Health is a Human Right

by Dr M Zakir Husain

The people individually and collectively have the right and responsibility to behave and act in a manner that protects and promotes their own health, and that of their families and communities. The people must exercise that right and participate in a responsible manner in institutions and activities that minimise hazards to health and promote maintenance of health.

TO be healthy is a human right. It is as basic as right to life. But why? Because, beginning with birth, health improves the chance of survival. In infancy and childhood, good health is essential pre-requisite for physical and mental growth and development. The foundation of our achievements in adult life, the chances of growing to an adult member of the society are greatly influenced by our remaining in good health.

During childhood and adolescence, good health not only prevents avoidable illnesses but also more importantly lets us acquire knowledge, skills, and attitudes necessary for us to lead a socially and economically productive life and to make contribution to personal gains as well as contribute to national advancement. In old age, being in health makes enjoyment of retirement from work a pleasure and we can remain useful members of the society.

Thus, for a variety of reasons, life without assurance of being in health is a violation of the basic right of a citizen. The right to health is not exclusively an individual responsibility as much as it is not a right without any individual obligation and responsibility. Apart from the individual, the State representing the sovereign will of its people has a social contract that among its other duties binds the State with the duty and obligation to create and maintain conditions that are conducive to health of its people. That is not to say the State, by itself, can make everybody enjoy good health nor does it mean that people will not suffer illness.

What the State can do is to empower and enable people; ensure equal access to health information, facilities, and services. A modern democratic State should also establish health equity which means access to, and use of, health information, resources and services by all — and not some — according to need without any economic or social barrier but does not mean equal distribution to each.

The State alone cannot do all this. The people individually and collectively have the right and responsibility to behave and act in a manner that protects and promotes their own health, and that of their families and communities. The people must exercise that right and participate in a responsible manner in institutions and activities that minimise hazards to health and promote maintenance of health. Health after all is a positive state of mind and body; it is not mere absence or cure of illness.

Good health is therefore a shared responsibility that is best performed through mutual partnership between private and public actions. In many emerging states which had been under colonial rule newly-elected governments promise to take healthcare to the doorsteps of everybody. This arises from a misplaced notion of charitable welfare. Unfortunately the promise is not made after determining either the financial or human resources capacity of the state. This promise is seldom fulfilled in actual practice since the resources do not permit even if the will is there. And the political will is often lacking too. It is not even appropriate to try to take healthcare to each doorstep.

Governments making such political pledge also make the mistake of understanding health of the people as a function of healthcare alone which it is not. More often than not, what they continue to do with their limited resources, is to set up western-style prestigious health facilities mostly in urban areas that are costly to build and far too expensive to operate in prevailing resource constraint. When health centres were built in the rural areas, these did not run regularly because of lack of funds, personnel, or supplies since the urban centres consumed most of limited budgets.

The promise of healthcare to everybody remained yet another promise and not a reality. This also widened the already existing inequity of healthcare in many cases.

Universality of Human Rights: A Hotly Debated Issue

There is the age of worldwide awareness of human rights. There are global conventions, Charters and Declarations that spell out human rights. With globalisation and emergence of democracy as the dominant world system, there is world wide acceptance and open debate on the subject of human rights; independent commissions, NGOs, and the media are generating reports and disseminating information on human rights globally. The current debate, inspite of established global covenants, is not devoid of controversies; a major controversy about whether there can or should be a single universal standard of human rights applicable and appropriate for all countries.

It is argued that since the traditions, culture, historical experience, and socio-political systems show plurality, there has to be different definition of human rights in its implementation. Value systems differ and so the concept and principles of human rights realisation could also differ amongst societies. A major issue is whether human rights as articulated by the West is applicable to the East since many social, cultural, and civilisational differences exist across the world.

Why Health in Human Rights?

However, without going into the issue of universality of human rights standards, it is noted that at the present time much of the concern and debate on human rights occur on themes and topics that may be perceived as peripheral if not irrelevant in many societies and countries who have different needs and value systems. Freedom of expression, assembly, gender equality, tolerance of individual norms of behaviour and social conduct etc., abound in human rights debates chiefly though not exclusively in the west.

But there are countries where many fundamental rights and freedoms for example opportunities for education, health, shelter, choice of life are yet to be secured for all. One of these is the subject of this writing: where is health in human rights? Today, in societies rich and poor alike there are wide and unacceptable disparities in health and health care; many remain denied of access to health as a human right.

