

HIV/AIDS: A Cross-cutting Theme in Human Rights –Domestic and International Dimensions

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Abstract

If we look at the rights guaranteed in the International Covenant on Economic, Social and Cultural Rights (1966), we can find several relevant rights related to non-discrimination and equality, freedom to work, social security, special protection for mothers and children, access to basic health care/services and education which are all of direct relevance to people living with HIV/AIDS. Furthermore, other rights enshrined in the International Covenant on Civil and Political Rights (1966) such as the rights to privacy, freedom of information, family life, and enjoyment of the benefit of scientific advances and to life itself are equally of specific importance for addressing the needs of people living with HIV/AIDS. Of course, it is impossible to deal with all of these various rights, but by looking at the specific case of language rights and HIV/AIDS prevention and treatment in Botswana I intend to illustrate this point.

Key Words: HIV/AIDS; human rights; clinical contexts; prioritization; treatment; prevention; education.

Introduction

Beyond the point made above, the case of south-Saharan Africa and Botswana in particular opens up another very important aspect of the human rights related to HIV/AIDS,

namely the way in which different sets of human rights interact with others. More specifically, is it possible or even appropriate to regard CPRs as more important than ESCRs or vice versa? This discussion, in turn, ties in with another equally important one concerning the relationship that exists between development (conceived of in its broadest sense as 'human development') and human rights. This is of extreme relevance to the guarantee of social rights (such as the right to health care) since it concerns not only the minimal right of 'subsistence' but requires also that attention be given to people's ability to be *active participants in and contributors to society*. Clearly, a failure to prevent and treat HIV/AIDS effectively denies many members of a given society such as Botswana this ability along with the related set of rights. Again, the case of HIV/AIDS is one that provides a very useful entry point to examining this question while also showing clearly both its domestic and international dimensions. The former covers, for example, the extremely hard choices that developing countries are often forced to make between guaranteeing one social right at the expense of another. The latter includes not only the issue of the right of citizens of poor countries to access to life-saving drugs in cheap, generic forms (and a concomitant duty on governments not to defend excessive profits made by their pharmaceutical companies) but also a broader international duty for cooperation for achieving equitable development and international social justice.

The Vienna Declaration (1993)¹ sought to resolve a long-standing controversy over the relative equivalence between civil and political ('first generation') and economic, social and cultural ('second generation') rights by emphasising the

“indivisibility” and “interrelated” character of all human rights. This view has been reinforced since the early 2000s by an increasing recognition among international human rights NGOs that it is not sufficient to defend civil and political rights (CPRs) alone but that economic, social and cultural rights (ESCRs) must also be promoted in order to ensure that their human rights advocacy is both meaningful and effective. Such rights as those to housing, food, health care and fair wages, then, should be promoted alongside the right to a fair trial and freedom from torture.

However, it is much less easy to ‘give meaning’ to ESCRs that require positive action and policy-making from governments to realise, especially since they are so closely tied up with broader economic and social issues that are often extremely complex.² Addressing the human rights-related aspects of HIV/AIDS prevention and treatment, given its cross-cutting character as a human rights issue, can provide a means of elucidating this complex picture and clarifying the interrelated character of all human rights.

Although it is, of course, of crucial importance the right to health is by no means the sole human right implicated in the relationship between AIDS patients and their families and governments. First, if we look at the rights guaranteed in the International Covenant on Civil and Political Rights (1966)³ there are several rights relevant to this question, such as the rights to:

- Privacy
- Freedom of information

- Family life
- Enjoyment of the benefit of scientific advances
- Life itself

Furthermore, in the International Covenant on Economic, Social and Cultural Rights (1966),⁴ we can find several relevant rights related to:

- Non-discrimination and equality,
- Freedom to work,
- Social security,
- Special protection for mothers and children,
- Access to basic health care/services
- Education

Other rights of direct relevance to government policies with regard to HIV/AIDS prevention and treatment are found in the human rights treaties dealing specifically with ensuring non-discrimination against women and the rights of the child.⁵ The connection between social rights such as access to basic education and health services and being able to lead a minimally good life is obvious. Hence, the direct connection between guaranteeing social rights (in the case of HIV/AIDS, providing fair and equal access to preventive health) and a life that allows for human dignity can be made. This is a point made strongly by Jack Donnelly:

If the denial of political rights will bring physical survival, a free people may choose survival (although even this is not obvious). But to reduce human rights to a

guarantee of mere survival is a perverse betrayal of any plausible conception of dignity.

