Processes and Challenges: The right to health for transnational Zimbabwean families affected by HIV

Martha Chinouya PhD

London Metropolitan University,
Ladbroke House, 62-66 Highbury Grove, London N5 2AD

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- Worked as the principal investigator
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- All Zimbabwean women and men who took part in our studies

Right to health

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

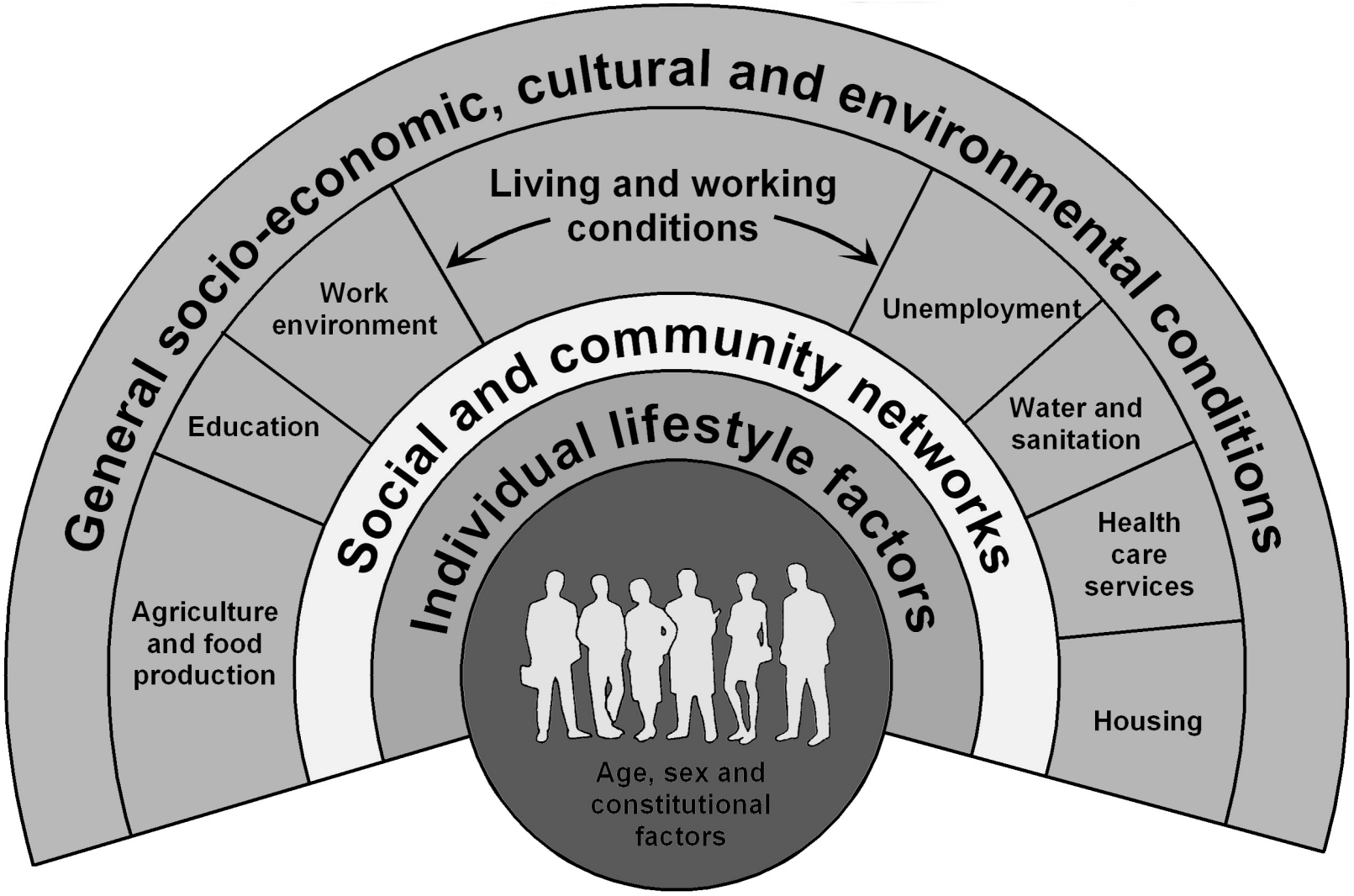
The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

My presentation

- Aim of presentation:
  - Discuss global/local processes that shape the right to health (prevention and treatment): Migrant black families affected by HIV (Zimbabwean case study)
  - Processes:
    - Global structural
    - Economic processes
    - Socio-cultural
    - Interaction of local and global to impact on health at individual level

