Common Strategies for Health and Human Rights: From Theory to Practice

Stephen P. Marks

My task is to encourage the participants in this Conference to think about the ways forward, to devise a strategy to move from theory to practice. In offering some thoughts about a common strategy for health and human rights, I am starting from two assumptions. The first assumption is that the health and human rights communities that the François-Xavier Bagnoud Center has brought together at these two Conferences share a growing awareness of a common agenda. There are numerous indicators of this trend. One is the increase in the number of participants from the first Conference to the second. It is truly extraordinary that five hundred people have come to explore a theme that, a few short years ago, might have appeared esoteric and marginal. A second indicator is the spectacular growth in subscriptions to *Health and Human Rights*, truly remarkable for a scholarly journal. There is something that is capturing the attention of people. A third sign of this shared perception is the extraordinary number of relevant projects under way around the world, about which participants have reported at this Conference.

The second assumption behind a strategy for the future is that the problems to which we would apply a common strategy of action are both numerous and urgent. The substantive program of this Conference is an excellent indicator of the quantity and urgency of the issues. The program lists eight or nine different forms of violence and interpretations thereof; it focuses on several emerging and existing diseases and approaches to dealing with them; it deals with a considerable number of health and society issues. Taken together, that list is itself an agenda calling for a common strategy.

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It is not enough to acknowledge the need for a common strategy; we need to move from thought to action. To do so I propose to focus on a) the actors or the partners who are going to join in a common strategy; b) the points of entry for such a strategy to be put into practice; and c) the resources that can be marshalled to make it possible to carry out such a strategy.

Partners for a Common Strategy

If the ideas shared at this Conference are to have a wider impact, we need to work with partners. Approximately five categories of potential partners can be mentioned as able to contribute, in one way or another, to this common strategy. The first are, of course, the professional categories, subdivided into two. The health professionals include *both* health professionals and the medical professionals, each with different professional backgrounds and approaches but working together in a remarkable way throughout this Conference. The human rights community includes those professionals who focus, to a large extent, on the application of law and on the use of advocacy. These two professional groups—of health and human rights—are the core partners in our common strategy.

The second category of actors are public institutions. Frequently during the conference the notion of the state itself was challenged. And yet we are constantly reminded that some of our best partners work for and represent the state. Some of those who have put together the most forward-looking programs belong to state institutions. We learned, for example, that the Swiss government has a new three-part policy of health and development that draws explicitly on the essential linkages between health and human rights. The Swiss officials who elaborated and who implement this program are ahead of us. They are putting our theory into practice already. Of the billions of dollars being spent on official development assistance (ODA), most goes through government channels. That is where the resources are; that is where policies can have an impact on a vast scale. Those who are in charge of implementing those policies need to be partners in this enterprise. I have learned from talking to some of the

people in government participating in this Conference that to mobilize their institutions will require sort of a pincer movement. You have to deal at the programmatic level with the mid-level professionals, and, at the same time, you have to deal with their bosses and their bosses' bosses. If you work only from the top down or the bottom up, the lead time between proposing a bold new idea and seeing it implemented in the best scenario is about ten years. If you work from both directions at the same time, you cut the lead time in half or less. We, therefore, need to reach both mid-level bureaucrats and assistant secretaries or vice-ministers with human rights sensitive health policies.

The third category of partners is the nongovernmental (NGOs) community. Two major categories are represented here: the advocacy NGOs, and the service-delivery NGOs. Amnesty International, Human Rights Watch and Physicians for Human Rights, for example, belong to the first category, while Médecins Sans Frontières (MSF), Oxfam, and the International Committee of the Red Cross belong to the second category. We have heard of some of the training courses that MSF is carrying out and wants to expand to all humanitarian organizations dealing precisely with the human rights dimensions of health policy and action. This effort appears exemplary of the strategy we are attempting to design.

The fourth category of potential actors in this common strategy are the intergovernmental organizations (IGOs). They are sometimes also criticized as being part of the problem, but we all know that they are also an important part of the solution. I would suggest that we need to utilize two of the ways in which IGOs operate in our common strategy: norm-setting and field operations. Regarding norm-setting, Stephen Lewis has eloquently described the impact an international convention can have in moving from theory into action affecting the lives of millions of children. At the operational level, IGOs are spending billions of ODA resources. The message coming from this Conference to our friends in IGOs is that they must spend these funds in ways that advance the health and human rights agenda.

The fifth category consists of the bystanders, ordinary people who are not directly involved in health or human rights policy but who are indirectly engaged as citizens and taxpay-

ers. These people need to be mobilized through the media and other means and made aware of the benefits to the public of wise policies of health and human rights. They vote; they join voluntary organizations; they write letters to public officials and the media. This is an untapped resource for the movement we are promoting today.

To engage these five categories of potential partners in a common strategy, we need to consider ways of mobilizing them more fruitfully, beyond having a conference every two years. One proposal, which the François-Xavier Bagnoud Center might consider implementing, is to establish a roster of persons in each of these categories who could be called upon, for example, to be a speaker at an event or to join a task force on a health policy issue at the local level. Such a roster would be a source of volunteer talent to implement the strategy.

