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Health and Human Rights

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## A b s t r a c t

*Health and human rights are complementary approaches for defining and advancing human well-being. This article presents a three-part provisional framework for exploring potential collaboration in health and human rights. The first relationship involves the impact (positive and negative) of health policies, programs and practices on human rights; the goal is to negotiate an optimal balance between public health goals and human rights norms. The second relationship posits that violations of rights have important health effects, thusfar generally unrecognized, that must be described and assessed. The third and most fundamental relationship proposes that promotion and protection of health are inextricably linked to promotion and protection of human rights and dignity. The interdependence of health and human rights has substantial conceptual and practical implications. Research, teaching, field experience and advocacy are required to explore this intersection. This work can help revitalize the health field, contribute to enriching human rights thinking and practice, and offer new avenues for understanding and advancing human well-being in the modern world.*

*Dos aproximaciones complementares de definir y avanzar el bienestar de la humanidad son la salud y los derechos humanos. El propósito de este artículo, cuya armazón está dividida en tres partes, es de explorar la colaboración potencial entre los campos de la salud y los derechos humanos. La primera relación abarca el impacto (positivo y negativo) de los políticos de la salud y los programas y las prácticas de los derechos humanos. El propósito es el encontrar el equilibrio óptimo entre las metas de la salud pública y las normas de los derechos humanos. La segunda relación propone que las violaciones de los derechos humanos tiene importante consecuencias para la salud que hasta ahora no hay sido reconsiderar y que deben de ser descritas y determinadas. La tercera relación, que es la más fundamental de todas, propone que la promoción y la protección de la salud esta asociada de modo inextricable a la promoción y protección de la dignidad y de los derechos humanos. La dependencia recíproca que existe entre la salud y los derechos humanos tiene importantes implicaciones conceptuales y prácticas. Hoy en día la investigación, la enseñanza, la experiencia práctica y la promoción son requisitos necesario para poder explorar la intersección entre la salud y los derechos humanos. Este trabajo a su vez intenta revitalizar el campo de la salud, contribuir al enriquecimiento de la teoría y la práctica de los derechos humanos, y ofrecer nuevas vías para comprender y avanzar el bienestar de la humanidad en el mundo moderno.*

*Les droits de l'homme et à la santé sont des approches complémentaires pour définir et avancer le bien être de l'homme. Cet article présente un plan provisoire en trois parties pour examiner la collaboration potentielle entre le domaine des droits de l'homme et celui de la santé. Le premier lien a trait à l'impact (positif et négatif) des politiques, programmes, et pratiques de la santé publique sur les droits de l'homme; le but est d'arriver à un équilibre optimal entre les objectifs de la santé publique et les normes des droits de l'homme. Par le deuxième lien, on affirme que les violations des droits ont des effets sur la santé publique, jusqu'à maintenant généralement non reconnus, qui doivent être décrits et évalués. Par le troisième lien, aussi plus fondamental, on propose que la promotion et la protection de la santé publique sont inextricablement liées à la promotion et la protection des droits de l'homme et de la dignité humaine. La dépendance réciproque de la santé publique et des droits de l'homme a des implications théoriques et pratiques. Les recherches, l'enseignement, les expériences de terrains et les plaidoyers sont nécessaires pour explorer cette relation. Ce travail peut ranimer le domaine de la santé publique, enrichir la pensée et la pratique des droits de l'homme, et offrir de nouveaux moyens pour comprendre et améliorer le bien être de l'homme dans le monde moderne.*

Articles

## HEALTH AND HUMAN RIGHTS

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**H**ealth and human rights have rarely been linked in an explicit manner. With few exceptions, notably involving access to health care, discussions about health have rarely included human rights considerations. Similarly, except when obvious damage to health is the primary manifestation of a human rights abuse, such as with torture, health perspectives have been generally absent from human rights discourse.

