

Welcome to the second issue of our celebratory 10th year anniversary volume. It is a special year for us as we look back at what we have achieved together for human rights in health and social care. Previously titled *Ethnicity and Inequalities in Health and Social Care*, our journal always focussed on bringing to the front healthcare inequalities impacting on some of the most marginalised communities internationally.

Since the last issue, we have seen some key developments in the national and international arena of human rights and healthcare. At the international level, on the 19 December 2016, the UN General Assembly ratified the Declaration on the Right to Peace (Resolution A/71/189). The rights therein are expected to have a significant positive impact on health entitlements as they are meant to promote a life of dignity for all. In this way, Article 2 of the Declaration on the Right to Peace proclaims the obligation of UN members to “respect, implement and promote” key principles grounded in the notion of human dignity, including “equality, non-discrimination, freedom from fear and want, as well as justice and the rule of law”.

But the law alone is not a sufficient driver for changing institutional culture within hospitals, care homes and other institutions serving the most vulnerable in need of help. I have written in the past for this journal (Gavrielides, 2011) that to instil a human rights culture, we first must understand that human rights are not abstract, legal entitlements that are meant for the few. They are what patients simply call dignity, respect, involvement in decision making, equality, fairness. My interactions with patients taught me that it is more important for them that they are treated with dignity and respect than having an expensive consultant or even a clean hospital (Gavrielides, 2008). The declaration on the right to peace is a critical milestone but realizing the goals of this instrument will require a global transformation towards a culture of peace.

At the national level, the developments are not so positive as funding for the National Health Service (NHS) is being questioned by the current administration. Patients’ waiting lists are longer than ever while access restrictions are being introduced for migrants and refugees some of the most vulnerable groups in our wealthy society. When did the values of NHS become profit and elitism? By definition the NHS concept and ethos were created to care for those in need – and we all are when it comes to health, even the wealthiest.

We start this issue with a timely paper looking at “Humanitarian healthcare: treating Syrian patients in Israeli hospitals”. The paper presents findings on the interpersonal relational processes of Israeli healthcare providers and Syrian patients and caregivers using data collected in two Israeli hospitals. Using a parallel mixed-methods design, data were integrated from observations, interviews, and surveys. In total, 20 healthcare providers and three Syrian patient-caregivers were involved. Quantitative data were also collected from 204 healthcare providers using surveys. The results are extremely interesting as they group healthcare providers’ experiences treating Syrian patients into three clusters. Factors were predicted by religious and occupational differences and included professional baseline, humanitarian insecurity, and medical humanitarianism. This is arguably the first critical examination of healthcare providers’ interactions with patients, a relationship that propels humanitarian healthcare in the face of a global migrant crisis.

The issue then proceeds with “Correcting malapropisms: strategies to bridge cultural and socioeconomic gaps”. In this paper, we find out that high health literacy is associated with both improved health outcomes and receiving better quality-of-care. Low health literacy

disproportionately affects people from marginalised ethnic and language groups. The paper argues that regardless of how a particular clinician feels about a patient, malapropisms and misattributions may cause patients to appear less intelligent or to have lower perceived health literacy, potentially affecting their healthcare experiences with other clinicians. The authors move on to recommend for “up-skilling” patients and uses principles from conversation analysis to demonstrate how malapropisms can be corrected sensitively. According to the findings, malapropisms are best corrected through modelling rather than calling attention to the error directly, as this allows the patient to save face. Explanations using drawings and clearly written materials may also be useful. Helping patients to improve their communication with clinicians may lead to improved health outcomes through improved quality-of-care.

Subsequently, in “Maternal health services: an equal or framed territory?”, our issue looks at the engagement of Ukrainian immigrant women on maternal and child healthcare services, exploring their perceptions and experiences in these contexts. Arguably, this is one of the most expressive nationalities of female immigration in Portugal. To construct its arguments, the paper used qualitative methodology for collecting semi-structured interviews, and was based on discourses of ten Ukrainian women who were pregnant or were mothers in Portugal. The findings indicate that the Ukrainian women were misinformed about their legal rights and free access to maternal health services. Some dissatisfaction emerges among them with regard to the quality of information provided by health professionals and their communicational skills. According to the interviewed women, limited access was given to them to medical specialties particularly in primary care and that their doubts are inappropriately clarified during medical appointments.

The fourth paper is titled “Nurses reciprocation of perceived organizational support: moderating role of psychological contract breach” and it aims to add to our knowledge around the nursing profession demands emotional and psychological attachment to perform well. In particular, the paper examines the role of perceived organizational support (POS) in enhancing nurses work engagement (WE) and extra-role behaviour (OCB). To this end, the study used a questionnaire based survey to collect data from 389 nurses. According to the findings, the relationships among POS, WE and citizenship behaviour may further be explained through affective commitment. Whereas, the association between POS and affective commitment is moderated by the psychological contract breach.

The following paper then looks at “The socio-economic impacts of AIDS on families caring for AIDS-orphaned children in Mbeya rural district in Tanzania”. The paper used a qualitative inquiry employing one-on-one in-depth interviews with 20 heads of families caring for AIDS-orphaned children, two local government staff and two staff from Isangati Agricultural Development Organisation – a non-government organisation. According to the findings, families caring for AIDS-orphaned children experienced severe socio-economic impacts of the epidemic. Reduction in household savings, increase in living expenses on healthcare, and increased education fees were the identified economic impacts on these families. Social impacts included labour shortage, withdrawal of children from school, and increased demand for food. It is apparent from the research that there is a need for urgent responses and for scaling up programmes delivered by organisations, institutions and the Government of Tanzania to help families cope with these impacts. It is hoped that a better understanding of these impacts can help governmental and non-governmental institutions and programme planners to address the problem of AIDS in their policies and develop evidence-based strategies and interventions. Supporting other studies in the area, this paper argues for a holistic approach that encourages the involvement of all sectors and agents outside of the health sector.

Finally, in “Evaluating service quality in the higher education sector in Iran: an examination of student’s perspective” looks at the quality of medical education from a user perspective. As declared in UN and other international instruments, education is a human right and access to high quality education is a key to sustainable socio-economic development. This is particularly true when it comes to the medical profession and education. Improving the quality of higher education institutes is essential for generating the productive human resources and protecting the most vulnerable. Assessing the quality of higher education from the students’ perspective can be considered a crucial factor in the monitoring of service quality in universities teaching medicine. This paper reported on the evaluation of the quality of educational services in a higher education

institute, Kermanshah University of Medical Sciences (KUMS), in the west of Iran. A multistage sampling method was used to select 346 students from KUMS, who were enrolled in the second semester of the academic year 2015-2016. According to the findings, there was a negative service quality gap in all five investigated dimensions. In particular, the study showed that the quality of educational services provided in KUMS did not meet students' expectations.

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