



COMMENTARY

Reverence for Life and Community Solidarity: An International Perspective

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Albert Schweitzer was a pioneer, a man who discovered, and tried to apply in deed, in his time and in his way, a fundamental truth about human life and solidarity. Pioneers and other leaders may show the way through the drama of their acts or the clarity and beauty of their ideas, but we know that they cannot do it for us. We know that we must also make that journey, to make these truths our own, and to seek our way to live our life in truth.

Dr. Schweitzer is speaking to us across a great historical divide. Although he lived and died not so long ago, we are separated from his time by enormous changes. Our historical age is historically conscious, and we are aware that we are part of history, not outside of it. We know that our hopes, dreams, and search are tightly bound to our societal lives, to

the economic, cultural, and political realities of our time.

We have entered a critical transition in world history that presents us with dangers and opportunities—a global crisis that demands vision, thought, and action, that places us, also, in the unsought-for role of pioneers.

Today, precisely because our world is evolving rapidly, community and health workers have a historic opportunity not only to mirror in their particular and local domain the changes occurring in economic, cultural, and political life but also to urge forward and help guide creative changes in our health and social systems.

Our capacity to participate actively in this task—in shaping the history of our time—will depend on our ability to understand and respond fully to a fundamental reality that is already upon us—the global interdependence of health. Interdependence in many spheres has become a recognized reality, but one that we in health have been quite slow—much slower than our colleagues in business or communications—to acknowledge.

The basis of global health interdependence is straightforward. It comes from the movement of people, goods, and ideas. However, the quantitative increase in volume, scope, and diversity of movement that has occurred during the past quarter century has been so extraordinary that a qualitatively different global reality has been created. The meanings of time and distance have changed. A new

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The concepts in this speech were developed in a seminar, *Globalism in Health*, held at the Harvard School of Public Health in the spring of 1991. Participants included: Oida Dittich, Pete Eerens, Octavio Gomez, Chris Hollis, Michael Kent, Zita Lazzarini, Carsten Mantel, Rob Moodie, Francisco Ramos-Gomez, Josiah Rich, Robert Simon, and Christoph Trautner.

health ecology has emerged, in which the determinants of health status are now much more explicitly and visibly connected with other people and places.

The past quarter century has been characterized by spectacular increases in the worldwide flow of people, goods, and ideas. Since 1950, international tourism has increased nearly 17-fold: in 1990, there were 1.2 billion air passengers, and the travel and tourist "industry" is now the largest in the world, employing over 6 percent of the global work force and involving about \$2 trillion in sales [1,2].

This increase in human movement has been paralleled by the expansion of international commerce, the rapid transfer of capital unconstrained by national boundaries, and the increasingly transnational character of labor market competition.

At the same time, the global movement of ideas and information has increased tremendously. Our planet has acquired an electronic coating. Pictures of Earth from space, unprecedented collection and dissemination of data, and global marketing of entertainment programming and commercial promotions all contribute toward making the world much more of a "global village" than when that term was coined.

Certain health consequences of these transnational flows of people, goods, and ideas are readily identified, such as the spread of infectious agents—whether the human immunodeficiency virus or cholera bacilli—or the problems of toxic waste disposal.

However, for our purposes, to identify the individual, community, and global dimensions of interdependence in health, a more far-reaching analysis is needed.

Four central ideas have deepened our understanding of global health interdependence. First, health itself was redefined by the World Health Organization (WHO) as "a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity" [3]. This definition embraces social, cultural, economic, and political dimensions of individual and societal life. Thus, beyond international transmission of infectious agents, health in any place is now seen to be connected with other places, precisely because socioeconomic, cultural, and political interdependence is already a reality. Just as it is no longer sensible to speak of purely local or national economies, so the new definition of health mandates that local or national health

cannot be considered without reference to global conditions

Illustrations of the general principle that health is tightly bound with economics and politics are plentiful. For example, studies of the tobacco epidemic have clarified the linkages between agricultural and trade policies, creation of markets through glamorization of unhealthy lifestyles, and devastating health impacts of tobacco use. Today, lifestyle diseases can be considered internationally communicable, to the extent that we can identify a deliberate process in which economic and political pressures generate demand for certain products or lifestyle choices.