Explanations for the dearth of communication between the fields of health and human rights include differing philosophical perspectives, vocabularies, professional recruitment and training, societal roles, and methods of work. In addition, modern

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concepts of both health and human rights are complex and steadily evolving. On a practical level, health workers may wonder about the applicability or utility (“added value”), let alone necessity of incorporating human rights perspectives into their work, and vice versa. In addition, despite pioneering work seeking to bridge this gap in bioethics,<sup>1,2</sup> jurisprudence,<sup>3</sup> and public health law,<sup>4,5</sup> a history of conflictual relationships between medicine and law, or between public health officials and civil liberty advocates, may contribute to anxiety and doubt about the potential for mutually beneficial collaboration.

Yet health and human rights are both powerful, modern approaches to defining and advancing human well-being. Attention to the intersection of health and human rights may provide practical benefits to those engaged in health or human rights work, may help reorient thinking about major global health challenges, and may contribute to broadening human rights thinking and practice. However, meaningful dialogue about interactions between health and human rights requires a common ground. To this end, following a brief overview of selected features of modern health and human rights, this article proposes a provisional, mutually accessible framework for structuring discussions about research, promoting cross-disciplinary education, and exploring the potential for health and human rights collaboration.

### **Modern Concepts of Health**

Modern concepts of health derive from two related although quite different disciplines: medicine and public health. While medicine generally focuses on the health of an individual, public health emphasizes the health of populations. To oversimplify, individual health has been the concern of medical and other health care services, generally in the context of physical (and, to a lesser extent, mental) illness and disability. In contrast, public health has been defined as, “...(ensuring) the conditions in which people can be healthy.”<sup>6</sup> Thus, public health has a distinct health-promoting goal and emphasizes prevention of disease, disability and premature death.

Therefore, from a public health perspective, while the availability of medical and other health care constitutes one of the essential conditions for health, it is not synonymous with “health.” Only a small fraction of the variance of health status

among populations can reasonably be attributed to health care; health care is necessary but clearly not sufficient for health.<sup>7</sup>

The most widely used modern definition of health was developed by the World Health Organization (WHO): "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."<sup>8</sup> Through this definition, WHO has helped to move health thinking beyond a limited, biomedical and pathology-based perspective to the more positive domain of "well-being." Also, by explicitly including the mental and social dimensions of well-being, WHO radically expanded the scope of health, and by extension, the roles and responsibilities of health professionals and their relationship to the larger society.

The WHO definition also highlights the importance of health promotion, defined as "the process of enabling people to increase control over, and to improve, their health." To do so, "an individual or group must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment."<sup>9</sup> The societal dimensions of this effort were emphasized in the Declaration of Alma-Ata (1978), which described health as a "...social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."<sup>10</sup>

Thus, the modern concept of health includes yet goes beyond health care to embrace the broader societal dimensions and context of individual and population well-being. Perhaps the most far-reaching statement about the expanded scope of health is contained in the preamble to the WHO Constitution, which declared that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being."<sup>11</sup>

### **Modern Human Rights**

The modern idea of human rights is similarly vibrant, hopeful, ambitious and complex. While there is a long history to human rights thinking, agreement was reached that all people are "born free and equal in dignity and rights"<sup>12</sup> when the promotion of human rights was identified as a principal purpose of the United Nations in 1945.<sup>13</sup> Then, in 1948, the Universal Declaration of Human Rights was adopted as a universal or common standard of achievement for all peoples and all nations.

The preamble to the Universal Declaration proposes that human rights and dignity are self-evident, the “highest aspiration of the common people,” and “the foundation of freedom, justice and peace.” “Social progress and better standards of life in larger freedom,” including the prevention of “barbarous acts which have outraged the conscience of mankind,” and, broadly speaking, individual and collective well-being, are considered to depend upon the “promotion of universal respect for and observance of human rights.”

Several fundamental characteristics of modern human rights include: they are rights of individuals; these rights inhere in individuals because they are human; they apply to all people around the world; and they principally involve the relationship between the state and the individual. The specific rights which form the corpus of human rights law are listed in several key documents: foremost is the Universal Declaration of Human Rights (UDHR), which, along with the United Nations Charter (UN Charter), the International Covenant on Civil and Political Rights (ICCPR)—and its Optional Protocols—and the International Covenant on Economic, Social and Cultural Rights (ICESCR), constitute what is often called the “International Bill of Human Rights.” The UDHR was drawn up to give more specific definition to the rights and freedoms referred to in the UN Charter. The ICCPR and the ICESCR further elaborate the content set out in the UDHR, as well as setting out the conditions in which states can permissibly restrict rights.