The main determinants of health



Source: Dahlgren and Whitehead, 1991

Affected: who and why

- Shift from focusing on the individual
- Individual living with HIV = Infected
- Close kin and friends = affected
- HIV infects and affects individuals and their families
- Entry point into the research field

Vital statistics (2006)

- Zimbabwean dollar
- **Inflation**7,892.1% (official - Sep 2007)[2]; unofficial est. 14,000% (Aug 2007)
- **Population below poverty line** 80% earn below ZWD 16 million per month (USD $21.33)
- Unemployment (85%)
- (dominated by the informal sector)

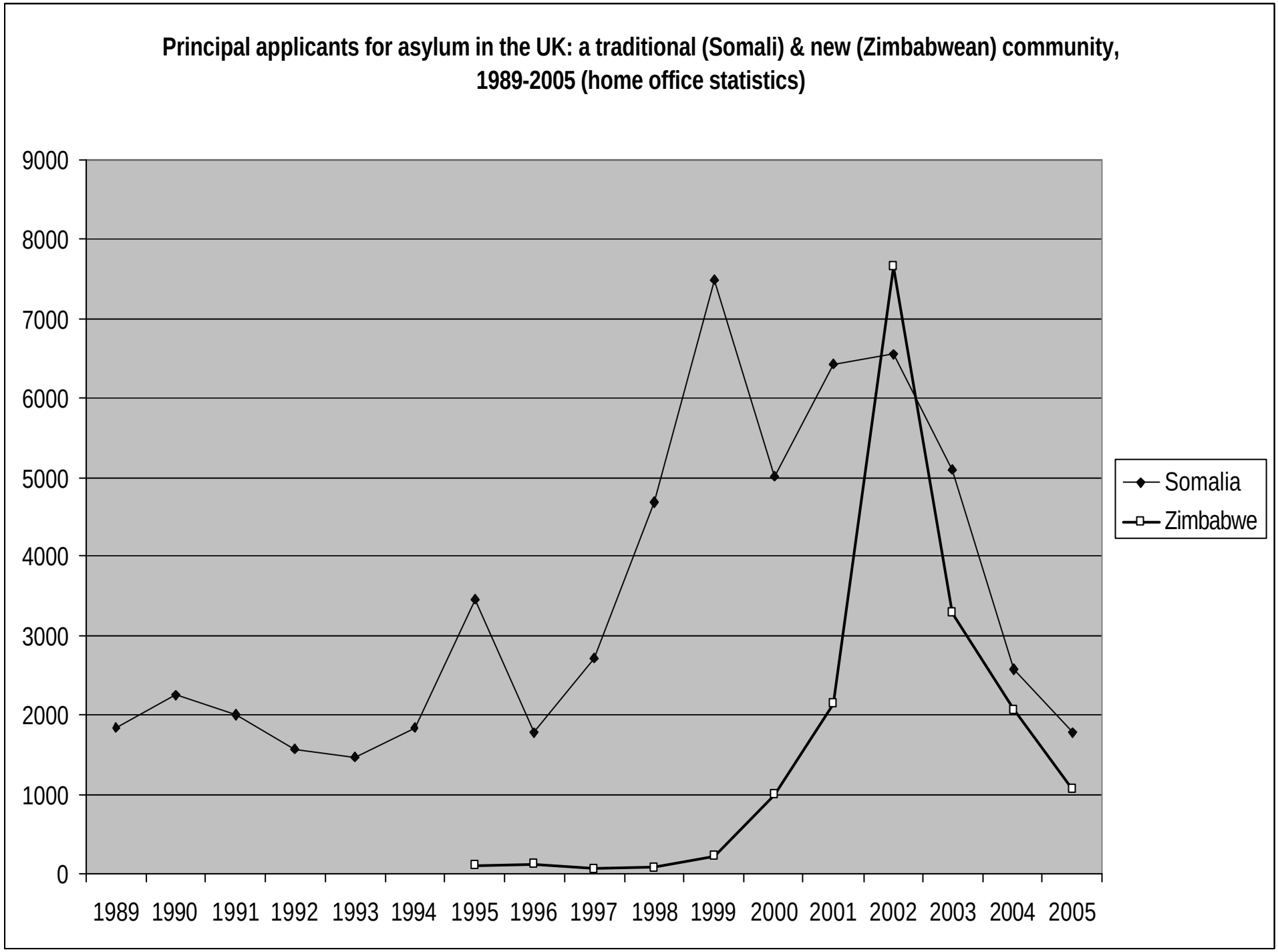
Contributory processes: Right to health in Zim