All of these rights cited above are of direct relevance to people living with HIV/AIDS. Of course, it is impossible to deal with them all here, but by looking at the specific case of language rights and HIV/AIDS prevention and treatment in Botswana I intend to illustrate this point.

Case Study – Language and HIV/AIDS Prevention and Treatment in Botswana

For people to enjoy good health, they need to have access to health services such as medical tests, drugs, health education, and others. It is important to stress that health services are provided through some linguistic media.⁶ This being the case, there is a need to take a serious consideration of how the language factor impacts on the delivery of health services in multilingual sub-Saharan African countries.⁷ For a long time, enormous language planning efforts in Africa and elsewhere have been devoted to the education domain,⁸ thereby neglecting other domains (e.g. the health domain). However, in view of the central importance of health to human life as well as to sustainable development, it is worthwhile to give increased attention to language planning in the health domain in sub-Saharan Africa.

Sub-Saharan Africa is generally characterized by linguistic diversity and a critical examination of the so-called ‘English-speaking’ countries shows us that such countries are not in reality countries in which the English language is dominant. The

official language is actually a minority language if one takes account of the numerical strength of its speakers. The vast majority of the people in sub-Saharan Africa can only communicate through local languages.

For the purposes of this paper, I have chosen to use the World Health Organization's definition of health, cited in Evans, as “a state of complete physical, mental and social well-being”. The delivery of health services, meanwhile, involves the provision of counselling, preventive and curative drugs as well as the provision of health related information. In considering the human rights related aspects of HIV/AIDS prevention and treatment, I will look briefly at two cases – the use of language in delivering an AIDS prevention message and the use of language in the clinical (i.e. treatment) context. Both of these illustrate how central respect for the language needs of speakers of ‘minority’ languages (often, in fact, local languages spoken by the majority population in a given area)⁹ when considering the prevention and treatment of HIV/AIDS.

Language in HIV/AIDS Prevention Education

Kamwendo makes reference to a real HIV/AIDS prevention message that has been seen on advertising billboards in Botswana that read: “People say small houses strengthen relationships. But having small houses spreads HIV. Having more than one relationship over the same period of time highly increases your risk of HIV infection”. He poses the question - how can small houses spread AIDS? The explanation is that, in the context of Botswana, a ‘small house’ is a man’s extramarital affair and signifies a woman who is lower in status than the

legitimate or senior wife. Of course, the term 'small house' is likely to be misinterpreted by anyone who is not familiar with the Botswana context and it is interesting that, here, the use of the English language has been localized and given a local flavour in terms of its content and references. Unfortunately, English is not the best medium for communicating with the local audience (i.e. the Botswana audience) since most people know and speak Setswana which is, in fact, the national language. Clearly, that would be the best medium for disseminating HIV/AIDS messages in Botswana and reaching both the widest audience and the constituency most in need of hearing it.¹⁰ Here, then, we see an example of a well-meaning but misguided attempt to get across the HIV/AIDS prevention message through using culturally-appropriate content that will not be as effective as it needs to be since it is delivered in an inappropriate language. In a country such as Botswana where up to 80% of the active adult population have contracted HIV, this is a serious issue with obvious human rights implications.

This example points to another complicating factor when seeking to educate the local African population about HIV/AIDS. Although the use of indigenous languages in HIV/AIDS education makes sense in terms of reaching a wider audience, there is a serious lack of culturally appropriate and acceptable terminologies in those languages that the billboard cited above sought to address. This is due in large part to the close association of HIV/AIDS with sexuality, which is a taboo subject in many African societies.¹¹ Therefore, HIV/AIDS education programmes have to seek ways of overcoming these cultural and linguistic hurdles and it is necessary in every

country to consider carefully the terminologies that are currently in use in HIV/AIDS education in order to determine their effectiveness and social acceptability. This is no easy task in a multilingual and multicultural society where ensuring equality of access to the HIV/AIDS education message may prove complicated for the reasons set out above.