Although the UDHR is not a legally binding document, nations (states) have endowed it with great legitimacy through their actions, including its legal and political invocation at the national and international level. For example, portions of the UDHR are cited in numerous national constitutions, and governments often refer to the UDHR when accusing other governments of violating human rights. The Covenants are legally binding, but only on the states which have become parties to them. Parties to the Covenants accept certain procedures and responsibilities, including periodic submission of reports on their compliance with the substantive provisions of the texts.

Building upon this central core of documents, a large number of additional declarations and conventions have been adopted at the international and regional levels, focusing upon either specific populations (such as the International Convention on the

Elimination of All Forms of Racial Discrimination, entry into force in 1969; the Convention on the Elimination of All Forms of Discrimination Against Women, 1981; the Convention on the Rights of the Child, 1989) or issues (such as the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, entry into force in 1987; the Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief, 1981).

Since 1948, the promotion and protection of human rights have received increased attention from communities and nations around the world. While there are few legal sanctions to compel states to meet their human rights obligations, states are increasingly monitored for their compliance with human rights norms by other states, nongovernmental organizations, the media and private individuals. The growing legitimacy of the human rights framework lies in the increasing application of human rights standards by a steadily widening range of actors in the world community. The awarding of the Nobel Peace Prize for human rights work to Amnesty International and to Ms. Rigoberta Menchu symbolizes this extraordinary level of contemporary interest and concern with human rights.

Since the late 1940s, human rights advocacy and related challenges have gradually extended the boundaries of the human rights movement in four related ways. First, the initial advocacy focus on civil and political rights and certain economic and social rights is expanding to include concerns about the environment and global socioeconomic development. For example, although the right to a "social and international order in which (human rights) can be fully realized" (UDHR, Article 28) invokes broad political issues at the global level, attention to this core concept as a right has only grown in recent years.

Second, while the grounding of human rights thinking and practice in law (at national and international levels) remains fundamental, wider social involvement and participation in human rights struggles is increasingly broadening the language and uses of human rights concepts.

Third, while human rights law primarily focuses on the relationship between individuals and states, awareness is increasing that other societal institutions and systems, such as transnational business, may strongly influence the capacity for realization of rights, yet they may elude state control. For ex-

ample, exploitation of natural resources by business interests may seriously harm rights of local residents, yet the governmental capacity to protect human rights may be extremely limited, or at best indirect, through regulation of business practices and laws which offer the opportunity for redress. In addition, certain individual acts, such as rape, have not been a traditional concern of human rights law, except when resulting from systematic state policy (as alleged in Bosnia). However, it is increasingly evident that state policies impacting on the status and role of women may contribute importantly, even if indirectly, to a societal context which increases women's vulnerability to rape, even though the actual act may be individual, not state-sponsored.

Finally, the twin challenges of human rights promotion (hopefully preventing rights violations; analogous to health promotion to prevent disease) and protection (emphasizing accountability and redress for violations; analogous to medical care once disease has occurred) have often been approached separately. Initially, the United Nations system highlighted promotion of rights, and the nongovernmental human rights movement tended to stress protection of rights, often in response to horrific and systematic rights violations. More recently, both intergovernmental and nongovernmental agencies have recognized and responded to the fundamental interdependence of rights promotion and protection.

In summary, despite tremendous controversy, especially regarding the philosophical and cultural context of human rights as currently defined, a vocabulary and set of human rights norms is increasingly becoming part of community, national and global life.

### **A Provisional Framework: Linkages Between Health and Human Rights**

The goal of linking health and human rights is to contribute to advancing human well-being beyond what could be achieved through an isolated health- or human rights-based approach. This article proposes a three-part framework for considering linkages between health and human rights; all are interconnected, and each has substantial practical consequences. The first two are already well documented, although requiring further elaboration, while the third represents a central hypothesis calling for substantial additional analysis and exploration.



First, the impact (positive and negative) of health policies, programs and practices on human rights will be considered. This linkage will be illustrated by focusing on the use of state power in the context of public health.