- Economic and structural adjustment programs
- The land reform
- Devaluation of the Zim dollar
- Migration of workers (Skills drain)
- Collapsing systems (health, education)
- Government policies (operation clean up; price cuts)
- Loss of confidence in investing in Zim

"…IMF and World Bank economic policy in the 1980s and early 1990s took little account of how these policies would potentially impact poor people in Africa. Many health and education systems began to break down. And all of this came just as AIDS began to take its deadly toll…"

Our Common Interest 2005:23

Principal applicants for asylum in the UK: a traditional (Somali) & new (Zimbabwean) community, 1989-2005 (home office statistics)



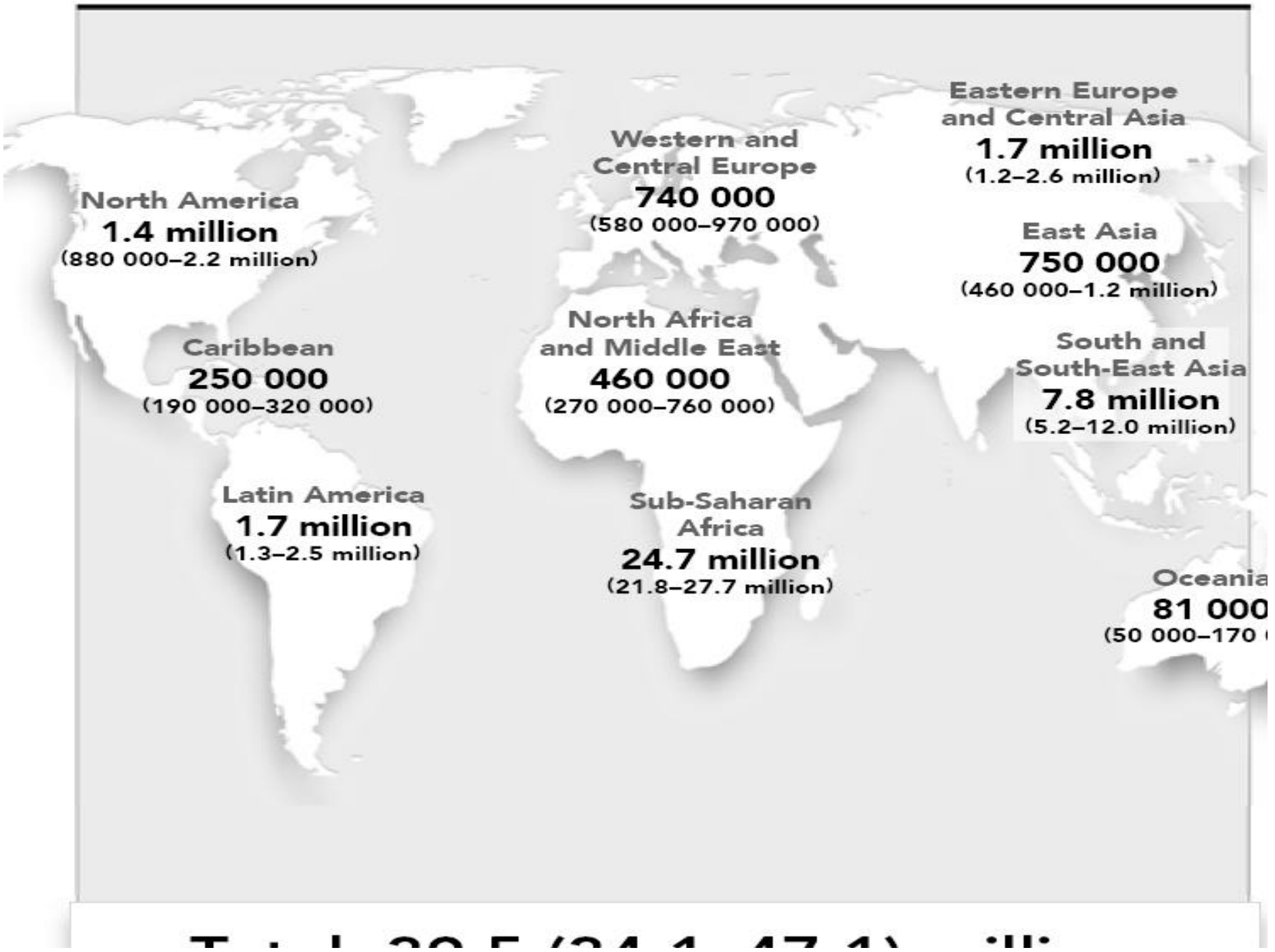
Zimbabwean Nurses: no. joining UK register 2003/4: 391

