Culture, health and human rights: Are they compatible?

A paper on cultural practices that influence healthcare. Presented are political cultures (e.g. communist), religious (e.g. Christian), Asian cultures (e.g. China) and the value judgements made by each culture through their choices.
Culture, health and human rights: Are they compatible?

‘All human beings are born free and equal in dignity and rights’

*Article 1 of the universal declaration of human rights*

‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...’

*Article 25 of the universal declaration of human rights*

Article 1 of the Universal declaration of Human rights declares that all people will have equal rights, and article 25 states that everyone has the right to adequate a standard of living adequate for health. Despite this, not everyone enjoys full human rights, nor is everyone is treated equally, and health and access to healthcare is not ‘adequate’ among all people. What the universal declaration allows us to do then is to say that this is not acceptable, and it forces us to consider intervening until the rights are enjoyed. Poverty and cultural sensitivity are two concepts that governments and policy makers often cite as reasons for their lack of intervention, however these are only superficial boundaries. As we will discuss there may be alternatives that could potentially provide a solution and allow for adequate health for all, although often a decision of to what degree one values culture over human rights or vice versa is necessary. Cultures may promote many things including social and emotional support, motivation, health care resources and my promote health lifestyle choices- or indeed they may do the opposite. As a result of the effect that culture has on behaviour, it may be at the cultural level we need to intervene in order to ensure human rights, and as such sensitivity to this culture may not be a good idea. This essay will address issues regarding culture: arguing that there is no justification for double standards in relation to human rights; that cultural beliefs may have an impact on health but this does not necessarily justify being culturally sensitive in all areas; the universal declaration of human rights, as a secular document written by western society but that has also been acknowledged in Asia, decides what practices are beneficial, and those practices should be made universal. After this argument the essay will then go on to deal with a selection of human rights health issues including HIV/AIDS; inequality of services across gender, socioeconomic status, race etc; health as a right versus a market; and situations where human rights clash with another among other issues.
This essay considers the universal declaration of human rights to be the best and most objective human rights document to date, and as such it is the document that should be adhered to. Written in 1948 the document aspires to give all equal rights and to protect all against injustices. There have been several notable responses to this document (Ministers and representatives of Asian States, 1993; Organisation of the Islamic conference, 2007) and there are also several philosophical issues we need to keep in mind when trying to choose rights for all (Talbott, 2005).

Two notable responses of the universal declaration of human rights include the Bangkok declaration and the Cairo declaration on human rights in Islam. The Bangkok declaration simply reaffirms what has already been argued here, namely stressing the

“universality, objectivity and non-selectivity of all human rights and the need to avoid the application of double standards in the implementation of human rights and its politicization”

However the Bangkok declaration also argues that poverty is one of the major obstacles hindering the full enjoyment of human rights. If we are to look at China, one of the signature countries of this document, in terms of this we will gain a much better idea of its policy and the reasons for it’s failure to fully adhere to this document. China is guilty of curtailing freedom of expression, along with the persecution and discrimination of Tibetan monks and the Falun Dafa, who say they have no human rights in China and are being murdered, tortured and are used as unwilling organ donors (Gutmann, 2006; Yardly & Hooker, 2008). Indeed severe limitations on expression as evident on the large scale censoring of the internet and emails in china (Gutmann, 2002), the official response is that it is a measure that must be taken to preserve national security, law and order, but this may just be a façade for authoritarianism. The lack of ethics with regards the alleged organ harvesting suggests that profit is the driving force. To suggest that these are issues we cannot tackle because they are relating to culture is a meaningless. Other entities have gone further however and tried to justify their ways by passing alternate rights declarations, as in the case of the Cairo declaration of human rights, and the US attempt to pass legislation that would justify the indefinite detention of prisoners at Guantanamo bay without trial. These actions on behalf of all these three bodies are clearly there to secure, exercise and increase their power over others. Increasingly larger steps are being taken by these and other cultures in order to change the universal declaration of human rights into a form that suits their vested interests, e.g. the recent amendment to the duties of Special Rapporteur of the right to the freedom of expression (Brown, 2008).