The second relationship is based on the understanding that human rights violations have health impacts. It is proposed that all rights violations, particularly when severe, widespread and sustained, engender important health effects, which must be recognized and assessed. This process engages health expertise and methodologies in helping to understand how well-being is affected by violations of human rights.

The third part of this framework is based on an overarching proposition: that promotion and protection of human rights and promotion and protection of health are fundamentally linked. Even more than the first two proposed relationships, this intrinsic linkage has strategic implications and potentially dramatic practical consequences for work in each domain.

#### **The First Relationship: The Impact of Health Policies, Programs and Practices on Human Rights**

Around the world, health care is provided through many diverse public and private mechanisms. However, the responsibilities of public health are carried out in large measure through policies and programs promulgated, implemented and enforced by, or with support from, the state. Therefore, this first linkage may be best explored by considering the impact of public health policies, programs and practices on human rights.

The three central functions of public health include: assessing health needs and problems; developing policies designed to address priority health issues; and assuring programs to implement strategic health goals.<sup>14</sup> Potential benefits to and burdens on human rights may occur in the pursuit of each of these major areas of public health responsibility.

For example, assessment involves collection of data on important health problems in a population. However, data are not collected on all possible health problems, nor does the selection of which issues to assess occur in a societal vacuum. Thus, a state's failure to recognize or acknowledge health problems that preferentially affect a marginalized or stigmatized group may violate the right to non-discrimination by leading to neglect of necessary services, and in so doing, may adversely affect the realiza-

tion of other rights, including the right to “security in the event of...sickness (or) disability...” (UDHR, Article 25), or to the “special care and assistance” to which mothers and children are entitled (UDHR, Article 25).

Once decisions about which problems to assess have been made, the methodology of data collection may create additional human rights burdens. Collecting information from individuals, such as whether they are infected with the human immunodeficiency virus (HIV), have breast cancer, or are genetically predisposed to heart disease, can clearly burden rights to security of person (associated with the concept of informed consent) and of arbitrary interference with privacy. In addition, the right of non-discrimination may be threatened even by an apparently simple information-gathering exercise. For example, a health survey conducted via telephone, by excluding households without telephones (usually associated with lower socioeconomic status), may result in a biased assessment, which may in turn lead to policies or programs that fail to recognize or meet needs of the entire population. Also, personal health status or health behavior information (such as sexual orientation, or history of drug use) has the potential for misuse by the state, whether directly or if it is made available to others, resulting in grievous harm to individuals and violations of many rights. Thus, misuse of information about HIV infection status has led to: restrictions of the right to work and to education; violations of the right to marry and found a family; attacks upon honor and reputation; limitations of freedom of movement; arbitrary detention or exile, and even cruel, inhuman or degrading treatment.

The second major task of public health is to develop policies to prevent and control priority health problems. Important burdens on human rights may arise in the policy-development process. For example, if a government refuses to disclose the scientific basis of health policy or permit debate on its merits, or in other ways refuses to inform and involve the public in policy development, the rights to “seek, receive and impart information and ideas...regardless of frontiers” (UDHR, Article 19) and “to take part in the government...directly or through freely chosen representatives” (UDHR, Article 21) may be violated. Then, prioritization of health issues may result in discrimination against individuals, as when the major health problems of a population defined on the basis of sex, race, religion or language are system-

atically given lower priority (e.g., sickle cell disease in the United States, which affects primarily the African-American population; or more globally, maternal mortality, breast cancer and other health problems of women).