It should also be remembered that linguistic exclusion in HIV/AIDS education does not only affect linguistic minorities in the classic sense, but can also have serious consequences for the visually impaired, the hearing impaired, indigenous peoples, and refugees or displaced groups of people. From this we can understand that 'linguistic exclusion' in relation to HIV/AIDS education refers to any situation in which a segment of a population is excluded from receiving that educational message on the basis of language in its broadest sense.¹² The use of a national language as the medium of HIV/AIDS education on the assumption that every one understands it is a classic situation of linguistic exclusion. Hence, in countries operating linguistic assimilation policies (as does Tanzania where Kiswahili is the national language) there may still be some linguistic minorities that may not understand the national language. In such cases, it is important to address the linguistic minorities through their own languages and the non-governmental sector has a major role to play in this.¹³ Another category is Deaf users of sign language represent another group of minority language users that is often ignored by health service providers. A point of significance from the human rights perspective is that, unlike most ethno-linguistic minorities who tend to live in geographically marked areas and are the intended subject of Article 27,¹⁴ deaf people are not born

in a specific deaf community but are scattered across any society among hearing people. For this reason, it is even less clear how the human rights relating to linguistic minorities should be applied to deaf people in relation to their health needs and protection against diseases such as HIV/AIDS and tuberculosis. As a politically, linguistically, socially and economically marginalized group, the deaf are usually not the targets of information and education on HIV/AIDS and sexuality.

The Use of Language in Clinical Contexts

It is an obvious point that language is a central feature of many if not most clinical activities. The importance of language in clinical services is succinctly put in the following observation by Cameron and Williams:

Although we may think that the primary tools of medicine are technological, the most fundamental tool, upon which all use of technology depends, is that of language. Language allows patients and care providers to make their intentions known, a crucial step in the process of identifying a problem, investigating how long it has existed, exploring what meaning this problem may have, and setting in action a treatment strategy. Thus if problems in linguistic encoding interfere with this process, there may be important consequences.

The ideal situation is clearly to have clinical encounters conducted in a language understood by both the clinician and the patient. According to Kamwendo,¹⁵ however, this is not always the case in sub-Saharan African clinical contexts. For example, a

patient may come across a local doctor with whom she or he does not share a common language or an expatriate doctor who does not speak a local language. The patient, if they are lucky, will know sufficient English to be able to communicate with the local or expatriate doctor (up to a point) through that medium. However, some expatriate health services personnel may not even be able to communicate effectively through English, as is the case of Taiwanese medical personnel working in Malawi. To make matters worse, interpretation is not always provided by competent people¹⁶ and so the quality of the language service may not be satisfactory, resulting in a far from satisfactory clinical outcome. To underline the prominent place of language in clinical encounters, Kamwendo¹⁷ cites the startling case of a fifty-six-year old Turkish woman who was refused a heart transplant by a clinic in Hanover (Germany). The decision to refuse her the transplant was linguistically based. She did not speak German and so the hospital feared that the “patient might not understand the doctor’s orders, might take the wrong medicine and might not be able to get help if there were complications”.¹⁸ The decision was that whenever there was no bridging language between a patient and his/her doctor(s), no operation should be carried out. This decision amounts to having an institutional language policy.

It is, of course, not surprising that there has been such a preoccupation with language issues in the education domain in view of the great importance attached to education in relation to development.¹⁹ However, education is not the sole catalyst for development and the good health of a society is also a prerequisite for achieving sustainable development. This fact

becomes clear when one looks at the Millennium Development Goals (MDGs), with three out of the eight goals relating specifically to health issues.²⁰ Since health service provision and preventive health care will always be made through a linguistic medium, the language factor should be considered whenever we plan for the provision of healthy services.

Prioritising Human Rights – the Case for Development

The case of south-Saharan Africa and Botswana in particular opens up another very important aspect of the human rights related to HIV/AIDS, namely the way in which different sets of human rights interact with others. Can one decide a priority of one set of rights over another? What relationship does this question have with the right to development? Amartya Sen put forward a thought-provoking approach as follows:

In the terrible history of famine in the world, no substantial famine has ever occurred in any independent and democratic country with a relatively free press.²¹

This would suggest that guarantee of certain civil and political rights takes precedence over economic and social ones and, of course, there is some truth in this statement. However, the case of Botswana in particular is a direct rebuttal of this since it is a democracy with reasonably good guarantee of civil and political rights (including freedom of the press) but it also has the world's highest incidence of AIDS. As Michael Ignatieff noted:

All the gains in civil and political rights that have been made there will be wiped out by the catastrophic losses in

economic and social rights. At this level of incidence of AIDS, the virus destroys the infrastructure of a society. It cuts into the defences that make civil and political rights possible.²²