Human rights is the second concept that has created a fundamental change in our perception of health and interdependence. The modern definition of human rights, as expressed in the Universal Declaration of Human Rights, is a powerful concept, which, by emphasizing the inalienable rights of each person, bridges the individual and the universal and establishes for the first time, in a secular or polyreligious world, a clear and explicit basis for equality, common humanity, and, therefore, a global approach to health problems. Organizations such as Physicians for Human Rights have shown that all human rights abuses have health consequences.

Yet it has been in confronting AIDS, a worldwide epidemic, that the essential relationship between health and human rights has been more clearly recognized. In the context of AIDS prevention and care, we now understand that there are at least four reasons why human rights must be respected. First, because it is right to do so; human rights do not require any practical or pragmatic justification. Second, because it is clear that when discrimination is prevented, programs to prevent HIV transmission are more effective. Third, because we now understand that being socially marginalized increases the risk of becoming HIV infected. And fourth, because communities, like individuals, cannot respond to the challenges of HIV unless they can express the basic right to be involved in decisions that affect them.

Through a human rights perspective, we understand that ensuring that rights are respected is an essential precondition of human dignity. And human dignity, expressing basic respect for the self and others, is increasingly being recognized as a central, even determining element in health. To take just one example: the most pervasive discrimination

in the world is discrimination against women. Until the role and status of women worldwide improves, it will be impossible to control the AIDS epidemic. A recent study of traditional behavior patterns in 11 African societies reported that regardless of whether premarital or extramarital sexual intercourse is or is not part of the tradition, spread of HIV was least likely when sexual standards were the same for women and men [4]. Worldwide, through the prism of AIDS, we can see that male-dominated society is a threat to public health.

The discovery of this inextricable linkage between human rights and health is one of the great advances in the history of health and society. As the major health challenges of the future involve behavior, both individual and collective, this discovery will be critical for the future of community, national, and global health.

Official development assistance is the third concept that has helped shape the emerging view of global interdependence in health. Since the end of the colonial era, official development assistance has been increasingly seen as an obligation of all governments. In the early 1960s, the World Council of Churches promoted a target contribution of 1 percent of gross national product (GNP). This target was subsequently lowered to 0.7 percent by the United Nations in 1970. Few countries have reached this target. In 1990, the donor country average was only 0.35 percent of GNP, and only 0.21 percent for the United States [5].

Only a small proportion (about 5 percent) [6] of official development assistance is assigned directly to health. It is easy to criticize official development assistance for its promotion of donor economic and political agendas, its support of repressive regimes, its cultural and social insensitivity, its corruption, and its heavy reliance on an international corps of expatriate experts. Yet even the checkered, often quite dismal, experience of official development assistance should not detract from the importance of the idea that we have a collective responsibility to contribute to development through sharing of resources.

The fourth concept of major importance for defining global health interdependence is the "right to interfere." As articulated by the French medical humanitarian organizations, Médecins du Monde and Médecins sans Frontières, the "right to interfere" means that a request from those who are suffering

is by itself sufficient to justify relief and support efforts from outside the national boundaries. This principle (expressed in action on behalf of the Kurds and in Bangladesh) describes a new ethic of humanitarian assistance and stands in direct challenge to the status quo standard that permits excessive respect for national sovereignty and abjures interference in so-called "internal" affairs.

In this dynamic world of movement and new ideas, two kinds of international organizations have developed. First, intergovernmental organizations, such as the United Nations, the European Economic Community, and the Organization of African States, have helped to institutionalize international thinking and action, even if, bound to respect the borders of their member states, they remain essentially "international," rather than global institutions.

Second, a remarkable proliferation of secular nongovernmental organizations has occurred since the Second World War. There are now at least 3,000 international nongovernmental organizations, of which about half are involved in health. Major nongovernmental organizations, such as International Physicians for the Prevention of Nuclear War (JPPNW), Amnesty International, Greenpeace, Médecins du Monde, and Médecins sans Frontières, have catalyzed powerful, secular movements. These movements have been created by people whose common motive was expressed by Michel Foucault, who said, "It is essential that we refuse the arbitrary division of tasks that assigns thought and action to governing bodies and indignation to the individual" [7]. We hear the echoing voice of Albert Schweitzer—the decision to make his life his argument—in this refusal to abdicate the realm of action to states and official organizations.

