland and Ireland all hold that if abortion is permitted, the right to privacy requires effective and accessible procedures to allow a pregnant woman to determine if she is entitled to an abortion and to resolve disputes between a doctor and the pregnant woman as to whether an abortion is permitted. This is particularly important in the context of criminal laws that have a chilling effect on access to lawful abortion. Denial of an access to lawful abortion may be tantamount to cruel, inhuman and degrading treatment depending on the impact on the pregnant women's health. The ECHR refuses to recognise a substantive right to abortion, including on health or wellbeing grounds because: Whilst a consensus does exist amongst European states to allow abortion for health and wellbeing grounds, there is no consensus on when life begins. Also the ECHR defers to the moral values of a State concerning the question of when life begins, therefore giving a State a wide margin of appreciation for

determining when to protect the life of the foetus. As the rights of a pregnant woman are inextricably linked to the right to life of the foetus, that margin of appreciation is considered to extend to determining how to balance the right of a pregnant woman against the right to life of a foetus (and when to allow abortion).

The partly dissenting opinion of six judges in the case in Ireland disagreed with the denial of abortion for health and wellbeing grounds: The relevant consensus was that relating to the balancing of a pregnant woman's rights against the rights of the foetus. There is a clear consensus in Europe that the right to life and health of a pregnant woman should prevail over the right to life of the foetus. The right to abortion for health and wellbeing reasons therefore should have been found by the majority of the ECHR. ECHR noted that abortion is available on request (subject to certain criteria, such as gestational limits) in some 30 Contracting States, for health grounds in some 40 Contracting States and on well-being grounds in some 35 Contracting States. Abortion is absolutely prohibited in only three Contracting States.

## VI. Annex

### Conference Programm: Human Rights under Pressure – Promoting Human Rights through Cultural Traditions?

Congress of the German Commission of Justice and Peace, December 9<sup>th</sup> to 10<sup>th</sup> 2016  
At the Katholische Akademie Berlin, Hannoversche Str. 5, 10115 Berlin

Friday, December 9<sup>th</sup> 2016

#### **Erosion of solidarity? New tendencies in Europe**

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[10:00] Commitment for Human Rights – A Challenge to Christian Identity  
Introduction  
*Bishop Dr Stephan Ackermann*, President of the German Commission of Justice and Peace, Bishop of Trier

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[10:50] Coffee break

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[11:00] What keeps our societies together? New and Old Challenges by Populist Movements  
European Perspectives  
*Aux. Bishop Krzysztof Zadarko*, President of the Commission on Migration at the Catholic Bishops' Conference of Poland, Diocese Koszalin-Kołobrzeg (Poland)  
*Archbishop Jean-Claude Hollerich SJ*, Archbishop of Luxemburg, President of the Conference of European Justice and Peace Commissions (Luxembourg)  
*Rebecca Harms*, President of The Greens–European Free Alliance group in the European Parliament, Brussels  
Chair: *Prof Dr. Andreas Lob-Hüdepohl*, Institute for Christian Ethics and Politics, Berlin

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[12:30] Lunch

## Human Rights Defenders: How to cope with the invocation of “Culture”

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[14:00] Honouring *P. Jacques Mourad*, Association Mar Musa, Syria  
P. Mourad is a syrian-catholic priest of the Association Mar Musa in Syria, who is involved in intensive Christian-Islamic dialogues. He stands up for Christian-Islamic reconciliation in the Middle East. Because of this Pater Jacques was abducted in Syria in May 2015 by the IS. He was released in October 2015. At present he is living in the monastery of Pater Jens Petzold in Suleymannia.