The third core function of public health, to assure services capable of realizing policy goals, is also closely linked with the right to non-discrimination. When health and social services do not take logistic, financial, and socio-cultural barriers to their access and enjoyment into account, intentional or unintentional discrimination may readily occur. For example, in clinics for maternal and child health, details such as hours of service, accessibility via public transportation and availability of daycare may strongly and adversely influence service utilization.<sup>15</sup>

It is essential to recognize that in seeking to fulfill each of its core functions and responsibilities, public health may burden human rights. In the past, when restrictions on human rights were recognized, they were often simply justified as necessary to protect public health. Indeed, public health has a long tradition, anchored in the history of infectious disease control, of limiting the "rights of the few" for the "good of the many." Thus, coercive measures such as mandatory testing and treatment, quarantine, and isolation are considered basic measures of traditional communicable disease control.<sup>16</sup>

The principle that certain rights must be restricted in order to protect the community is explicitly recognized in the International Bill of Human Rights: limitations are considered permissible to "(secure) due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society." (UDHR, Article 29). However, the permissible restriction of rights is bound in several ways. First, certain rights (e.g., right to life, right to be free from torture) are considered inviolable under any circumstances. Restriction of other rights must be: in the interest of a legitimate objective; determined by law; imposed in the least intrusive means possible; not imposed arbitrarily; and strictly necessary in a "democratic society" to achieve its purposes.

Unfortunately, public health decisions to restrict human rights have frequently been made in an uncritical, unsystematic and unscientific manner. Therefore, the prevailing assumption that public health, as articulated through specific policies and

programs, is an unalloyed public good that does not require consideration of human rights norms must be challenged. For the present, it may be useful to adopt the maxim that health policies and programs should be considered discriminatory and burdensome on human rights until proven otherwise.

Yet this approach raises three related and vital questions. First, why should public health officials be concerned about burdening human rights? Second, to what extent is respect for human rights and dignity compatible with, or complementary to public health goals? Finally, how can an optimal balance between public health goals and human rights norms be negotiated?

Justifying public health concern for human rights norms could be based on the primary value of promoting societal respect for human rights as well as on arguments of public health effectiveness. At least to the extent that public health goals are not seriously compromised by respect for human rights norms, public health, as a state function, is obligated to respect human rights and dignity.

The major argument for linking human rights and health promotion is described below. However, it is also important to recognize that contemporary thinking about optimal strategies for disease control has evolved; efforts to confront the most serious global health threats, including cancer, cardiovascular disease and other chronic diseases, injuries, reproductive health, infectious diseases, and individual and collective violence, increasingly emphasize the role of personal behavior within a broad social context. Thus, the traditional public health paradigm and strategies developed for diseases such as smallpox, often involving coercive approaches and activities which may have burdened human rights, are now understood to be less relevant today. For example, WHO's strategy for preventing spread of the human immunodeficiency virus (HIV) excludes classic practices such as isolation and quarantine (except under truly remarkable circumstances) and explicitly calls for supporting and preventing discrimination against HIV-infected people.

The idea that human rights and public health must inevitably conflict is increasingly tempered with awareness of their complementarity. Health policy-makers' and practitioners' lack of familiarity with modern human rights concepts and core documents complicates efforts to negotiate, in specific situations and

different cultural contexts, the optimal balance between public health objectives and human rights norms. Similarly, human rights workers may choose not to confront health policies or programs, either to avoid seeming to under-value community health or due to uncertainty about how and on what grounds to challenge public health officials. Recently, in the context of HIV/AIDS, new approaches have been developed, seeking to maximize realization of public health goals while simultaneously protecting and promoting human rights.<sup>17</sup> Yet HIV/AIDS is not unique; efforts to harmonize health and human rights goals are clearly possible in other areas. At present, an effort to identify human rights burdens created by public health policies, programs and practices, followed by negotiation towards an optimal balance whenever public health and human rights goals appear to conflict, is a necessary minimum. An approach to realizing health objectives that simultaneously promotes—or at least respects—rights and dignity is clearly desirable.

### **The Second Relationship: Health Impacts Resulting from Violations of Human Rights**

Health impacts are obvious and inherent in the popular understanding of certain severe human rights violations, such as torture, imprisonment under inhumane conditions, summary execution, and “disappearances.” For this reason, health experts concerned about human rights have increasingly made their expertise available to help document such abuses.<sup>18</sup> Examples of this type of medical-human rights collaboration include: exhumation of mass graves to examine allegations of executions;<sup>18</sup> examination of torture victims;<sup>20</sup> and entry of health personnel into prisons to assess health status.<sup>21</sup>