In recent years three issues have achieved truly global stature. These issues, each connected intimately with health and, therefore, with reverence for life, are the prevention of nuclear war, the protection of the global environment, and the response to the global AIDS epidemic. The work carried forward on each of these issues has much to teach us about global thinking, interdependence, and health.

As an illustration, let us consider the HIV/AIDS pandemic. Although starting in the mid-1970s, the pandemic was identified in 1981. By late 1986, AIDS was recognized to be a serious global health problem. WHO then developed a strategy against this disease, its first disease strategy of truly global pro-

portions, which was approved by all nations. The strategy was global both in its international applicability and in its attention to the broad dimensions of health. The reactions, impacts, and responses to AIDS on all social, political, and economic dimensions were identified as integral parts of the problem and, therefore, central to its solution. Explicit opposition to discrimination and explicit protection of human rights and dignity were incorporated into the strategy. Therefore, it was highly symbolic and important that, in October 1987, the U.N. General Assembly discussed the issue of AIDS. For the first time in its history, the U.N. debated how best to respond, as a global community, to a disease.

This epidemic of infectious disease has also taught us about the value of community, for the history of the fight against AIDS has been dominated by unprecedented action, activism, and courage in communities around the world.

Community organizations have been the pioneers, advancing ahead of timid or reluctant governments, reaching people with credible information, providing necessary services, and fighting against discrimination and prejudice. Community organizations have not just raised issues and awakened social conscience. They have stayed to do the hard, long, and daily work of prevention and of care. This work still desperately needs to be done.

For having spoken when others remained silent and for taking action while others waited, the world owes community organizations its gratitude.

Now, unexpectedly, this decade of hard work and struggle is beginning to change the ways we think and act. When AIDS was first discovered, who would have thought that it would lead beyond a virus, laboratories, and hospitals to fundamental health and social issues? Who would have had the audacity, 10 years ago, to think that our individual and community response to a viral epidemic would catalyze a revolution in health based on right, not privilege?

This revolution has occurred because, as individuals and communities facing AIDS, people found the courage to refuse to accept the unacceptable just because it was the norm. When the status quo in health, educational, or social systems was simply not good enough, when specific human needs for information, care, and support encountered unresponsive or uncaring institutions, professionals, or societies, people could have just given up. But they

did not. Instead, they took up the challenge and either developed their own programs for prevention, for care, for protection of human rights and dignity, or pressured those charged with such work to do what should and must be done.

This community-based response has been so critical to the fight against AIDS in every country that the strength, diversity, and extent of community organizations working against AIDS is the single most important measure of the quality and power of a national AIDS program.

In carrying forward this community response to a new health threat, other issues were inevitably raised, other human needs were validated, other aspirations were given voice, and other hopes were kindled.

Community organizations discovered and taught that solidarity is not a luxury, but an indispensable part of thought and action. Solidarity is a fundamental need. Solidarity is not charity. Charity depends on goodwill, episodically expressed as good works; solidarity emerges from a genuine understanding of our interdependence both in the community and in the world. In this country, we need not a kinder, gentler society (this is charity speaking), but a generous, sharing society (this is solidarity). Because respect for human rights and dignity is the only sound foundation for solidarity, promotion of human rights is promotion of solidarity. Programs or nations that discriminate and stigmatize diminish themselves and their capacity to achieve solidarity.

Another major discovery—or rediscovery—from the community is that, to prevent HIV infection, to meet the challenge of information, education, and influencing human behavior, national wealth and sophisticated technology are not the critical determinants. The essential resources are, instead, human innovation, creativity, and wisdom. Every society is facing the same issues of human behavior with similar resources, and no society or culture has a monopoly on them. A decade of experience in AIDS prevention and care has shown clearly that most innovative ideas and programs emerge at the community level and that creativity is greatest when people are facing specific, quite concrete, and immediate problems. Thus, every community is a potential source of vital innovation, and every community can genuinely learn important lessons from others. This is the lesson of global learning and is

an antidote to the outdated notion (pervasive in Schweitzer's time and in our own) that ideas and resources can only be handed "down" from the so-called developed countries to the so-called developing countries. Therefore, global solidarity does not simply reflect compassion for those who suffer and who have less, but recognizes that all peoples and nations have something useful, something precious to contribute toward the solution of a common problem.