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[14:30] Interviews

*P Rigobert Minani-Bihuzo SJ*, Jesuit African Social Centers Network  
JASCNET, Director, Nairobi, Kenya Nairobi

*Archbishop Sebastian Francis Shaw*, Archbishop of Lahore, Pakistan

Chair: *Dr Daniel Legutke*, German Commission of Justice and Peace,  
Bonn; *Johannes Seibel*, missio – International Catholic Mission Society,  
Aachen

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## The Human Right to Health – Capitalizing on Tradition for a Non-Discriminatory Implementation

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[15:30] Introduction

The Human Right to Health – Sketches for a Better Understanding of an Underestimated Human Right?

Input: *Prof Dr Stephan Rixen*, Chair of Public Law, University of Bayreuth, Bayreuth

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[16:00] Coffee break

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[16:15] Parallel Workshops

- Religious Motivations and Potentials of Interreligious Cooperation for the  
[17:45] Human Right to Health

*Dr Azza Karam*, UNDP Interagency Task Force Religion and Development,  
New York, USA

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*Dr Alissa Wahid*, General Secretary of Nahdlatul Ulama's Family Welfare Agency, Yogyakarta, Indonesia

*Dr Marlies Reulecke*, Medical Mission Institute, Würzburg

Chair: *Prof Dr Stephan Rixen*, Bayreuth

Brain Drain and Care Drain: Responsibility of the North?

*Prof Dr Eva Senghaas-Knobloch*, Sustainability Research Center (artec), University of Bremen, Bremen

*Dr Maria Kipele*, Medical Mission Institute, Würzburg / Mwanze (Tanzania)

*Archbishop Jude Thadaeus Ruwa'ichi OFM Cap*, Chairman of the Department of Pastoral Health Care of the Tanzania Episcopal Conference, Archbishop of Mwanza, (Tanzania)

Chair: *Dr Hildegard Hagemann*, German Commission of Justice and Peace, Bonn

„Traditional Medicine“–Indigenous Practices for Human Rights from 'Bottom Up'?

*PD Dr Walter Bruchhausen*, University Aachen,

*Prof Anand Grover*, Lawyers Collective, form. UN Special Rapporteur on the Right to Health, New Delhi, India

Chair: *Dr. Daniel Legutke*, German Commission of Justice and Peace, Bonn

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[18:15] Presentation of the main findings of the Workshops in plenary

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[19:00] Dinner and Reception  
Music by Jürgen Hahn Trio

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Saturday, December 10<sup>th</sup> 2016

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[07:30] Holy Mass  
Bishop Dr. Stephan Ackermann

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### **Potentials and Problems: The Right to Health and Religions**

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[09:00] Between Crisis Management and the Strengthening of Health Structures  
– The Role of Religious and Cultural Sensitization?

*Archbishop Jude Thadaeus Ruwa'ichi OFM Cap*, Chairman of the Department of Pastoral Health Care of the Tanzania Episcopal Conference, Archbishop of Mwanza, Tanzania

*Dr Azza Karam*, UNDP Interagency Task Force Religion and Development, New York, USA

*Mareike Haase*, Consultant for Health - Bread for the World, Berlin

Chair: *Dr Marlies Reulecke*, Medical Mission Institute, Würzburg

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[10:30] Right to Health and Cultural Traditions: Typological analysis of emerging fault lines

*Prof Anand Grover*, Lawyers Collective, form. UN Special Rapporteur on the Right to Health, New Delhi, India

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[11:30] Coffee break

### **Closing Panel**

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[11:40] Human Rights and Cultural Traditions: The Potentials of Faith Based Organizations

*Prof Dr Dr h.c. Heiner Bielefeldt, Erlangen*

*Dr Bernhard Felmberg, Director, Directorate Civil Society in the Federal Ministry for Economic Cooperation and Development, Berlin*

*Dr Alissa Wahid, General Secretary of Nahdlatul Ulama's Family Welfare Agency, Yogyakarta (Indonesia)*

*Prelate Pirmin Spiegel, Director General Misereor, Aachen*

Chair: *Karin Kortmann, Vice-President of the Central Committee of German Catholics, Berlin*