However, health impacts of rights violations go beyond these issues in at least two ways. First, the duration and extent of health impacts resulting from severe abuses of rights and dignity remain generally under-appreciated. Torture, imprisonment under inhumane conditions, or trauma associated with witnessing summary executions, torture, rape or mistreatment of others have been shown to lead to severe, probably life-long effects on physical, mental and social well-being.<sup>22</sup> In addition, a more complete understanding of the negative health effects of torture must also include its broad influence on mental and social well-being; torture is often used as a political tool to discourage people

from meaningful participation in or resistance to government.<sup>23</sup>

Second, and beyond these serious problems, it is increasingly evident that violations of many more, if not all, human rights have negative effects on health. For example, the right to information may be violated when cigarettes are marketed without governmental assurance that information regarding the harmful health effects of tobacco smoking will also be available. The health cost of this violation can be quantified through measures of tobacco-related preventable illness, disability and premature death, including excess cancers, cardiovascular and respiratory disease. Other violations of the right to information, with substantial health impacts, include governmental withholding of valid scientific health information about contraception or measures (e.g., condoms) to prevent infection with a fatal virus (HIV).

As another example, the enormous worldwide problem of occupation-related disease, disability and death reflects violations of the right to work under “just and favorable conditions” (UDHR, Article 23). In this context, the World Bank’s identification of increased educational attainment for women as a critical intervention for improving health status in developing countries powerfully expresses the pervasive impact of rights realization (in this case to education, and to non-discrimination on the basis of sex) on population health status.<sup>24</sup>

A related, yet even more complex problem involves the potential health impact associated with violating individual and collective dignity. The Universal Declaration of Human Rights considers dignity, along with rights, to be inherent, inalienable and universal. While important dignity-related health impacts may include such problems as the poor health status of many indigenous peoples, a coherent vocabulary and framework to characterize dignity and different forms of dignity violations are lacking. A taxonomy and an epidemiology of violations of dignity may uncover an enormous field of previously suspected, yet thusfar unnamed and therefore undocumented damage to physical, mental and social well-being.

Assessment of rights violations’ health impacts is in its infancy. Progress will require: a more sophisticated capacity to document and assess rights violations; the application of medical, social science and public health methodologies to identify and assess effects on physical, mental and social well-being; and

research to establish valid associations between rights violations and health impacts.

Identification of health impacts associated with violations of rights and dignity will benefit both health and human rights fields. Using rights violations as an entry point for recognition of health problems may help uncover previously unrecognized burdens on physical, mental or social well-being. From a human rights perspective, documentation of health impacts of rights violations may contribute to increased societal awareness of the importance of human rights promotion and protection.

### **The Third Relationship: Health and Human Rights—Exploring an Inextricable Linkage**

The proposal that promoting and protecting human rights is inextricably linked to the challenge of promoting and protecting health derives in part from recognition that health and human rights are complementary approaches to the central problem of defining and advancing human well-being. This fundamental connection leads beyond the single, albeit broad mention of health in the UDHR (Article 25) and the specific health-related responsibilities of states listed in Article 12 of the ICESCR, including: reducing stillbirth and infant mortality and promoting healthy child development; improving environmental and industrial hygiene; preventing, treating and controlling epidemic, endemic, occupational and other diseases; and assurance of medical care.

Modern concepts of health recognize that underlying “conditions” establish the foundation for realizing physical, mental and social well-being. Given the importance of these conditions, it is remarkable how little priority has been given within health research to their precise identification and understanding of their modes of action, relative importance, and possible interactions.

The most widely accepted analysis focuses on socioeconomic status; the positive relationship between higher socioeconomic status and better health status is well documented.<sup>25</sup> Yet this analysis has at least three important limitations. First, it cannot adequately account for a growing number of discordant observations, such as: the increased longevity of married Canadian men and women compared with their single (widowed, divorced, never married) counterparts;<sup>26</sup> health status differences

between minority and majority populations which persist even when traditional measures of socioeconomic status are considered;<sup>27</sup> or reports of differential marital, economic and educational outcomes among obese, compared with non-obese women.<sup>28</sup>

A second problem lies in the definition of poverty and its relationship to health status. Clearly, poverty may have different health meanings; for example, distinctions between the health-related meaning of absolute poverty and relative poverty have been proposed.<sup>29</sup>

A third, practical difficulty is that the socioeconomic paradigm creates an overwhelming challenge for which health workers are neither trained nor equipped to deal. Therefore, the identification of socioeconomic status as the "essential condition" for good health paradoxically may encourage complacency, apathy and even policy and programmatic paralysis.