Zimbabwean Doctors: total no. on UK register 1.1.04: 117

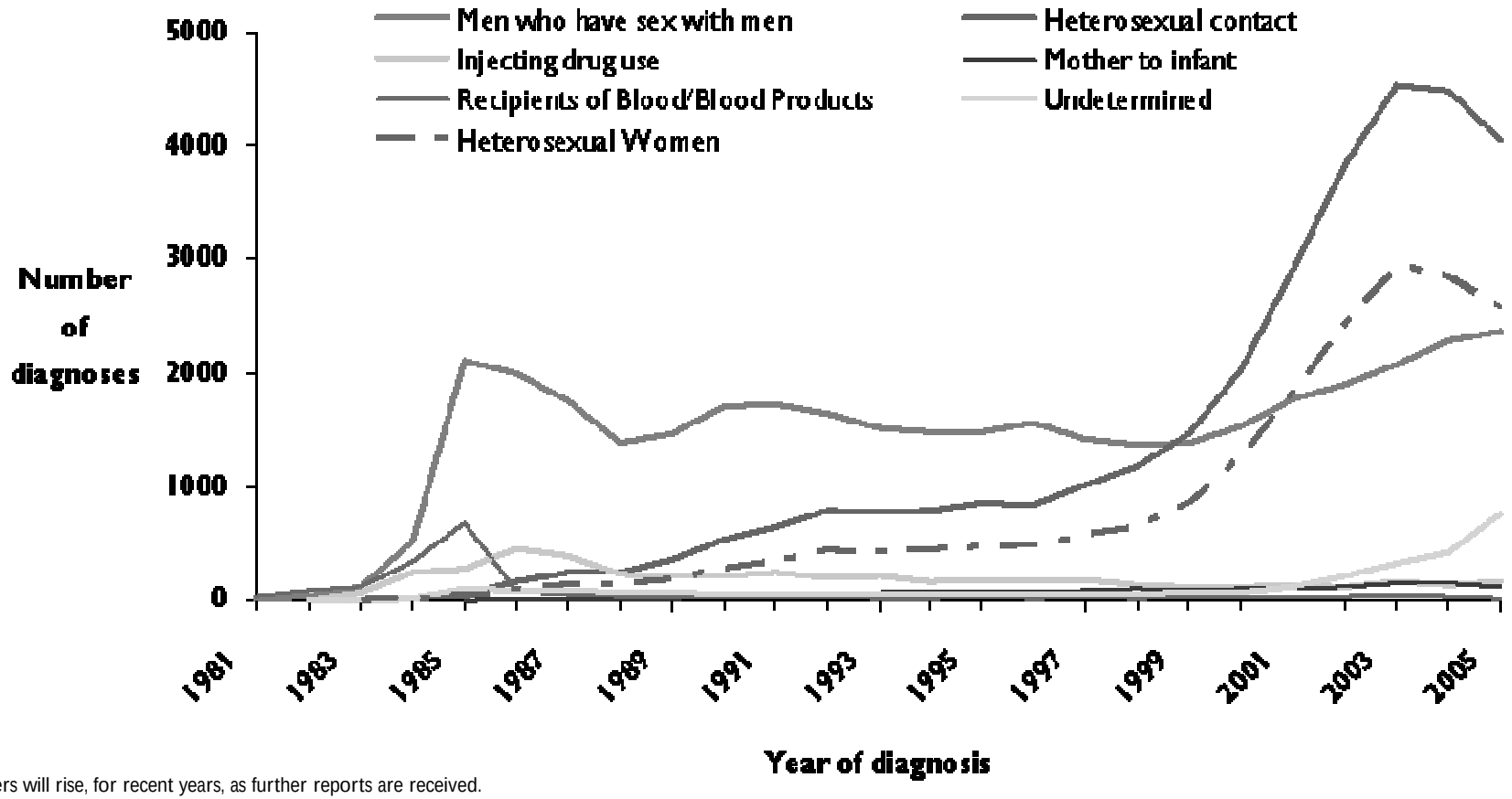
Zimbabwean Life expectancy at birth 2002: 37.9

Zimbabwean Health Care Expenditure /head ($) 2002: 45

Sources: NMC 2004, GMC 2004, WHO (www.who.int/countries) accessed 3.2.05.