The Universal declaration of human rights, declaring that all people have equal rights, without double standards between cultures, is the only way of avoiding a situation whereby we can hope to avoid rules that seek to benefit one party over all others.
We can expect that there are many more cultural practices and beliefs that on close inspection will be found to be inimical, and will in some way serve to create, increase, or maintain inequalities. Despite this beliefs are important for therapeutic effects in medicine, and the power of the mind and beliefs has long been demonstrated in research on the placebo effect, the nocebo effect, expectations and perceived limitations (Kirsch, 2006). Patient’s beliefs can activate mechanisms that will relieve pain or even the effects of Parkinson’s disease (de la Fuente-Fernandez et al., 2001; Petrovic, Kalso, Petersson, & Ingvar, 2002). It may also be true that if a patient believes that a treatment cannot cure them, if they believe that the treatment is not treating the cause of their illness, then they may prevent themselves from receiving the clinical benefits of the treatment. It has been argued then that it is in the clinician’s interest to address the beliefs of the patient and to treat the illness according to the way the client believes it should be treated (McCullough, 2002). It should be expected that any belief adopted could be curative, and if one generation of a group has a belief system that promotes breaking one or more of the universal rights then we should not be sensitive to that set of beliefs but rather condemn it. An example of this would be an individual’s belief that illness is due to lack of religious behaviour, an underlying assumption like this might be therapeutically beneficial in that you could suggest a treatment that was compatible with their theory of how they believed their illness was caused, but it also may lead to an attitude in a community that the sick are “getting what they deserve”. Furthermore sometimes cultural beliefs will have a more direct effect in decreasing health, as some religions will directly oppose certain healthcare interventions such as blood transfusions or contraception.

Moral paternalism is when one imposes their moral judgements on others preventing them from doing something that may comply with their beliefs but not your own. Moral paternalism is likely to occur in a society that has a particularly influential subsection of its community with any set of cultural beliefs should treatment such as the previously mentioned religious example be given. This situation where the community is treated on the basis of their beliefs could escalate to become a situation that those without a given cultural belief have the belief forced upon them in treatment. Moral paternalism is also possible in arguments such as this and any other argument on values, rights, or culture. Harnessing any opinion about values in society that cannot be based around empirical evidence thus has risks. This does not mean that we should throw all these beliefs and practices out the window however, it may still be possible to keep the effectiveness but create neutral theories for such practices. In psychotherapy, for instance, for the most part there is very little difference in effectiveness between different types of therapy, although they may have non-compatible theories (Luborsky et al., 2002). It must then be that all or most of theories about where the benefits of these psychotherapies are coming from are wrong, and that the theory, or myth, can
be changed, to a certain degree, without affecting the efficacy of the treatment. There many other cultural practices that may be therapeutically beneficial such as yoga that can promote health (Raub, 2002), but at the same time such practices may impose a religious belief system tied up within the practice. While yoga is a practice that is once again enmeshed in spiritual theory, it may be possible to recreate the practice with a neutral and secular theory that could avoid problems that lead to discrimination or imposing religious viewpoints.

Now that we have considered the dangers of allowing for double standards in relation to applying the UDHR, the power of cultural beliefs in creating therapeutic benefits, and the dangers of being sensitive to non-neutral cultural theories behind health practices, we must consider in detail the health issues and human rights that these relate to. As stated above, one of the main tenants of the UDHR is that there should be equality of rights, and services adequate for health and well-being. Of course the way we ensure that this is achievable varies both across countries and within countries. Across countries there is huge variance of life expectancy rates; Japan has a life expectancy at birth of 82.3 years and Angola has an average life expectancy almost half that at 41.7 years (United Nations Development Programme, 2007); within countries there are differences between different races, and genders with Asian males living 15.4 years longer than low-income southern rural black males in the USA (Murray et al., 2006). Of course a causal effect cannot be drawn here, but it seems plausible that culture, racial discrimination, socioeconomic status, and lifestyle are factors that in part explain these differences. Many if not most cultures do not value women as highly as men, and this is evident in female foeticide, female infanticide, selective neglect of girls and son preference (Bandyopadhyay, 2003; Grewal & Kishore, 2004), as well as in men’s violence on women (Ilika, 2005). Indeed some argue that this is a universal problem that talk of multiculturalism is only distracts from (McKerl, 2007). Thus such behaviour can be allowed to continue when we pathologize it as culturally derived and therefore untouchable.