Of course, health deprivations differ in extent and cause, but the disparities are there whether in industrialised West or in poverty stricken East. Conceptually there has been very little affirmation of health as a human right even though to some it may be of greater importance and of more substance than other better articulated rights. As argued earlier in this text, health is so closely inter linked with human survival and development that common sense as well as wisdom would put health way above other rights concerned with expression of views, assembly or dissent or right to vote.

It could even be argued that health is so basic a right that it need not wait for democracy to be realised. One may not fault too much an autocratic State, as defined by its not being ruled by democratically elected government, if it secures for its people health as a right and thereby assures the survival and development of its people. It could well be that their other rights will then begin to acquire some meaning to them. No right is perhaps an end by itself and does exist in a vacuum when so many other rights are not enjoyed.

Health in this writer's view is a right which ranks above certain other rights as we have come to know these. It is strange that there has been so little evidence of health being put in its rightful place in the global agenda on human rights. The writer draws attention to this void with the plea that all societies especially the newly-emerging democracies put health high on their political and socio-economic agenda, and accept and advocate health in human rights agenda, and that international convention and debates on human rights include direct reference to health with the priority it deserves. Perhaps that would be one component of human rights on which universal agreement and concerted action will be possible.

Can Health Rights be a Start to Achieve Other Rights?

As stated before, it is reasonable to expect health to be a good focal point to rally national and global consensus on human rights. It might break new common ground for international political will and cooperation that is much harder to agree in matters of commerce, trade, and international security. Health right is attainable with relatively modest resources, health is a more benign and non-controversial subject, health is in everybody's interest, health enjoyment and benefits are immediately and directly relevant and meaningful to all.

Is it therefore possible that as a starting point, health rights movement and action will succeed most when rights remain contested? Is it also likely that the expected success with health might well raise confidence and desire to secure other human rights? The answer to both according to this writer is yes, most likely.

In fact, if indeed health is seen to be an established and tangible right, then it might add impetus and rationale to the movement for other rights — the enjoyment of which is also improved by improved health for all. Here I wish to mention for the record that in 1977, the World Health Organisation — the specialised UN agency for health — had launched an universally acclaimed goal of Health for All by the year 2000 to be attained by all its member-states.

Subsequent global events and diversion of resources to numerous conflicts distracted the will and resources of the international community; the goal remains unachieved 20 years after it was launched. But that does not prove the goal or the approach of primary healthcare is any less valid today, or any less attainable. Now in the post-Cold War era, at least some of the dividends of peace and co-operation might be channelled into securing some of the economic and social rights, of which health is probably the least controversial and most promising for co-operation and world peace.

Admittedly, the so-called peace dividends are as yet unfulfilled; conflicts and strife still abound; the world order of justice and cooperation remains elusive. Yet, there has to be hope and some trust in the future of world peace and shared prosperity. Is that too much to expect? Let us hope it is not.

At the national level, human rights organisations and commissions should begin to focus on the issue of right to health as a rallying point to the struggle for realising other human rights. Almost certainly, such a movement will be readily recognised, understood, and gain wide acceptance. It is not for the organisations and commissions on human rights alone, but it is for the elected legislators, policy makers and bureaucrats, the activists, and the civil society at large to take up the "health as a human rights" issue as one with high relevance and priority. Only then will governments and societies jointly move to establish health as a human right. The writer believes that will sensitise the State and the Society to start to define and deliver other components of human rights. Is this an utopian hope?

Glad Tidings on New Year Start, but Will It Last?

Paranjoy Guha Thakurta writes from New Delhi

THE first ten days of the New Year appear to have brought glad tidings to the Indian government which has been unsuccessfully struggling for more than nine months to revive the country's sluggish economy.

It is much too early to predict a turnaround but there are indications that 1999 would be better than 1998 -- how much better is, of course, a far more difficult question to answer.

The week ended with the sensitive index of the Bombay Stock Exchange (comprising 30 actively-traded scrips) jumping by 11 per cent. More importantly, the rise was accompanied by a growth in trading volumes, particularly purchases by foreign institutional investors (FIIs). The year 1998 was the first since 1991 — when foreign investors were allowed to enter India's capital markets for the first time — that there was a net outflow of FII investments to the tune of $340 million.

On Friday last, the Ministry of Petroleum and Natural Gas cut the officially administered prices of high speed diesel (HSD) by roughly one rupee per litre. While this decrease does not match the much sharper fall in international prices of HSD, the government has nevertheless taken a calculated risk in reducing diesel prices.