North America
1.4 million
(880 000–2.2 million)
Caribbean
250 000
(190 000–320 000)
Latin America
1.7 million
(1.3–2.5 million)
Western and
Central Europe
740 000
(580 000–970 000)
North Africa
and Middle East
460 000
(270 000–760 000)
Sub-Saharan
Africa
24.7 million
(21.8–27.7 million)
Eastern Europe
and Central Asia
1.7 million
(1.2–2.6 million)
East Asia
750 000
(460 000–1.2 million)
South and
South-East Asia
7.8 million
(5.2–12.0 million)
Oceania
81 000
(50 000–170

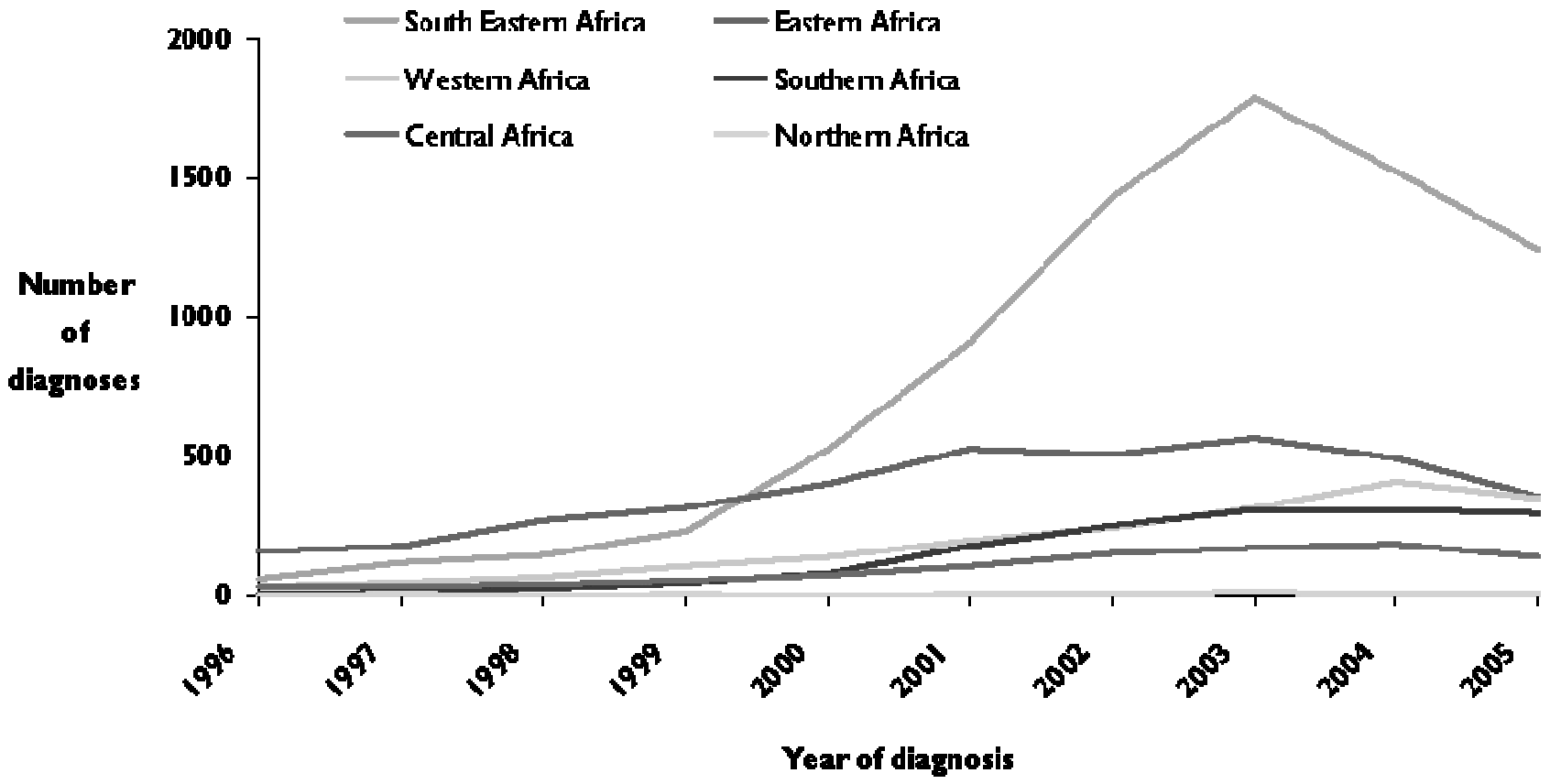
HIV diagnoses by exposure category, UK (Health Protection Agency, 2006)



Numbers will rise, for recent years, as further reports are received.

