HEALTH AND HUMAN RIGHTS: If Not Now, When?

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This is clearly a very exciting and exhilarating time to be working in health and human rights—but it is necessarily also a difficult time. For we are creating, participating in, and witnessing an extraordinary moment in social history—the emergence of a health and human rights movement—at the intersection and at the time of two enormous paradigm shifts. Stimulated in the first instance by pressures within each field, both public health and human rights are undergoing major transformations, so that the linkages between them, and the outcomes of their association have now become dynamic and even more challenging than may have been evident just a few years ago. Fortunately, as the tectonic plates are shifting in the domains of both public health and human rights, interest in health and human rights has intensified—a reality manifested in, and symbolized by, this 2nd International Conference.

This extraordinary situation in which both the public health and the human rights paradigms—and the systems of thought and action which flow from them—are rapidly evolving has become evident during this Conference. The challenge of applying human rights concepts in analysis and response to health problems, such as violence, has helped reveal previously unrecognized difficulties and limitations in traditional human rights work; similarly, efforts to define, expand and protect human rights in health-relevant settings, such as sexual rights and health, uncover substantial gaps or inconsistencies in health thinking and practice.

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A major contribution of this Conference has been to highlight the extent to which new work is both needed, and underway, within each of the recognized elements of "health and human rights." That the importance of progress would become so evident during this Conference is not surprising. For while we are generally aware of flux within the field in which we are personally engaged, with its major internal debates and conflicts around definitions, first principles and modes of work, we often assume, unthinkingly, that other fields have pretty much worked things out—at least about the basic issues. Yet this is patently untrue. Thus, for example, there was recently an article in the *New York Times* which announced the discovery of thousands of previously unknown galaxies—galaxies, not stars—and quoted a prominent astronomer's relief, because until that time, astronomers had not been able to find or account for about two-thirds of the universe!

In public health, we are struggling mightily with a major paradigm shift. Public health involves "ensuring the conditions in which people can be healthy," and we do know that the so-called "societal factors" constitute the major determinants of health status. Yet despite much research (usually focusing on socioeconomic status as the principle variable) we are painfully aware of our ignorance about precisely what these societal determinants actually are; thus, we too are not sure where large chunks of our universe might be found!

The health and human rights linkage, as seen from the public health side, proposes—based at this time more on insight and experience than data—that modern human rights provides a better guide for identifying, analyzing and responding directly to the critical societal conditions than any framework inherited from the biomedical or recent public health tradition. Thus, promoting and protecting health is proposed to depend upon the promotion and protection of human rights and dignity.

The consequences of this line of thinking are nothing short of revolutionary for public health practice. Public health has traditionally sought, through application of standard epidemiological techniques, to identify risk factors associated with disease, disability and premature death; these risk factors were considered to reside at an individual level, such as tobacco smoking, over-eating, excess alcohol intake, lack of exercise; and then, based on this analysis public health sought to stimulate individual behavior change through information, education, and clinic-based services.

In contrast, to take a health and human rights analysis—which is to say a societally-based analysis—seriously, requires uncovering the rights violations, failures of rights realization, and burdens on dignity which constitute the societal roots of health problems. This approach would consider a whole human being made vulnerable to a wide variety of pathogens and unhealthy conditions as a result of how the person is treated by society—expressed and articulated in the language of human rights and dignity. It is difficult to imagine a more fundamental shift of taxonomy and a more extensive reorienting of necessary actions to protect and promote health.

Human rights is also undergoing a major paradigm shift. Traditional conceptual frameworks, and methods of work are increasingly understood to be inadequate, or incomplete. The concept of rights is expanding rapidly, propelled by increased knowledge and experience, changing societal challenges and conditions, and realization of the inherent limits inherent in the earlier rights concepts and practices. Large chunks of the universe of real human rights violations are being discovered. The earlier categories of positive and negative rights are blurred, new rights are conceptualized, rights concepts are expanded by considering how rights are affected by important non-state actors, and state responsibility is increasingly invoked in areas of life which used to be considered part of a private sphere outside the ambit of rights—such as rape and domestic violence. At the same time, the limits of modes of human rights action which were developed at an earlier time, such as embarrassing national governments and pressing for the adoption of human rights treaties, are evident when facing challenges of genocide prevention, and rights violations by non-state actors or in places without viable state structures. While traditional modes of work are still extremely useful—as is also the case in public health—new forms of action to promote and protect human rights are clearly needed.

This dual paradigm shift in both public health and human rights imposes special burdens and challenges as we seek to move from concepts to action in health and human rights. It would, of course, be specious—and we would immediately reject—the argument that health and human rights work should be suspended until the human rights movement better defines the nature and content of rights, or until the health community figures out the precise meaning of "physical, mental and social well-being" and how to measure it. For the health and human rights perspective, precisely because it lives at the intersection of both fields, can cast a particularly revealing and constructive light on each part.

But before exploring the future of health and human rights, it is important to consider ground rules for exploration, dialogue and common work in a complex field, under conditions of rapid and simultaneous changes. For while we seek to foster a community of belief, we must avoid creating, inadvertently, an oppressive orthodoxy.

One element of what might be called an "ethic of health and human rights work" is the need for inclusiveness and tolerance. We insist upon tolerance of diversity and respect for dignity from others; we must also ensure that we manifest that same tolerance and respect in our own analysis and action. This requires that we transcend a solidarity of exclusion to achieve a solidarity of inclusion—for indeed, this is the only true solidarity.