Points of Entry for a Common Strategy

Now I come to the second element: points of entry for a common strategy. The first is the policy-making process, which has been given greater attention at this Conference. Specifically, the time has come to implement the health and human rights policy optimization model published in *Health and Human Rights.* This concept should move from theory to practice as soon as possible. Both preventive and curative health policies are being devised at the community, national, regional and international levels, all over the world, without the application of this very insightful approach. We must generalize the practice of human rights people and health specialists working together to critique a public health policy from both the human rights and health policy perspectives in order to optimize both sets of concerns. I became convinced two years ago of the soundness of this approach and yet we have not moved very far from the theory to the practice of this model. The time has come.

The second point of entry is the norm-setting environment. Norm-setting environments are pertinent in three main areas relevant to people drafting standards relevant to health and human rights. Professional associations are engaged in this process but efforts could be broadened and deepened. We learned during the Conference, for example, that the American College of Physicians has recently adopted a policy on

sanctions and health and human rights after being convinced of the need to do so by the International Association of Bioethics and Physicians for Human Rights. This is what I mean by intervening in the norm-setting arena.

A second norm-setting environment is the legislature. Parliaments draft laws and elaborate principles that affect health and human rights. We have heard at this Conference about a magnificent example happening in South Africa where legislation is being drafted which draws upon the principles we are articulating here. Parliamentarians and their staffs are not likely to reinvent on their own the ideas that have been presented at this Conference; we need to bring the ideas to them. We need to create opportunities to discuss our strategic objectives with members of parliaments and their staffs.

Intergovernmental organizations constitute a third norm-setting environment where the principles we are elaborating here can be adopted in the form of resolutions and normative instruments (i.e. conventions and recommendations). Many opportunities have been discussed, such as sessions of the World Health Assembly and the Commission on Human Rights. We have heard about the African Commission on Human Rights and its role, the Sub-Commission on the Prevention of Discrimination and Protection of Minorities; the Committee on Economic, Social, and Cultural Rights and other human rights treaty bodies. We have learned about the technique of counter- or shadow-reports submitted to the Committee on Economic, Social, and Cultural Rights. A complaints procedure would also be useful. Draft optional protocols allowing individual complaints are in preparation for both the Covenant on Economic, Social and Cultural Rights and the International Convention on the Elimination of All Forms of Discrimination Against Women. These procedures would put some teeth into the standards that are basic to health and human rights concerns. Lobbying efforts within the intergovernmental organizations will be increasingly valuable as we move from theory to practice.

The third point of entry is the service delivery area, covering such issues as refugee relief, vaccination programs, and humanitarian actions taking place on a vast scale around the world. With few exceptions—all of which were probably mentioned at this Conference—these programs function with-

out a conscious policy of integrating health and human rights. It is an urgent and vital point of entry.

The research agenda is the fourth point of entry. There is no need to give any examples because the agenda of this Conference provides a rich list of research themes that can be taken up by any number of our partners willing to focus on the intersection of health and human rights, as well as their application to the policy agenda.

And the fifth point of entry for this strategy, I would argue, is the educational level. We were reminded by Jacqueline Pitanguy at the opening session that you cannot educate politicians. They are "hopeless." This reminds me of experiences I have had with programs to teach human rights to military and police officers. A two-week seminar will not create a new value system nor alter the thought and behavior of adults, already socialized in their political, military or correctional environment. It is a slow process, the crucial moments of which exist much earlier on the individual's psychological development. Before educational activity can change the behavior of those individuals who may participate in torture and other acts that violate human rights or who might be inclined to adopt an unsound health policy or practice violative of human rights, it is essential to obtain firm directive at the top of the hierarchical structures in which those individuals operate. The order comes from the top down, from the commander of the troops, the commissioner of police or the top of the party structure or bureaucracy. When the order comes from the top down, as a result of the political pressures brought upon the person issuing the order, those who execute the order tend to obey, assuming the system of rewards and negative inducements with which they are familiar, is operative. A politician who knows there is a constituency that believes that health is a human right does not need to be educated about human rights texts; that politician wants to be re-elected, and will begin to believe that health is a human right. Without such inducements where it counts, the politician will not budge. This is also true for the torturing police officer. If the police officer knows that he or his superior is out of a job if torture occurs, and maybe even prosecuted, the order is given in a way that the torturing police

officer understands. Now, an educational program can reinforce and direct the behavior of officials who already have an objective motivation to observe sound health and human rights practices. With this proviso, an education program directed at officials belongs in our common strategy.

A second observation on the educational level applies particularly to the United States. This month of October is Roosevelt History Month. Instead of Roosevelt history, we are fed lengthy articles about the death of liberalism and how being tainted with the "L-word" means political suicide. However, this country has a political tradition of believing that, even after a devastating war, freedom from want is a fundamental human right, is a part of human rights, and should attain a normative level beyond that of merely "desirable" governmental programs. That heritage, that legacy, needs to be reclaimed. This, despite the reality that this tradition is on the wane today, is making the United States one of the least-developed countries, normatively, in the world.