Clinician reports of new HIV/AIDS diagnosis

HIV diagnoses in England, Wales and Northern Ireland by African region of infection where the infection is attributable to heterosexual contact in Africa



Clinician reports of new HIV/AIDS diagnosis

Populations living with diagnosed HIV aged 15 to 59, England: 2005 (Health Protection Agency)

	Black African	Black Caribbean	Indian/ Pakistani/ Bangladeshi	White
HIV-diagnosed individuals	15,750	1,185	473	20,246
Population	442,300	384,500	1,522,400	26,977,300
Percent living with diagnosed HIV	3.6%	0.3%	0.03%	0.08%

Census of individuals accessing HIV-related care and ONS 2004 population estimates (based on 2001 census)

Millennium Development Goals (MDGs) to be achieved by 2015.

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

MDG 6: HIV/AIDS

Target: to have halted and begun to reverse spread of new infections by the 2015.

Indicators to monitor activity in relation to the target are:

- HIV prevalence amongst 15-24 year old pregnant women
- Number of children orphaned by HIV/AIDS

Greatest obstacle re HIV/AIDS MDG:

"appalling state of health systems..particularly the acute shortage of skilled health workers…"

Rusin et al (2005) Lancet

Skills and resource shortages

- Nurses and doctors to help monitor health in the context of HIV (CD4 counts, viral loads)
- Few participants in our work had had counts
- Equipment shortage
- ARVs (10% of the HIV infected population on ARVs)

“Human Rights” used:

typically to apply to entitlement of health workers who hope to migrate

less commonly to show impact on right to health of people in source country

Bueno de Mesquita & Gordon 2005: 4

Right to healthcare not universal in the UK

- You need to have been an ordinary resident
- Challenges:
  - Failed asylum seekers
  - Visitors
  - Undocumented migrants

Right to health: HIV+ve Zimbabweans in England

Right to health: UK NHS guidelines

- Emergency treatment is free for anyone
- Who is not entitled to free primary care and secondary care
  - Visitors
  - Failed asylum seekers
  - Anyone who is not an ordinary resident
- 2007 guidelines who is entitled:
  - Asylum seekers with pending applications
  - Anyone who is an ordinary resident

TABLE OF ENTITLEMENT TO NHS TREATMENT (Correct as of October 2007)		
Status	**Primary Care**	**Secondary Care**
Asylum Seeker	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.	A person who has formally applied for asylum is entitled to NHS treatment without charge for as long as their application (including appeals) is under consideration. They will have to pay certain statutory NHS charges (e.g. prescription charges) unless they also qualify for exemption from these (see notes section), and will go on waiting lists. Since asylum seekers are entitled to free NHS treatment, they can apply to a general practitioner to register as a patient. Asylum seekers are exempt from charges for NHS hospital treatment.
Asylum Seeker refused but appealing decision.	Access to **primary care** without charge. As for Asylum Seeker	Access to **secondary care** without charge As for Asylum Seeker.
Asylum Seeker denied support under Section 55 of the 2002 Act, but still claiming asylum.	Access to **primary care** without charge. As for Asylum Seeker	Access to **secondary care** without charge As for Asylum Seeker.
Failed asylum seekers – including those getting Border & Immigration Agency (BIA) Section 4 support while awaiting departure from the UK	The Department of Health has sought to allay confusion over the entitlements of failed asylum seekers to primary care without charge. Health service Circular 1999/018 states that failed asylum seekers should not be registered, but equally, GP practices have the discretion to accept such people as registered NHS patients. In cooperation with the Home Office, DH will review access to NHS healthcare by foreign nationals this year. The review will include access to both primary and secondary care and will look at a range of issues relating to immigration and asylum arrangements, particularly the eligibility of failed asylum seekers and the status of children, whether accompanied or unaccompanied, as well as public health issues. Emergencies or treatment which is immediately necessary should continue to be provided free of charge within primary care to anyone, where in the clinical opinion of a health care professional this is required.	For secondary care, failed asylum seekers are not generally eligible for free hospital treatment. However, immediately necessary treatment to save life or prevent a condition from becoming life-threatening should always be given to failed asylum seekers without delay, irrespective of their eligibility for free treatment or ability to pay. However if they are found to be chargeable, the charge will still apply, and recovery should be pursued as far as the trust considers reasonable. Any course of hospital treatment already underway at the time when the asylum seeker's claim, including any appeals, is finally rejected should remain free of charge until completion. It will be a matter for clinical judgement as to when a particular course of treatment has been completed. Any new course of treatment, begun after the asylum claim is finally rejected, will be chargeable (unless the treatment itself is exempt under the provisions of the NHS (Charges to Overseas Visitors) Regulations 1989, as amended, e.g. TB). Trusts should refer to the document "Implementing the Overseas Visitors Hospital Charging Regulations - Guidance for NHS Trust Hospitals in England" for advice on how and when to make the charge in these cases. In cooperation with the Home Office, DH will review access to NHS healthcare by foreign nationals this year. The review will include access to both primary and secondary care and will look at a range of issues relating to immigration and asylum arrangements, particularly the eligibility of failed asylum seekers and the status of children, whether accompanied or unaccompanied, as well as public health issues.
Given Refugee Status (successful asylum seeker or, arriving in the country through a Government initiative, i.e. Refugee Gateway Scheme)	Access to **primary care** without charge. As for Asylum Seeker.	Access to **secondary care** without charge As for Asylum Seeker.