The move would naturally benefit transporters. Since HSD accounts for around half of the total consumption of all liquid fuels in India, the reduction in diesel prices would adversely affect the government's revenue collections during a year in which indirect tax collections have been well below target on account of the slowdown and recession in many segments of the manufacturing industry.

The government on Jan 9 approved the draft Ninth Plan for 1997-2002 which aims at a 6.5 per cent average growth rate with a total outlay of Rs. 3,740 billion ($89.04 billion). Planning Commission Member-Secretary S R Hashim announced that this includes Rs. 220 billion ($5.23 billion) for the Prime Minister's Special Action Plan which would concentrate on infrastructure and social development. The commission also approved a Rs. 3 billion ($71 million) to support the information technology sector.

The decision to hike import duties on gold was ostensibly aimed at increasing customs revenues, but dealers in the yellow metal argued that the widening of the gap between Indian and world prices could again provide a fillip to gold smuggling, which had been on the decline since the authorities liberalised imports.

Commerce Minister Ramakrishna Hegde complained that the Finance Ministry had taken the decision to increase customs duties on gold imports without consulting his ministry. This episode has provided yet another example of how one hand of the government does not have the foggiest idea of what the other is doing. On the subject of fog, the capital's airport has been thrown out of gear for the better part of the last three weeks thanks to inclement weather: the cost to the economy is still being totted up.

Finance Minister Yashwant Sinha continued his frequent interactions with the media with less than seven weeks remaining for the presentation of the annual budget for the coming financial year which would end in March 2000. He was confident the next session of Parliament would witness the passage of a key legislative bill to do away with the government's monopoly on the insurance business. Meanwhile, the President re-promulgated two ordinances, one to change the country's patent laws and the other allowing companies to buy back their own shares.

Sinha claimed he saw strong signs of an industrial revival with demand for steel and demand picking up. But he provided no figures to substantiate his contention.

All this is, however, one side of the story, obviously the brighter one. Of the country's total foreign exchange reserves — which has just crossed the $30 billion mark — a chunk of over $4 billion has accrued from the Resurgent India Bonds (RIBs) purchased by non-resident Indians which carry a hefty "effective" servicing charge of around 12 per cent per year for the government.

More significantly, the bad news on the foreign trade front is that there is no indication of exports picking up. The data for the period April-November 1998 shows that exports from India in US dollar terms has actually declined by a substantial five per cent. The slump has to be seen in the context of a five per cent growth in exports during the corresponding seven months of the previous year and the fact that export earnings in dollars had jumped by nearly 20 per cent for three consecutive years.

On Friday last, Bimal Jalan, the Governor of the country's central bank and apex monetary authority, the Reserve Bank of India (RBI), said he wanted interest rates to be "lower than what they are". The prime lending rates of Indian banks currently vary between 12.75 per cent and 13 per cent. Whether Jalan's wishes would come true or not is a debatable issue given two facts: money supply continues to grow by nearly 20 per cent and the inflation rate is still high (the annual increase in wholesale prices is around seven per cent at present but retail prices have risen by 16 per cent).

The federal government's decision to cut interest rates on small savings (collected mainly through post offices) has been opposed by provincial governments since three-fourths of the amount raised goes back to the states. The government of West Bengal in eastern India has been especially vociferous in its criticism of this move which aims at indirectly bringing down the New Delhi government's deficit.

On the privatisation front, there has been more talk than action, but that is slowly changing. The Gas Authority of India Limited (GAIL) announced that it would offload five per cent of its shares to the public later in the month. Another blue-chip public sector enterprise, Videsh Sanchar Nigam Limited (VSNL), the government-owned overseas communications corporation which is reluctantly relinquishing its monopoly position, will be commencing its roadshows for a capital issue later in the month.

Car manufacturers continued to woo potential customers. Ind Auto, a joint venture of Premier Automobiles and Italy's Fiat, joined its price-cutting rivals Maruti Udyog Limited (MUL) and Tata Engineering & Locomotive (TELCO) in offering small cars at attractive prices. MUL, in which the Indian government and Japan's Suzuki Motor Corporation are equal shareholding partners, recently reduced car prices on the ground that sales had dropped by nearly 20 per cent last year. Its competitors, on the other hand, argue that prices were cut because the company fears an erosion in its 80 per cent market share by a host of new entrants.