Any group faced with oppression and discrimination develops, in response, a group solidarity which is most often—unfortunately—a solidarity of exclusion. This inward thinking, while providing some psychological and practical benefits to members of the group, yields only short-term relief, and is ultimately self-defeating. Just as Martin Luther King refused to sign a Bill of Rights for African-Americans, so we must refuse, despite the intensity of injustice, to work only for our own. Perhaps it might be best to work preferentially with others for their rights—a perspective based on the understanding that protecting one's own rights is only possible when rights of others are respected—a perspective entirely consistent with modern, crossing-borders human rights thinking.

A second, closely related element of an "ethic of health and human rights" work is to avoid demonizing others. To promote rights of heterosexuals by demeaning gay and lesbian people is absurd and self-defeating; as is stereotyping men in order to promote women's rights; or promoting children's rights by treating parents and other adults only as perpetrators and violators. We must have the courage and intellectual integrity to refuse the methods used by the violators; prejudice expressed by human rights advocates remains prejudice and is unacceptable.

The fields of public health and human rights can learn much from each other. Listening to frustrations about the ignorance and inaction of politicians and other so-called "decision-makers" about human rights issues is remarkably reminiscent of similar concerns expressed in the context of public health. Public health requires prevention, yet—as with human rights violations—responding to the emergencies, the injury or illness, is generally given priority. Public health professionals often bemoan, quite appropriately, the lack of political commitment to and public interest in prevention, even after its economic and humane benefits have been abundantly demonstrated.

Nevertheless, to leave the analysis at this level—blaming the political characters and classes, and believing somehow that if only they knew what we know they would behave differently, is transparently insufficient and incomplete. Preventing preventable illness, disability and premature death, like preventing human rights abuses and genocide, to the extent that it involves protecting the vulnerable, must be understood as a challenge to the political and societal status quo. The dream of a beneficent power elite is just that. Thus, educating the powerful in hopes they will relinquish, or at least share some of their prerogatives may be useful, but is highly unlikely to be sufficient.

Another aspect of public health work which might also be relevant to human rights is the lesson that successful prevention is rarely the consequence of a single tactic or the result of applying a single technique. A multiplicity of approaches, selected and designed locally by people directly concerned, is best. In the context of public health, take the example of injecting drug use and HIV infection: it is the mixture of many approaches, applied more or less simultaneously, including prevention education, counseling, law enforcement, drug treatment and rehabilitation, and needle exchange, which has been shown to be optimal.

What about the future of health and human rights? Two years ago, at the time of the first conference, there was widespread skepticism about health and human rights in the public health community. The phrase itself, "health and human rights" was usually spoken with an implied question mark at the end, as in "health and human rights?" Today, as a result of considerable work at local, national and international levels around the world, the concept of health and human rights is much better accepted and is even assumed, even if its precise content remains to be more fully developed.

I would like to propose that the future of public health and the future of human rights have now become—to a previously unanticipated degree—mutually interdependent. Progress in the new public health, based on awareness that societal factors determine, more than anything else, who lives and who dies, of what and when, requires further development of human rights analysis and methods of action. Similarly, contemporary human rights, seeking to understand how to advance human well-being in diverse real-life settings, needs to draws upon a more sophisticated understanding of health, health status and health realities.

The health and human rights perspective challenges both public health and human rights. What might be done—concretely—to proceed?

Action is liberating: it can teach what cannot be learned nor imagined in the abstract. As much as we believe in the power of rhetoric—for after all, we live our lives, implicitly or explicitly, according to beliefs which could be considered rhetorical: ideas about life, values, or the soul—we need to see how and to what extent realizing human rights and increasing respect for dignity can operate to diminish the societal contribution to disease, disability and death.

While this work can draw upon traditional and well-developed modes of public health and human rights work, it will require innovation, experiment, and risk-taking. Certainly, we who are gathered at this Conference are ready to be bold. People engaged in public health, like those concerned with human rights are, by definition, uneasy, uncomfortable, dissatisfied with the state of the world. We keep identifying things we think should change. We keep trying to prevent or mitigate assaults on human well-being, expressed either as preventable disease, disability and premature death, or as violations of human rights and dignity. We do so by seeking to change the "givens" of personal and social life, the inherited so-called "natural" order of things, the assumed "inevitable." Thus we continually call the status quo into question—and we have learned, slowly over time, that calling the larger societal status quo into question is the true task.

Perhaps paradoxically, this eternal restlessness, this constant challenge to the societal status quo, first requires that we re-examine the status quo within ourselves. It is difficult to challenge the "givens" of an economic system, of political power, or of religious or cultural traditions. We can do so only if we are anchored by something within ourselves—and if we are linked, connected, and nourished by others. The struggle within our own lives (before it is about the structures, practices or traditions of public health or human rights) are about a way of looking at the world. It is about a fundamental, deeply rooted confidence. Not a superficial, "all will be well" attitude, but a deeper belief that the world can change, that in joining together to change the world we create something that gives meaning. The Chinese refer to drug abuse as "feeding the empty fire"; in health and human rights, we seek to feed the real fire, the inner fire which nourishes rather than consumes, that burning bush, that inner voice whose call we hear. And thus we believe in the ever-present possibility, but not the inevitability, of change for the better.

We have gathered here, and shared ideas and dreams. We are in the vanguard of a movement which is also a new kind of movement. For we share much, but we do not seek an officialdom, a dogma or complex organizational structures. Instinctively, we know that we are setting out into a new world, which requires leaving behind many familiar ways of organizing, thinking and acting. Yet, despite uncertainty and in the midst of profound changes in the two fields, health and human rights are increasingly understood and felt to be—actually—two entirely complementary ways of speaking about—and working to ameliorate—human suffering in all its forms and wherever it occurs. We share a confidence in the future—and in our ability to contribute—each in our own ways and yet together to the healing of the world. Martin Luther King, perhaps the greatest American of this century, said "the arc of history is long, but it bends towards justice..." This is our modesty, also our boldness, also our aspiration—and together we form a multitude.