There has also been considerable discussion here about the forms of education, of mass education, and the relationship between the health and human rights agenda on the one hand and the human rights education agenda on the other. Our common strategy should place a priority on issues linking health and human rights within the framework of the Plan of Action of the UN Decade for Human Rights Education.

Planning and Funding the Common Strategy

Let me make a specific proposal for the implementation of the strategy I have outlined. What is needed to transform these ideas into action is a plan of action for implementing a common health and human-rights strategy. It would not be hard to draft. The François-Xavier Bagnoud Center, with one or two other partners, could hold a one-day meeting to transform what has been discussed here into concrete projeet proposals. While the Center is not in a position to provide the resources to carry out many projects, this should not be an obstacle. For I am proposing a plan of action based on the premise that the most likely groups to carry them out would be able to incorporate them into their respective budgets and

planning for the future. There are plenty of organizations who could put in a small project here, a small mission there, a trip to Geneva here, a pilot task force for a policy project there.

The costs of such a plan of action are not excessive. The budget should be adequate to cover the following four types of expenditure:

a) costs of travel and incidentals for task forces to implement the health and human rights policy optimization program. If participating experts volunteer their time, the cost could be kept to between $1,000-$5,000 per task force. The costs would obviously increase if in-depth impact or other studies needed to be commissioned.

b) costs of travel and incidentals for brief missions by people on the roster mentioned earlier to accept speaking engagements, engage in advocacy, and other opportunities to have an impact. These activities would cost between $500-$3,000.

c) legal expenses for a litigation program where lawyers could put into practice the theories we have been discussing by challenging destructive policies. A modest program of two or three cases per year could utilize *pro bono* attorneys and cost about $10,000 per case or less, depending on whether the project lawyers act as amicus or as counsel.

d) fees and staff time for research projects on key issues raised at this Conference. If partners collaborate, several studies could be carried out with a contribution of about $20,000 per study, assuming similar contributions from other partners.

Those four sets of activities might amount to $100,000 to 200,000 per year. That is a modest level to start implementing our common strategy. Three sources of funding could be tapped: governments, including the ministries of health; intergovernmental organizations; and foundations. With a co-

herent plan of action and involvement of relevant partners, the common strategy can be transformed into fundable projects.

Political Realities

The common strategy outlined here has generally stayed away from discussion of political realities. However, power relations are fundamental to the causes and cures of most health and human rights emergencies. Health professionals tend, I believe, to be less comfortable than human rights workers with the politics of action. But speakers here have reminded us that the existing power structures favor three "elites" that affect what we are trying to accomplish with this strategy. First are those who benefit from exploitation, inequality, and repression, including patriarchal structures; they have no motivation to seek a human rights policy in the health field. Second, those who do not need improvements in health delivery. You do not need to ask the authors of the "personal responsibility legislation," the so-called welfare reform in the United States, whether health is a human right. They have no reason to believe that health is a human right. Ask the people who are denied health care if health is a human right, and they will give you a different answer. The third category are the lawyers and doctors themselves—not those who are here, because those who are here have a different motivation—but the vast majority of our professional colleagues who are conservative by tradition and by interest.

If we take these political realities into account, we need to adjust our strategy for mobilizing partners around health and human rights issues to give it both a "reformist" and a "transformative" orientation. It should be reformist insofar as it seeks to operate within the system, within the current power structures. What this means is developing approaches that are sensitive to human rights-related causes of injury and illness and human rights consequences of health policies. Landmines are a good example of this orientation. Their elimination is urgent and compelling and can be pursued without challenging any basic structures of power, although there are plenty of interests resisting their elimination. This reformist motivation applies to much of our agenda; and is appealing to most of our partners.

But there are numerous participants here who are willing to go further, to develop a transformative strategy that challenges the prevailing power structures and attitudes, that pursues the pedagogies of liberation and hope mentioned in several sessions of this Conference. Both human rights education and liberation medicine are relevant to this more radical strategy. This strategy flows from the awareness that the governments, corporations and financial institutions responsible for practices contrary to health and human rights are structurally incapable of overcoming injustice. Numerous references have been made in this regard to the processes of globalization of the world economy. The role of a health and human rights strategy is to delegitimize policies and practices that favor the powerful at the expense of those whose health is regarded as expendable for corporate and national material wealth. This transformative strategy requires new forms of accountability of governments, of corporations, and of health and legal professionals.

This politically charged agenda within the common strategy is not for all of us, however. Some believe that realism and professional responsibility dictate caution in challenging existing structures. I call on them to join in the innumerable components of our common strategy that seek the application of existing norms and procedures for a human rights-sensitive health policy. I conclude, therefore, with a call to action addressed to everyone here, so that we will not remain bystanders while millions upon millions of children, women, and men continue to live in ignorance, poverty, and deprivation of their fundamental dignity and integrity. Ideas do change the world, and the linkage of human rights and health work is one of those ideas.