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[13:00] Lunch and Departure

## Participants

### *In German*

Ackermann, Stefanie	Berlin
Bischof Dr. Ackermann, Stephan	Vorsitzender der Deutschen Kommission Justitia et Pax, Bischof von Trier, Trier
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Pfr. Bittner, Winfried	Fulda
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Breunig, Nicola	Brot für die Welt, Berlin
PD Dr. Bruchhausen, Walter	Universität Aachen, Bonn
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DK Msrg. Ertl, Manfred	Bistum Passau
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Harms, Rebecca	Fraktion der Grünen/EFA im Europaparlament, Brüssel

Hilgers, Jörg	Exposure and Dialogue Program e.V.
Erzbischof Hollerich SJ, Jean Claude	Erzbischof von Luxemburg, Vorsitzender der Europäischen Justitia et Pax Konferenzen
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Dr. Kipele, Maria	Ärztin, Mwanza, Tansania/Würzburg
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Markert, Inga	Deutsche Kommission Justitia et Pax, Bonn
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Rösch-Metzler, Wiltrud	Pax Christi, Berlin
de Rozario, Cecil	Justitia et Pax, Schweden
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Prälat Spiegel, Pirmin	Hauptgeschäftsführer Misereor Aachen
Steeb, Michael	Geschäftsführer der Arbeitsgemeinschaft für Entwick- lungshilfe e. V., Köln
Sturm, Anne	Berlin
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## Biographical Notes of the Contributors

### **Bishop Dr Stephan Ackermann**

- \*1963
- Studies of Catholic Theology and Philosophy in Trier and Rome
- 1987 Ordination
- 2006 Episcopal Ordination (Bishopric Trier)
- since 2009 Bishop of Trier
- Chairman of the German Commission of Justice and Peace
- Delegate to the German Bishops' Conference for abuse cases

### **PD Dr Walter Bruchhausen**

- Studies of Medicine, Catholic Theology and Ethnology in Bonn and Würzburg
- 1991 Doctorate
- 2004 Habilitation
- since 2012 research associate at the Institute for History, Theory und Ethics of Medicine at the University Aachen

### **Prof Anand Grover**

- Senior Advocate, Supreme Court of India
- Director, Lawyers Collective HIV/AIDS Unit
- 2008-2014 UN Special Rapporteur on Right to Health

### **Dr Azza Karam**

- Studies of Economics and Business Administration and Politics of Development Strategies in Cairo and Rotterdam
- 1996 Doctorate
- 1996-1998 Senior Programme Officer - International Institute for Democracy and Electoral Assistance
- 2000-2004 Special Advisor, Arab and Islamic Affairs, Women's Programmes – Religions for Peace
- 2004-2007 Senior Policy Advisor – United Nations Development Programme
- since 2007 Senior Advisor - UNDP Interagency Task Force Religion and Development, New York

**Dr Maria Kipele**

- 2009-2014 Medical Studies in Bugando and Dar es Salaam, Tanzania
- 2016 Assistant Doctor at the Christina Medical Trust, Dodoma, Tanzania
- 2016 Approbation
- fromon February 2017 Neurosurgery studies at University Hospital Würzburg

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- 2003 Master in International Health Troped Europe Programme, Humboldt University Berlin
- since 2007 Special Consultant Missionsärztliches Institut, Würzburg

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- \*1967
- Studies of Law in Tübingen and Leuven
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- 2007-2010 Chair for the Law of Social Services and Institutions, University Kassel
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- \*1954
- 1981 Ordination
- 1999 Episcopal Ordination
- 1999-2005 Bishop of Mbulu
- 2005-2010 Bishop of Dodoma
- 2006-2012 Chairman of the Tanzania Episcopal Conference
- since 2011 Archbishop of Mwanza
- Chairman of the Health Commission of the

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- Studies of Sociology, Psychology, History and Theology in Tübingen and Berlin
- 1978 Doctorate
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