Health care is probably one of the more influential factors of life expectancies in a given country. In order for all to have access to health there must be low costs of health care and health insurance, and the price of health care will very much depend on whether the country sees it as a right for all and as such provides free medical care on a universal basis and pays for it through tax, or whether the country views it as just another market in which people are forced to pay for the quality of service they wish to receive. In the latter situation there will be those who will not be able to afford to pay for an adequate quality of health care, while the former is perhaps more typical of communist countries in which the working class are seen as the foundation of society and thus all will receive at least a minimum level of healthcare. In terms of providing adequate healthcare for all the socialist
system seems better, on a theoretical level at least. Of course with rising prices in healthcare both systems have had to take action (binstock, 2000; as cited by filinson, 2003). Market-oriented systems have provided consumers with either extra-costs to reduce demand and by restricting services at given levels of insurance premiums, while socialised systems have sought to privatise the health system (Filinson, Chmielewski, & Niklas, 2003). Furthermore, in order to promote widespread dissemination of medical services it has often been necessary for socialist countries to pay doctors less than factory workers, and to avoid purchasing expensive new drugs, technologies and treatments (Leven, 2005). As such there have been clear disadvantages in past attempts to try to fund adequate healthcare for all, just as there are in converting to a market-oriented service that distribute health services differentially basis of socioeconomic factors. While it is difficult to define ‘adequate’ in terms of healthcare, it does seem possible to provide a minimum level to all, though it necessarily requires sacrifice of the upper end of technologies and treatments that those who are of higher socioeconomic status may feel they are entitled to. Again we must decide what we value, but to those who value human rights there are difficult yet plausible answers.

While the accessibility to financial resources required for health is clearly important, it is also important to look at other cultural factors that promote and those prevent health and human rights. To simply say that a certain cultural factor only acts to promote health, or only acts to prevent health is probably flawed however, and instead it will be that cultural factors are complex and may contain elements that promote health and some that prevent health. To develop on an earlier example we will consider religion and HIV/AIDS under this light. One of the great advantages of having religious cultures and religious gatherings is that the information being preached has the power to reach a great many people, including those with minimal education, and low socioeconomic status. Theoretically such a position is then of great potential in terms of providing the community with health education, and beliefs and practices that promote health. However, while this may be sound in theory, there are a great many barriers preventing this from happening in practice. Difficulties that religious groups have with providing health information relating to AIDS in parts where it is needed stem from the fact that there is often a taboo on topics such as sex, and homosexuality, and use of contraceptives are explicitly forbidden in many religions. Despite this, it has been shown that religious faith can be a protective factor against AIDS (Elifson, Klein, & Sterk, 2003). This may be because the religion also condemns high risk sexual behaviours or it might be due to other factors associated with the religion. A vital question here would be can we extract those elements of religion that are protective, remove those elements that increase risk, and create something new that could potentially be even more beneficial. Indeed religious participation may be associated with a number of socioeconomic, lifestyle, ethnic and geographic factors that may
affect health (Lee & Newberg, 2005) and the setting itself, a situation where large numbers of the community gather together to be given guidance on how to live a good life seems to be missing from atheistic society. It may be possible to slowly introduce some form of state run humanistic style religion that promotes health and moral benefits without including any harmful elements.

Thus to conclude while there are some elements of culture that can be beneficial, there are many elements that potentially can cause great harm. The choice between culture and human rights is as such a value judgement, and there may be alternatives that could better provide for human rights if we should choose to opt for them. Alternatives such as guaranteed minimum level of healthcare for all across the world or beneficial interventions similar to those we see in present day religions but without the spiritual emphasis would no doubt require sacrifices in terms of the altered culture it would create. However, developing such a health promoting culture, free some of the problems that exist in today’s society is a task that potentially could be rewarding if designed with enough thought, research, and given enough time to be successfully implemented; Alternatively it may be that culture is valued too much to be changed in the interest of human rights.
References


