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. . . .

Both the public health and the human rights paradigms—and the systems of thought and action which flow from them—are rapidly evolving. . . . 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.

New work is both needed, and underway, within each of the recognized elements of "health and human rights". . . . 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. . . .

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 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. . . . The concept of rights is expanding rapidly, propelled by increased knowledge and experience, changing societal challenges and conditions, and realization of the inherent limits in the earlier rights concepts and practices. . . .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. . . .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. . . . 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. . . . 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 inactions 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. . . .

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. . . . 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

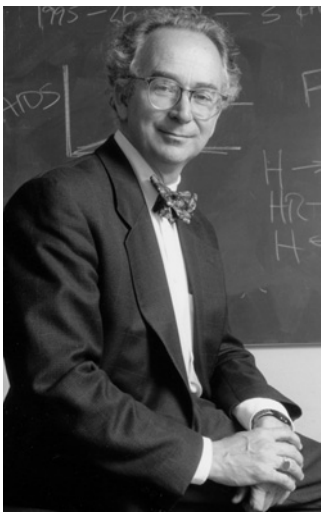
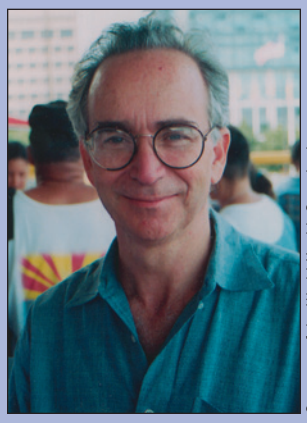


Photo by Kent Dayton, 1995. Courtesy of the Harvard School of Public Health.

Johnathan Mann, MD, MPH



Courtesy of the World Health Organization.

Jonathan Mann

Founder of the Health and Human Rights Movement

JONATHAN MANN COULD BE best characterized by 3 words: vision, audacity, and charisma. Mann would be nearing his 60th birthday had he not—together with his wife, Mary Lou Clements-Mann—been among the victims of a plane crash on September 2, 1998. Born in Boston, Mass, Jonathan graduated from Harvard College, studied at the Institut d'Études Politiques in Paris in 1967 and 1968, and obtained his MD from the Washington University School of Medicine, St Louis, Mo, in 1974. In 1975 he joined the Centers for Disease Control and Prevention as an epidemiological intelligence officer and was assigned to the New Mexico Health and Social Services Department as a state epidemiologist.

By 1977, Mann was New Mexico's state epidemiologist, chief medical officer, and deputy director of the Health Services Department. By 1984, he was managing a staff of more than 400 and had published 58 articles, received 6 significant professional awards, and earned an MPH from the Harvard School of Public Health. Drawn to the challenges of the newly discovered AIDS epidemic, Mann moved his family to Zaire (today the Democratic Republic of the Congo), where a new AIDS research program was about to begin. Mann spent 2 intense years there, helping accumulate some of the initial epidemiological, clinical, and biomedical evidence on HIV and AIDS in an African context. In 1986, the Mann family—Jonathan; his first wife, Marie-Paule; their daughters, Naomi and Lydia; and their son, Aaron—moved to Geneva, where, after several years of hesitation, the World Health Organization (WHO) had embarked on a modest AIDS program.

Mann was assigned a small cubicle in the vast WHO headquarters. Within months, he had spearheaded the development of the first global strategy on HIV/AIDS, mobilized interest across industrialized and developing countries, and obtained promises of funding from potential donors. By January 1987, the Global Program on AIDS had been born. Mann recognized that HIV infection rates were closely connected to inequality, injustice, discrimination, and the failure of public health to recognize the deep roots of vulnerability worldwide. The program's global strategy was unprecedented in international public health in that it specifically incorporated human rights principles. By 1990, the Global Program on AIDS had fostered a number of truly revolutionary policies and engaged nontraditional partners—sex workers, men who had sex with men, and drug users—to work with government officials and WHO staff in the fight against HIV/AIDS. By the end of 1989, 160 countries around the world had HIV/AIDS programs.

Mann spoke with convincing power and had a capacity to transmit empathy that had seldom been seen in public health forums. His eloquence and charisma made it possible for him to convey controversial social, cultural, and political issues in ways that his audience could understand and accept. He became a world leader in public health and a huge media personality. Some WHO leaders, perceiving Mann to be "too big" for the organization, took action to clip his wings. The organization lowered Mann's public profile, imposed administrative constraints on the Global Program on AIDS, and—most important—toned down the human rights

risk-taking. . . . 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 we should change. . . . 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) is 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

facet of WHO's global AIDS strategy, which had generated discomfort among a few influential member states. Mann felt he had no choice but to resign from WHO in March 1990.

Mann then moved to the Harvard School of Public Health as a tenured professor and director of the International AIDS Center of the Harvard AIDS Institute. There, one of his early projects was to present a new vision of the HIV/AIDS pandemic in a book titled *AIDS in the World*,[1] which explained how vulnerability to HIV was intertwined with the lack of realization of human rights. Four years later, he and collaborators showed how the lessons learned from the pandemic allowed a deeper understanding of the relation between health and society.[2]

As the founding director of the Harvard-based Francois-Xavier Bagnoud Center for Health and Human Rights, Mann laid the ground for development of a conceptual framework for health and human rights. Mann and colleagues described this framework in the first issue of the journal he founded, *Health and Human Rights*.[3] He left Harvard in 1998 to become dean of the newly created school of public health at the Allegheny University of Health Sciences, Philadelphia, Pa. However, the school was shut down for financial reasons, and Mann and his second wife, Mary Lou—a renowned scientist in the field of vaccine research—decided to spend some time working in a developing country. They were on their way to discuss this at WHO headquarters when they boarded the ill-fated flight from New York to Geneva. Jonathan Mann projected a vision of modern public health—a vision that continues to inspire new generations of health and human rights practitioners. ■

Daniel Tarantola, MD
Sofia Gruskin, JD, MIA
Theodore M. Brown, PhD
Elizabeth Fee, PhD

About the Authors

Daniel Tarantola is with the School of Public Health and Community Medicine, University of New South Wales, Sydney, Australia. Sofia Gruskin is with the Program on International Health and Human Rights, Harvard School of Public Health, Boston, Mass. Theodore M. Brown is with the Department of History and the Department of Community and Preventive Medicine, University of Rochester, Rochester, NY. Elizabeth Fee is with the History of Medicine Division, National Library of Medicine, Bethesda, Md.

Requests for reprints should be sent to Elizabeth Fee, PhD, History of Medicine Division, National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20974 (e-mail: feee@mail.nih.gov or changb@mail.nih.gov).

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we believe in the ever-present possibility, but not the inevitability, of change for the better. . . .

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. . . . [D]espite 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 whenever 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 toward justice. . . ." This is our modesty, also our boldness, also our aspiration—and together we form a multitude. ■