However, alternative or supplementary approaches are emerging about the nature of the "essential conditions" for health. For example, the Ottawa Charter for Health Promotion (1986) went beyond poverty to propose that, "the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity."<sup>9</sup>

Experience with the global epidemic of HIV/AIDS suggests a further analytic approach, using a rights analysis.<sup>30</sup> For example, married, monogamous women in East Africa have been documented to be infected with HIV.<sup>31</sup> Although these women know about HIV, and condoms are accessible in the marketplace, their risk factor is their inability to control their husbands' sexual behavior, or to refuse unprotected or unwanted sexual intercourse. Refusal may result in physical harm, or in divorce, the equivalent of social and economic death for the woman. Therefore, women's vulnerability to HIV is now recognized to be integrally connected with discrimination and unequal rights, involving property, marriage, divorce and inheritance. The success of condom promotion for HIV prevention in this population is inherently limited in the absence of legal and societal changes which, by promoting and protecting women's rights, would strengthen their ability to negotiate sexual practice and protect themselves from HIV infection.<sup>32</sup>

More broadly, the evolving HIV/AIDS pandemic has shown a consistent pattern through which discrimination,



marginalization, stigmatization and, more generally, a lack of respect for the human rights and dignity of individuals and groups heightens their vulnerability to becoming exposed to HIV.<sup>33,34</sup> In this regard, HIV/AIDS may be illustrative of a more general phenomenon in which individual and population vulnerability to disease, disability and premature death is linked to the status of respect for human rights and dignity.

Further exploration of the conceptual and practical dimensions of this relationship is required. For example, epidemiologically-identified clusters of preventable disease, excess disability and premature death could be analyzed to discover the specific limitations or violations of human rights and dignity which are involved. Similarly, a broad analysis of the human rights dimensions of major health problems such as cancer, cardiovascular disease and injuries should be developed. The hypothesis that promotion and protection of rights and health are inextricably linked requires much creative exploration and rigorous evaluation.

The concept of an inextricable relationship between health and human rights also has enormous potential practical consequences. For example, health professionals could consider using the International Bill of Human Rights as a coherent guide for assessing health status of individuals or populations; the extent to which human rights are realized may represent a better and more comprehensive index of well-being than traditional health status indicators. Health professionals would also have to consider their responsibility not only to respect human rights in developing policies, programs and practices, but to contribute actively from their position as health workers to improving societal realization of rights. Health workers have long acknowledged the societal roots of health status; the human rights linkage may help health professionals engage in specific and concrete ways with the full range of those working to promote and protect human rights and dignity in each society.

From the perspective of human rights, health experts and expertise may contribute usefully to societal recognition of the benefits and costs associated with realizing, or failing to respect human rights and dignity. This can be accomplished without seeking to justify human rights and dignity on health grounds (or for any pragmatic purposes). Rather, collaboration with health experts can help give voice to the pervasive and serious impact

on health associated with lack of respect for rights and dignity. In addition, the right to health can only be developed and made meaningful through dialogue between health and human rights disciplines. Finally, the importance of health as a pre-condition for the capacity to realize and enjoy human rights and dignity must be appreciated. For example, poor nutritional status of children can contribute subtly yet importantly to limiting realization of the right to education; in general, people who are healthy may be best equipped to participate fully and benefit optimally from the protections and opportunities inherent in the International Bill of Human Rights.

### Conclusion

Thus far, different philosophical and historical roots, disciplinary differences in language and approach, and practical barriers to collaboration impede recognition of important linkages between health and human rights. The mutually enriching combination of research, education and field experience will advance understanding and catalyze further action around human rights and health. Exploration of the intersection of health and human rights may help revitalize the health field as well as contribute to broadening human rights thinking and practice. The health and human rights perspective offers new avenues for understanding and advancing human well-being in the modern world.

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