— India Abroad News Service

Of Breast Lump and Related Breast Conditions

by Dr Anisur Rahman

BREAST lump or a swelling in the breast is a complaint frequently encountered by general surgeons. It is a common reason for a female patient to seek surgical help. Due to religious and cultural modesty prevailing in our society, as well as various misinformation, breast diseases are still shrouded in mystery.

What is a breast lump? In my surgical practice the most common question that I face from the patients is, "Is it cancer?". Breast lump has become synonymous with breast cancer. This is far from the truth. I shall try to shed some light on this problem, which I hope will help the female readers and their relatives. Only 20 per cent of breast tumours turn out to be malignant!

Breast lumps which are not cancers: Commonest benign breast lump is called *fibroadenoma*. It is typically found in young women. It is generally smooth, spherical, painless and very mobile without any attachment to skin or surrounding breast tissue. More than one may be present. It gradually increases in size and may eventually fill the whole breast but usually its size varies between 2-3 cm. During pregnancy fibroadenoma may increase in the size but return to original size after birth of the baby.

Fibroadenoma is usually treated by surgical removal. It is a minor operation commonly done under short general anaesthesia. It is possible to plan the cut in the breast skin in such a way that there is almost no postoperative scar. In case of unavoidable large cuts, it is placed in such a way that the scar is hidden under the clothing. It requires several hours of hospital stay. In patients with other medical problems it may be safer to spend one night in the hospital. In case of superficial fibroadenomas the surgery may be performed under local anaesthesia. It is essential to send the tumour for pathological examination to confirm the diagnosis.

The other common breast lump is called *fibroadenosis*. By definition it is not a tumour. The cause of this condition is too technical to be discussed here but in short it is due to an abnormality in female hormone level. In this condition multiple lumps of various sizes are found in the breast. Typically both breasts are involved, although the lady may complain about one breast only. Lump size may be anywhere between a size of grain to 3-4 cm. The breasts are painful and tender to touch. The pain may become intense at or near the time of menstruation. The pain may radiate to the arm or back, and may be so severe so as to interfere with normal life. In most patients it is the pain that brings them to a surgeon and not the lump. There may be nipple discharge in the form of clear sticky fluid. There is a strong psychological association of this disease.

Fibroadenosis is a disease of the reproductive age. It may be self-limiting, usually disappearing after the first pregnancy. In most patients the disease is of mild form and simple analgesic with adequate explanation usually bring about a relief. In others stronger analgesics may be required during the painful phase. More resistant cases are treated with hormone therapy. Surgery is reserved for extreme cases. A particularly painful cyst or lump is removed under general anaesthesia. As in fibroadenoma it is possible to plan the skin cut to provide best cosmetic results. The most important point to remember from the patient's point of view is the possibility of recurrence, and more than one operation may be required.

Painful breast conditions: *It is important to remember that breast cancers are rarely painful.*

Commonest painful condition of breast is *cyclical mastalgia*, or pain in breast during menstruation. The intensity of pain varies from person to person. The exact cause is unknown but it may be due to accumulation of fluid in breast during this particular time. It is most commonly seen in the young ladies. It is self-limiting and usually disappears after marriage and pregnancy. However in some patients it may continue unto middle age. There is a well proven association of this pain with psychological stat . Explanation, assurance and an analgesic are all that is required for its treatment.

Breast abscess is a very painful condition seen most often in lactating mothers. Injury to nipple from baby's sucking allows bacteria to enter the breast and produce abscess. The area of the breast become swollen, tender, hot to touch and the skin may take a reddish hue. In very early stage it may be possible to treat breast abscess by antibiotics alone but most patients require surgery to drain the pus. It is done under general anaesthesia and the patient may go home the next day. But she will require repeated dressing till healing is complete.

The painful condition of fibroadenosis has been discussed previously. In elderly postmenopausal women with large breast, minor trauma may lead to a condition called *fat necrosis*. It is found in the form of an irregular painful lump in one breast. It is sometimes difficult to distinguish it from cancer without making any tests. Because of the age in which it is commonly found, it is mandatory to thoroughly investigate a suspected fat necrosis.

Nipple Discharge: Milk is of course the commonest nipple discharge, but at times there may be other discharges. A *clear fluid* may come out during pregnancy and is normal. Fibrocystic disease which has been discussed above, may be associated with a clear or some time *greenish dirty* discharge. *Blood stained* discharge is commonly associated with a benign tumour called duct papilloma, but it may also be an indication of cancer. All nipple discharge should be taken seriously and a doctor consulted

Breast Cancer: It is third most common cancer in the female. Unfortunately there is no statistics for Bangladesh but in the US 100,000 new cases are diagnosed each year. The incidence is lower in countries of Asia and Africa.