HIV and Maternity Services

1. In the case of services which relate to HIV/AIDS only the initial test and counselling is free to all. People not eligible for free NHS treatment should pay

2. Maternity services should be classed as immediately necessary treatment even if the woman is unable to pay in advance, however the patient remains chargeable and necessary steps should be taken to recover the debt

The studies: Rights disclosure and religions

- Use of language
- Manicaland
- England
- Ethnographic (support groups, word of mouth, churches, traditional healers:
- Ubuntu-Hunhu (research ethics)

Ubuntu

- The art of being human
- A person is a person through others
- I am I because of you
- Harm reduction strategies

England and Zimbabwe: access to treatment

Zimbabwe (ESRC study)	Nuffield Foundation Grant (UK)
-All born in Zimbabwe	All born in Zimbabwe
-More women than men	More women than men
-Few on HAART (less than 10%)	Most on HAART (90%)

Employment and right to health

Manicaland

-86% unemployed

-Treatment can be accessed privately at a fee

- Most could not afford the payment for CD4 counts and ARV
- Family support available

- England
- 77% unemployed

-A few, during the research had their application for settlement fail

?deportations = challenge to right to health

?pay for treatment

?made homeless

?Unable to work

?Limited family support

Confidentiality

- A right for most infected with HIV
- Contradictory pathway in realising right to health
- Women questioning this as this is gendered

Results: Gendered Confidentiality

- Affects men and women differently
  - Breast-feeding
  - Antenatal care
  - Death of a partner/child
  - An HIV positive child
  - Death or illness of the ‘small house’

  - All the above point to a definitive diagnosis of the mother with men implicated remotely

Confidentiality…a professional discourse of rights?

- Official definition not always shared

  It means things that are confident….as a woman…you can stand up for yourself. My nurse is very good. She wants me to be a strong woman and she tells me about confidentiality every time I visit the clinic.

Right to information

- Half Zimbabwean sample respondents likely to be widowed
- Most find out after an illness or death of a partner
- Women less likely to ‘hide’ a diagnosis

Stigma slowing down the process to right to health

- More so in developed countries like UK
- Less so in Zimbabwe
- Everyone is affected

Prevention of HIV

Manicaland

- Stigma more for the affluent/prominent members

More visible community based HIV prevention initiatives such as:

(TV, radio, billboard, buses, church services, drama (soap opera), mobile HIV testing and treatment centres

- England
- Stigma
- Less visible (flyers –most in English –not taking into account diversities;

Media and the law in UK

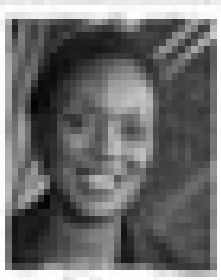
- Negative presentation of HIV
- Link between migration and HIV not always helpful for a public HIV campaign
- Criminalisation of those who pass on HIV knowingly

The media

The SUN Headline: Monday, September 18, 2006

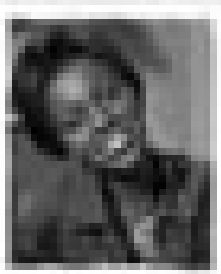
Camp monster gave me HIV: SEX monster's former lover tells of terrible moment she found out she was HIV positive

Being HIV positive does not define me... it helps me to be a better person



Colleague

'Johanna is a great teacher who always brings out the best in everyone, especially the pupils. To us she is not HIV positive – she is just Johanna'