Clearly, a failure to prevent and treat HIV/AIDS effectively denies many members of a given society, such as Botswana or South Africa,²³ the ability to function and live full lives along with the related set of rights. As noted above, the importance of good health for sustainable development is highlighted in a special way by the fact that three of the eight Millennium Development Goals (MDGs) actually address health issues. A clear message coming from the MDGs is that there can be no sustainable development when a significant number of people in a society do not enjoy good health. This is especially true of AIDS since the professionally active age group is disproportionately affected by the virus. It is only healthy people that can contribute significantly and meaningfully to national development. As Shue notes,²⁴ “No-one can fully ... enjoy any right that is supposedly protected by society if he or she lacks the essentials for a reasonably healthy and active life ...”

How, then, should development be understood in this context? First, the ‘human development’ paradigm (promoted by UNDP in its *Human Development Reports*) is clearly the most appropriate one since it stresses that development is not just about economic growth but about advances in terms of social, cultural and political indicators too. As such, it has a strong parallel with ESC human rights. This view of development is of extreme relevance to the guarantee of social rights (such as the

right to health care) since it concerns not only the minimal right of ‘subsistence’²⁵ but requires also that attention be given to people’s ability to be *active participants in and contributors to society*. The direct connection between the emphasis placed on human capacities or capabilities²⁶ in this development paradigm and the human rights issues surrounding HIV/AIDS is set out clearly by UNDP.²⁷

[It] incorporates the most elementary capabilities such as living a long and healthy life ... Indeed, longevity is itself an important means to other capabilities, since one does not have the freedom to do much unless one is alive.

The UNDP Report also draws out the relationship between human development and human rights in an interesting manner, noting that they are “linked in a compatible and complementary way” and that human rights provide the extremely important aspect of “claims that individuals have on the conduct of individual and collective agents” to facilitate these capabilities.²⁸ Gauri²⁹ adds a further argument for taking a human rights approach to development issues in that they concentrate on the quality of the process, and not just the outcomes. Moreover, the distribution of these outcomes across a population is emphasised in a way that takes account of inequity in delivery in a way that considering averages would not. Here, Donnelly provides us with a succinct expression of the fundamental importance of taking a rights-based approach to development:

[A] Developmental perspective is aggregate and focuses on production. Economic and social rights, by

contrast, are concerned with distributions of goods, services, and opportunities, which must be guaranteed to every person even when pursuing the most noble social goals.³⁰

Again, the case of HIV/AIDS is one that provides a very useful entry point to examining this question while also showing clearly both its domestic and international dimensions. The former covers, for example, the extremely hard choices that developing countries are often forced to make between guaranteeing one social right at the expense of another.³¹ The latter raises a profound question for human rights law as a whole – how far do all States (in particular developed ones) hold an international duty to support the guarantee of rights in the poorest or otherwise most challenged States of the world?

International Dimension of the Question

In addressing the aforementioned question, I refer again Ignatieff who stated, “[d]oing something about AIDS in Africa is not about charity or public health prevention. It is a matter of obligation”.³² The question, however, is whether such an obligation can be seen to exist in international human rights law and, if it does, on what basis does it exist. Of course, the whole issue of the existence of such an international duty framed in terms of a right to development remains a controversial one. However, I take the following statement by Mohammad Bedjaoui,³³ an international legal authority, as my starting point in this discussion:

The right to development is a fundamental right ...It is the alpha and omega of human rights, the first and last human right, the beginning and end, the means and the goal of human rights, in short it is the *core right* from which all others stem ... In reality, the international dimension of the right to development is nothing other than the right to an equitable share in the economic and social well-being of the world.

This view than clarifies for us the international dimension to human rights in relation to HIV/AIDS – it relates to obligations on the international community to ensure that the citizens of no States are denied this “equitable share in the economic and social well-being of the world” by virtue of the lack of human and/or economic resources of their country to provide at least minimal HIV/AIDS prevention, care and treatment. This is further underlined by Thomas Pogge³⁴ who reminds us of the content of Article 28 of the UDHR (1948) that was, tellingly, never incorporated into either of the two 1966 Charters:

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

The key international issue in this regard is the right of citizens of poor countries to have access to life-saving drugs in cheap, generic forms and a concomitant duty on governments not to defend excessive profits made by their pharmaceutical companies. Here is not the place to enter into the arcane complexities of intellectual/industrial property rules relating to

the patenting of medicinal drugs, but it is sufficient to draw out the point that many governments of rich States where the major pharmaceutical industries are headquartered hide behind IPRs as a means of avoiding this international human rights obligation.