Risk Factors: Is any particular group of women at higher risk? Again there is no clear answer. *Age is a crucial variable.* More than 66 per cent of women with breast cancer are above the age of 50 years and 80 per cent are at least 40 years old. *Only 2 per cent of newly diagnosed patients are under the age of 30.* Family history also plays an important role. The chances of developing cancer are two to three times higher for women with a close female relative (mother, sister) who has had breast cancer. Factors related to reproductive history which have shown high risk of breast cancer are, early onset of menstrual bleeding, late first pregnancy, late menopause and no pregnancy. Other factors that have been identified are obesity and high socio-economic status.

Diagnosis: *Early diagnosis is the key to effective treatment. If detected early it may be possible to completely cure the patient.* Most breast cancers are detected by the patient herself. Thus the importance of self-examination by the patient. The self-examination can be done in a few minutes in the bathroom. Since the feel of female's breast vary according to time of menstruation, a particular date in each month should be reserved for self-examination. A routine of once a month is sufficient, if there is any suspicion a surgeon's help should be sought. *Carcinoma breast usually presents as a painless, irregular, firm, somewhat fixed lump. There may be associated swellings in the armpit of the same side.* Other changes that are suspicious: change in beast shape, contour, dimpling to the skin, retraction of the nipple etc. Some patients because of our social taboos may come to a doctor with late manifestations; like a large tumour fixed to skin or chest wall, breast lump which have ulcerated and smelling very offensive, bone pain, bone fracture, jaundice, fluid in the abdomen etc.

Mammography, a special type of X-ray for the breast, is quite accurate in diagnosing very early cancers which cannot be felt. *But it must be emphasized that mammography can never replace examination by a doctor because of the various variables involved.*

Treatment: In early breast cancer, surgery is the mainstay of treatment. In most cases the involved breast is removed under general anaesthesia, along with the glands of armpit (*total mastectomy*). In very early cancers, it may be an option to remove a part of the breast with the cancer (*lumpectomy*). In that case the patient must be under regular checkup of a qualified surgen. Mastectomy is done under general anaesthesia and blood transfusion may be necessary. It takes about one to one and half hours and the patient can start eating normally in 3-4 hours. Stitches are usually removed between 7-10 days. After surgery almost all patients will require *radiotherapy* and/or *chemotherapy* for a certain period as determined by an *oncologist* (doctors specialized to treat cancer). At present *hormone based treatment* is also found to be very effective.

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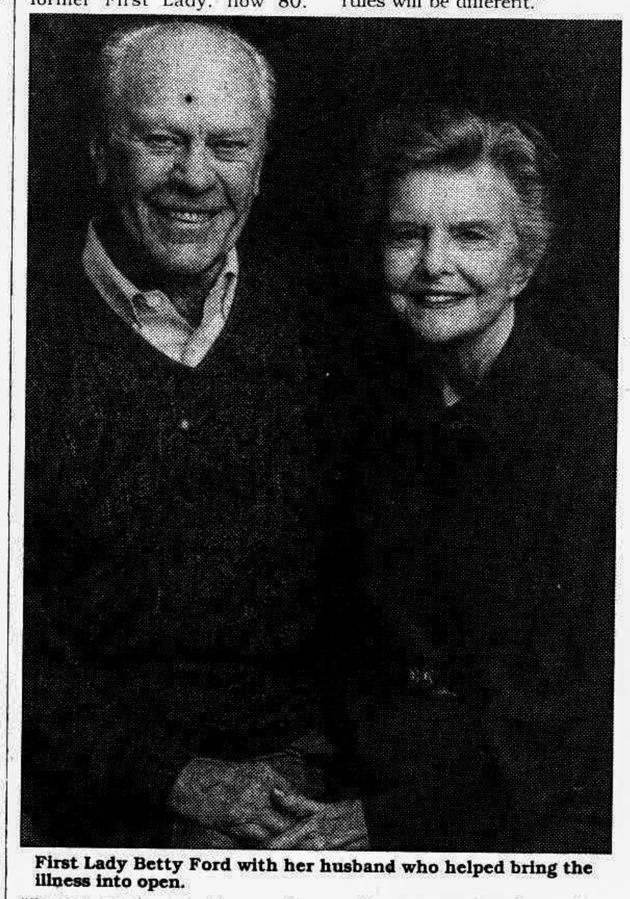
Breast Cancer: The Word that Terrifies Women of All Ages