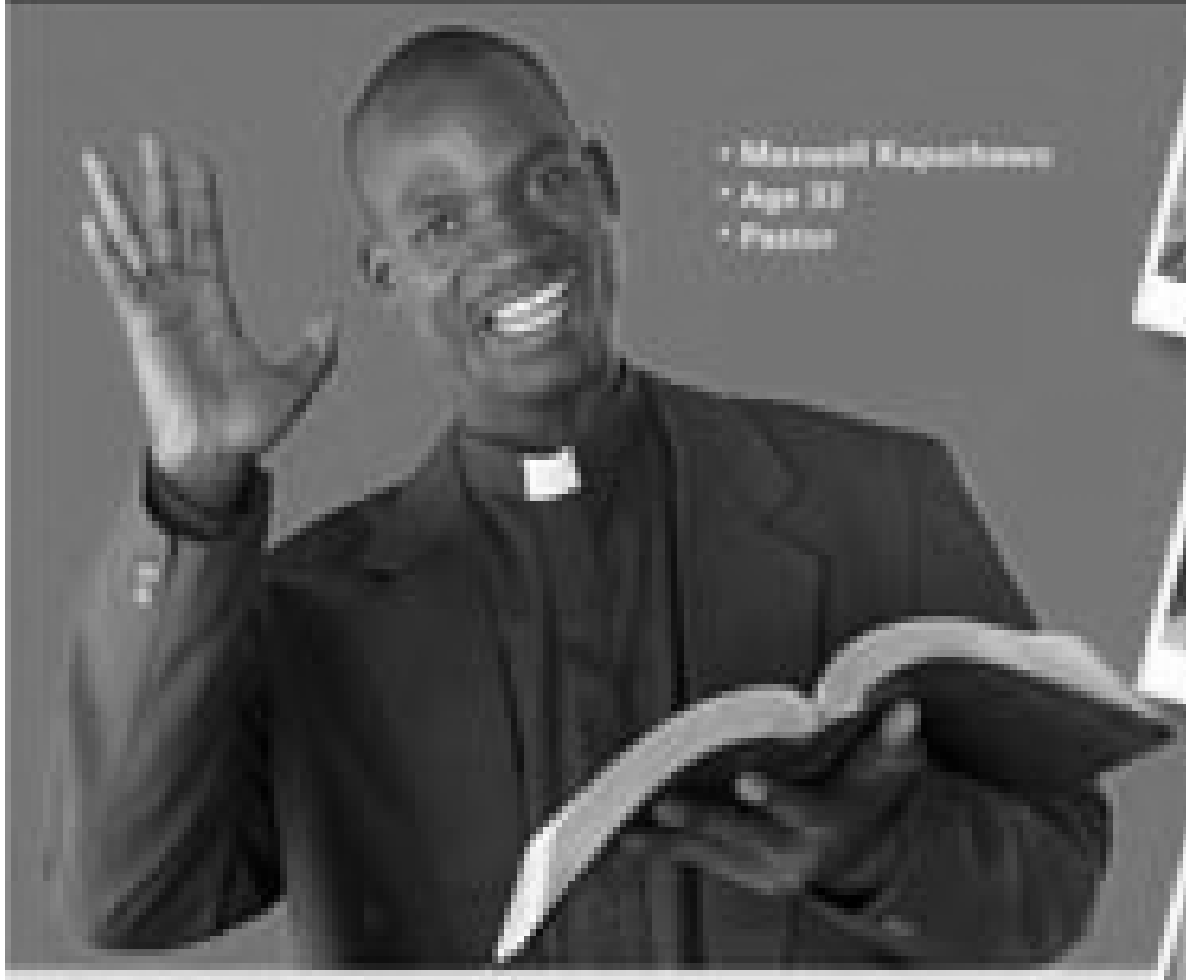
Daughter

My love for true love is to ask a man of fat down me and my HIV positive mother too

My students ask me what it's like to be HIV positive
My answer... Just because I've got it, doesn't mean I'll die today

Don't be afraid about being Positive

I'm an HIV positive Pastor... it can happen to any one



- Maxwell Kapachewo
- Age 33
- Pastor

Pastor Kapachewo is not ashamed of his status. In the eyes of the Lord we are all equal, HIV positive or negative, infected or affected.

It was very difficult at first to nurse someone with HIV, worse when I knew I was positive too. But I love and respect my husband and we support each other.

I don't think the Pastor has changed at all in his preaching. In fact, it now comes straight from the heart.

Let's make churches channels of hope, acceptance and love
I am proud to be doing my part.

Voices from Africa about being Positive

Key messages

- HIV no longer a local problem
- More global focus on right to health (policies and prevention)
- Gendered rights
- Health impact assessment of policies targeting developing countries