However, their arguments which are usually based on statements that IP rules cannot be changed because of their venerable history fail to convince. For example, the World Intellectual Property Organization has been looking into developing *sui generis* rules for dealing with traditional knowledge and genetic resources since 2000 (work that may result in drafting a new international IP Convention). Similarly, the development of special IP rules that allow access to life-saving treatments for the citizens of less developed countries should also be considered. There is nothing inherent in the intellectual property regime to preclude this, simply the unwillingness on the part of the developed States to pursue such an approach. As the stark case of countries unable to provide their citizens with anti-retroviral or drugs to prevent mother-to-child transmission of HIV demonstrates, this is an issue of huge international importance and one indeed where the catastrophic consequences of ignoring it are not only for those countries alone but for the whole world.

Footnotes

- 1- World Conference on Human Rights, 'Vienna Declaration of the World Conference on Human Rights' (25 June 1993), online: <<http://www.ohchr.org/english/law/vienna.htm>>. Paragraph 3 reads: "All Human rights are universal, indivisible and inter-dependent and inter-related. The global community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis".
- 2- See, for example: I. Merali and V. Oosterveld, *Giving Meaning to Economic, Social and Cultural Rights* (University of Pennsylvania Press, 2000); J. Symonides (ed.) *Human Rights: International Protection, Monitoring, Enforcement* (2003: UNESCO Publishing).
- 3- International Covenant on Civil and Political Rights (UN: Geneva, 16 December 1976), online: <<http://www.ohchr.org/english/law/ccpr.htm>>.
- 4- International Covenant on Economic, Social and Cultural Rights (UN: Geneva, 16 December 1966), online: <<http://www.ohchr.org/english/law/cescr.htm>>.
- 5- Convention on the Elimination of All Forms of Discrimination Against Women (UN: 18 December 1979), online: <<http://www.ohchr.org/english/law/cedaw.htm>> at Art.12 and the Convention on the Rights of the Child (UN: 2 September 1990), online: <<http://www.ohchr.org/english/law/crc.htm#art31>> at Art.24.
- 6- For a general discussion of language-related rights, see: T. Skutnabb Kangas and R. Phillipson (eds.) *Linguistic Human Rights: Overcoming Linguistic Discrimination* (Mouton de Gruyter, Berlin, 1995).
- 7- For this discussion of language use and health care, I draw on the excellent work on language, health and human rights of Professor Gregory Kamwendo a linguist at the University of Botswana. See: G.H. Kamwendo *Language Policy in health Services: A Socio-linguistic Study of a Malawian Referral Hospital* (Institute for Asian and African Studies, Helsinki, 2004).
- 8- L.A. Grenoble and L.J. Whaley (eds.) *Endangered Languages: Language Loss and Community Response* (Cambridge University Press, 1998); L. King and S. Scheoman, *The Challenge of Indigenous Education – Practice and Perspectives* (UNESCO Publishing, 2004).
- 9- As protected by Article 27 of the ICCPR (1966). The issue of whether a minority is always a numerical minority in every area of a given country is an interesting one, addressed by P. Thornberry *International Law and the Rights of Minorities* (Clarendon Press, Oxford, 1991).
- 10- Kamwendo *op.cit.* n.16
- 11- For more on the notion of linguistic exclusion, see: Skutnabb Kangas and Phillipson *op.cit.* n.9. R. Smeets 'Language as a Vehicle of the Intangible Cultural Heritage,' *MUSEUM International*, Nos. 221-222, Vol.56, No.1-2, 2004, pp.156-164 also makes the point that 'language' is a

broad notion that includes sign language and other forms of linguistic communication.

12- An example from sub-Saharan Africa cited by Kamwendo *op.cit.* n.11 is that of a non-governmental organization (KFO) working among the San (the so-called 'Bushmen') in Botswana that has produced culturally and contextually relevant educational tools on Tuberculosis and HIV/AIDS.

13- Art.27 of the ICCPR on the rights of linguistic, ethnic and religious minorities.

14- Kamwendo *op.cit.* n.11.

15- Sometimes medical staff or patients may interpret for other patients, or relatives may also interpret for patients.

16- Kamwendo *op.cit.* n.11.

17- B.Spolsky *Language Policy* (Cambridge University Press, 2004) at p. 1. Cited in Kamwendo *op.cit.* n.11.