TWENTY-four years ago, when the press professionals crowded outside Bethesda Naval Hospital to hear president Gerald Ford announce that his wife, Betty, had undergone a mastectomy, "it was the first time they had seen him cry," recalls the former First Lady, now 80. "Breast cancer pretty much meant death back then." Two decades later the disease still ranks among women in the US as the most common form of cancer and the sixth leading cause of death. Still breast cancer is no longer an automatic death sentence. In the 1970s a woman with the disease had a roughly fifty-fifty chance of surviving. Today, thanks largely to earlier detection through mammograms, her chances are nearly 80 per cent.

Soon those odds are likely to improve even more. Medical advances, including more selective lymphnode biopsies and chemotherapy with fewer side effects, have improved care and reduced the need for mutilating surgery, and there have been significant innovations in breast reconstruction. Even more tantalizing are the new drug therapies especially the estrogen-blockers tamoxifen, raloxifene and the tumor killer Taxotere that mark the first significant steps toward possible prevention and cure of the disease. "The story isn't over, and there are a lot of people who are going to die of this disease before we're done," says Dr Marc Lippman, director of the world's largest breast-cancer research programme, at Georgetown University Medical Center in Washington DC. "But there has been a quiet revolution. We are entering an era in which the rules will be different."



First Lady Betty Ford with her husband who helped bring the illness into open.

For now, experts know that breast cancer's likeliest victims share three primary traits: They are over 65, have blood relatives who have suffered from the disease, or have been exposed to excess estrogen (a potential cancer fuel) because they menstruated early, began menopause late or were never pregnant. Still 70 per cent of women diagnosed have not known risk factors at all. Until there is a cure, then, the best advice is familiar: Practice self-examination, schedule regular doctor's exams and (for women beginning at 40) annual mammograms.

That, and bear in mind the words of actress Marcia Wallace, herself a 13 years survivor: "If you're a woman and you're alive you can get breast cancer". Some medical advances revolutionize the treatment and survival of breast cancer. Ninety per cent of breast cancer can be cured if detected early.

There is one drug called Taxotere, which is most potent for breast cancer. The success rate is as high as 90 per cent if breast cancer detected early and treated by surgery followed by Taxotere and Adriamycin.

"Diagnosis of cancer is not a death sentence rather beginning of a heroic fight" says onco psychiatrists. Every cancer patient has to survive so that she can get the benefit of a better drug in future.

Almost all found the cancer diagnosis difficult to accept but who fought back and, with the support of their loved ones can survive and lead productive life.

MEDICAL ADVANCES

Drug therapies

Raloxifene: Pros: could reduce the risk of breast cancer by up to 54 per cent without hormone's uterine cancer effect.

Cons: Yet to be proven, and can cause blood clots.

Taxotere: Pros: Can treat almost 70 per cent cancers effectively as a single agent even in very advanced stage.

Cons: Expensive medicine.

HER2: Pros: With few side effects, shrinks and delays the spread of tumours in women whose cancer cells overproduce the HER2 gene.

Cons: Does nothing for the 70 per cent of breast cancer without HER2.

New Treatment Options

Sentinile Node biopsy: Determines if cancer has spread by removing and dissecting just one or two key lymph nodes instead of stripping numerous nodes from the chest and arms.

Lumpectomy: Removes only part of the breast, which along with sentinile node biopsy makes for less invasive surgery.

Antiemetic drugs: New antinausea drugs reduce the debilitating sickness associated with chemotherapy.

In the Future

Ultrasound: Scientists are testing a device on humans that uses energy from ultrasonic sound waves to selectively heat and destroy cancer cells without damaging adjacent tissue.

Anti-angiogenesis: Drugs that block the growth of the blood vessels that feed tumors have already been shown to cure cancer in mice and now being tested in humans.

Gene therapies: One product is being formulated p53 gene therapy in which genetically engineered viruses have been used to invade cancer cells and replace damaged genes that promote the growth of the tumor with healthy ones.

Cloning: Breast cells harvested from a patient could one day be genetically engineered, then used to grow healthy breast tissue for use an implant.

Early Detection

Fact: Most breast cancers detected early can be cured.

Self-exam: recommended monthly for all women over 20.

Mammograms: Recommended annually for women aged 40 and over.

Adopted and compiled by Dr Pinaki Bhattacharya