This individual and community activism in response to AIDS has shaken the pre-existing balance between community and national roles in health. The primacy of national governments in matters of health has receded before initiatives taken at the community level. We are in the process of taking health back from government control, while at the same time demanding that government perform its necessary functions well. Curiously, in health as in economics and perhaps also in political life, what happens in the community and what happens at the global level seem more relevant to the real concerns of people than what happens at a national level.

Thus, globalism in health explicitly recognizes that, in order both to understand and to act effectively to resolve many health problems in our world, an approach limited to a single nation, a single culture, or a single discipline is simply not good enough. In its place, a transnational, transcultural, and transdisciplinary approach must be developed. At the same time, the explicit recognition of common humanity is a powerful and positive stimulus for active solidarity and a blurring of borders. Yet global thinking must not become monolithic and oppressive; rather, local action must be promoted, and diversity, the ecologically appropriate response to uncertainty and change, must be fostered.

How may these universes of individual, community, and global thought and action connect and act together?

Let us consider two examples: disasters and AIDS vaccine. Presently, we respond to man-made or natural disasters in a spasmodic and intermittent manner. Headlines about the Kurds vanished in the face of news about the cyclone disaster in Bangladesh, which also crowded out urgent appeals about famine in Sudan. The media spoke of "donor fatigue" when sympathetic people in rich countries were confronted simultaneously with profound human suffering in several parts of the world. In the

past, disasters could pass unnoticed; today, with CNN-era immediacy, no major disaster will escape attention.

Is this not an opportunity for a global approach? By taking the planet as the unit of concern, analysis, and action, the current episodic and capricious actions in the face of disaster, which are charity-based, could be replaced with a global system that develops disaster response and prevention strategies and programs.

A second example involves AIDS vaccine. At the 1991 International AIDS Conference in Florence, some predicted that a vaccine would become available before the year 2000. Questions are now arising about how such a vaccine would be distributed. Although science is universal, its practical benefits are not. A global strategy for vaccine production and distribution is urgently required. Unless the status quo of vaccine production were changed, the AIDS vaccine would only be made available to the rich countries or to the rich in any country. A global approach would dictate that, when it became available, the vaccine should first be distributed, as were the limited first stocks of Salk polio vaccine, on the basis of epidemiological criteria—the greatest good for the greatest number. This approach would contribute most to control of the pandemic and would express in action the basic principle, so evident to Albert Schweitzer, that a life in Zambia, a life in Brazil, and a life in the United States are all equal and of equal value.

The transience and fundamental irrelevance of national borders is becoming increasingly evident, while the boundaries between the self and the other are also being redrawn. The Talmud teaches that each life is as an entire world. Across a great divide of history, the voice of Albert Schweitzer reaches us today, linking the most highly personal with the universal through an ethic of reverence for life.

In this time of transition and crisis, the connections between individuals, their communities, and the peoples of the world are being newly forged. IPPNW has shown how powerful the joined skill and purpose of health workers worldwide can be. A new humanitarianism without borders—globalism in health—will also require innovation, in order to develop new bridges, to help people to connect, to express this basic need—their thirst, their hunger for human solidarity. To link individuals and communities around the world, we may need a new

international movement, a grand alliance of peoples, a global Charter 77 of health.

Committed to health, and believing that global interdependence is the special, critical insight of our time, we must go beyond reacting to threats to health and play our full role in shaping the emerging global view. We must ensure that this global view does not become a new vehicle for domination or oppression, that it instead promotes diversity, supports local action, and fosters solidarity. Through the splendid gateway opened by our specific expertise, with our science and our humanism, we must boldly define, promote, and defend the vital, inescapable interdependence that links health and human rights, health and solidarity, health and peace.

This historic task, this local and global responsibility, cannot be left to others. We must take from Schweitzer his most important and timeless message: to make our lives, as he did his, our argument for human rights, health, solidarity, and peace. For

as the proverb declares, "when the leaders lack vision, the people suffer"—and we have suffered; but it continues on to say, "yet there is hope and strength in the councils of the people"—and we are the people. ■

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