18- P. Francois *Social Capital and Economic Development* (Routledge, London, 2002).

19- The three health-related MDGs are Goals 4,5 and 6: to reduce child mortality; to improve maternal health; and, to combat diseases such as HIV/AIDS, Tuberculosis and malaria. United Nations *Millenium Declaration* [A/Res/55 (2000)].

20- A. Sen *Poverty and Famine: An Essay on Entitlement and Deprivation* (Clarendon Press, Oxford, 1981). See also: A. Sen *Development as Freedom* (Oxford University Press, 1999).

21- M. Ignatieff cited in *The Economist* 18 August 2001 in a Special Report on *Human Rights* at p.20.

22- In South Africa, one in six adults have contracted HIV and 1,000 people die per day of AIDS-related conditions. Despite being a relatively wealthy country in its region, the South African government was held by the Constitutional Court on Appeal to have failed in its duty to provide equitable access to health care over its restriction of the use of an anti-retroviral drug Nevirapine (used to prevent mother-to-child HIV transmission) in public health services even though it received the drug free of charge. The Court judgment was based in part on the South African government's international obligations under the 1966 ICESCR. *Treatment Action Campaign v. Ministry of Health*, Constitutional Court of South Africa, Case CCT 8/02, 5 July 2002.

23- H. Shue *Basic Rights*, second edition (Princeton University Press, 1996) at p. 24 cited in Nickel *op.cit.* n.7 at p.145.

24- As the social rights of the ICESCR are sometimes understood. See: .B. Orend *Human Rights: Concept and Context* (Broadview Press, Ontario, 2002) at p.139.

25- See, for example, J. Alexander "Capabilities, human rights and moral pluralism," (2005) 9(1) *International Journal of Human Rights* 451-469; and A. Appadurai "The Capacity to Aspire: Culture and the Terms of Recognition," in V. Rao and M. Walton *Culture and Public Action* (2004, Stanford University Press) pp.58-84.

26- UNDP *Human Rights and Human Development* (UNDP, New York, 2000).

27- *Ibid* .

28- Donnelly *op.cit.* n.8 at p.111.

29- K. Roth, 'Defending economic, social and cultural rights: practical issues faced by an international human rights organization,' (2004) 26 *Human Rights Quarterly* 63.

30- Ignatieff *op.cit.* n.33.

31- M. Bedjaoui "The right to development," in M. Bedjaoui *International Law: Achievements and Prospects* (1991) at p. 1182. See also, R. Stavenhagen, *the Ethnic Question: Conflicts, Development and Human Rights* (United Nations University, Tokyo, 1990).

32- T. Pogge (2005) "Recognized and violated by international law: the human rights of the global poor," available online at: <<http://www.ucl.ac.uk/spp/download/seminars/0506/Paper-Thomas-Pogge.doc>>. See also: T. Pogge *World Poverty and Human Rights* (Polity Press, Cambridge, 2002).

References

- Niec, H. 'Casting the foundations for the implementation of cultural rights,' in H. Niec (ed.) *Cultural Rights and Wrongs* (UNESCO Publishing, 1998) pp.176-190.
- Nickel, J.W. *Making Sense of Human Rights*, second edition (Blackwell Publishing, London, 2007) at p.145.
- Donnelly, J. *Universal Human Rights in Theory and Practice*, second edition (Cornell University Press, 2003) at p.112.
- Kamwendo, G. H. and T. Mooko "Language planning in Botswana and Malawi: a comparative study," 182 *International Journal of the Sociology of Language* (2006) 117-133.
- Evans, T.A Human Right to Health? 23 (2) *Third World Quarterly* (2002) 197-215 at p.198.
- Kamwendo, G.H. "'But having small houses spreads HIV': problems of language and communication in health services in sub-Saharan Africa," paper presented to UNESCO/UNU conference on *Globalization and Languages: Building on Our Rich Heritage*, Tokyo 27-28 August 2008.
- Cameron, R. and J. Williams "Sentence to tent cents: a case of relevance and communicative success in non-native-native speaker interactions in medical settings," 18 (4) *Applied Linguistics* (1997) 416-445 at p.419. Cited in Kamwendo *op.cit.*n.16.
- Gauri, V. "Social rights and economics: claims to health care and education in developing countries," in P. Alston and M. Robinson (eds.) *Human Rights and Development* (2005) at p.65.

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