Editorial

Human Rights, Reproductive Health and Economic Justice: Why they are Indivisible

Rosalind P Petchesky

'THE public hospital system in South Africa is so short of cash that it lacks enough workers, medical equipment, ambulances, linens and medicine to provide proper care to the poor, a government commission has found... Outdated medicine routinely appears in wards. And at two hospitals, several patients died because the equipment they needed was broken or unavailable.'[1]

'Due to the nonavailability or poor quality of medication [including contraceptives], patients utilizing services at mostly all PHCs [primary health centres] surveyed in both Gujarat and Rajasthan [India] were required to purchase drugs from the market. Disposable syringes were also purchased by patients as these were usually not available.'[2]

'A study [in Dhaka, Bangladesh] looked at people's ability to pay for [maternity] services to determine whether cost is a factor contributing to low utilisation. The mean cost of a normal delivery was 25 per cent of average monthly household income; the cost of a caesarean section was 95 per cent... 51 per cent of the families did not have enough money to pay for maternity care. Among these families, 79 per cent had to borrow from a relative or money lender. A quarter of families were spending two to eight times their monthly income for maternity care.'[3]

BOTH the Cairo and the Beijing conference documents affirmed that reproductive and sexual health are part of fundamental human rights. Those documents base reproductive and sexual health in the personal rights of bodily integrity and security of the person as well as the social right to the highest attainable standard of health care, and the information and means to access it.[4,5] Yet as globalisation and market forces trample older notions of social ethics in most countries, it is becoming all too evident that reproductive and sexual rights for women will remain unachievable if they are not connected to a strong campaign for economic justice and an end to poverty. That is the crucial link in the syllogism that is still weakest in international documents and policies and national efforts to implement them.

It is no longer necessary to plead the case in United Nations forums that basic human needs such as health, education, environmental protection, social development and gender equality must be placed within a 'human rights framework'. More than a decade of NGO advocacy and grassroots activism has given this framework greater legitimacy in UN debates, so that today 'human rights' covers a much broader swathe of issues than egregious state crimes (e.g. torture of prisoners and genocide), to which it was typically limited in the past. Furthermore, 'gender' and 'gender equality' – concepts that only a few years ago were highly disputed by many government delegates and the Holy See as linguistically and culturally 'alien' – seem likewise to have gained a grudging international acceptance, at least at the rhetorical level. This too is the result of relentless, determined effort by feminist NGOs, especially from the global South.

Nonetheless, a stubborn kind of fragmentation seems to persist, not only among international organisations and national policy-makers, but also among women's movement groups. It is a fragmentation born of professionalisation, donor-driven agendas, and a number of other forces. One result is a compartmentalisation of women's movement work into discrete 'issues' - violence, reproductive rights, sexuality, girls and adolescents, women in development (economics, work) – without sufficient attention to the vital points where these intersect. Such compartmentalisation obliterates the most important operational principle of a human rights framework – the principle of *indivisibility*.[6]

In technical terms, the indivisibility principle refers to the necessary integration among the different 'generations' of human rights, that is,

among civil and political, economic, social and cultural and so-called solidarity rights (such as sustainable human development and environmental safety). More practically speaking, it has to do with the real-life fact that a woman cannot avail herself of her right 'to decide freely and responsibly the number, spacing and timing of her children' (ICPD Programme of Action, 7.3) if she lacks the financial resources to pay for reproductive health services or the transport to reach them; if she cannot read package inserts or clinic wall posters; if her workplace is contaminated with pesticides or pollutants that have an adverse effect on pregnancy; or if she is harassed by a husband or in-laws who will scorn her or beat her up if she uses birth control.

An integrative approach to human rights and health

The view that 'health is a cross-sectoral issue' and can only be addressed effectively through a broad gender and development lens goes back at least 22 years.[7,8] In 1978 the International Conference on Primary Health Care adopted the WHO Charter's definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of infirmity' and as 'a fundamental human right.' The Alma Ata Declaration not only emphasised 'health for all people of the world' but also asserted that primary health care:

'Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs....

'Involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors.'

Feminist advocates have written about the theoretical importance of the indivisibility principle as it relates to reproductive and sexual rights and of the various economic and social enabling conditions that must be realised for those rights to become effective.[9-11] The practical, daily reality of this principle came home to me sharply, however, during a recent trip to South India. Health indicators are widely thought to be relatively high on the scale in Kerala, Andhra Pradesh and Tamil Nadu compared with other developing countries and other Indian states. But the ways in which poverty creates barriers to reproductive and sexual rights remain daunting, even in these 'healthier' states.

An example is in Kerala, where Vanita Nayak Mukherjee has conducted qualitative research among women in fishing communities on the possible links between reproductive tract infections (RTIs) and menstrual and toilet practices. Her findings tell a grim story in which the combination of lack of sanitary and toilet facilities and culturally-embedded gender discrimination seem to exacerbate reproductive, urinary and gastric morbidity among poor women. Poverty and the absence of toilets affect both sexes. But women alone are condemned by the norms of modesty and shame to suffer bladder retention and postponed defecation until they can sneak outdoors in the dark of night; whereas men apparently feel free any time of day to defecate on the beach and urinate by the roadside. In addition, because of the lack of sanitary pads and private places to use them during menstruation, women feel compelled to go about their lives with unhygienic layers of soiled garments underneath their skirts.[12] What could be more graphic evidence that access to clean water and sanitation – commonly associated with 'economic infrastructure' – is essential, not only for health in general, but also for reproductive health and gender equality?

In Andhra Pradesh, for *dalit* women (women in 'scheduled castes'), issues of health and reproductive and sexual rights form a seamless web with land issues, indebtedness and caste discrimination. One of the biggest concerns for activists is to organise and politicise dispossessed agricultural labourers, many of whom have lost the small plots allocated to them through land reform measures because of debt. But debt itself is inextricable from the unjust economics of the health care system. As a recent survey confirms, 'the second most common cause of rural indebtedness' in India is 'the increased cost of medical care' due to cost

recovery and privatisation trends in the health sector.[13] The new 'target free approach' (TFA), instituted by India's family planning programme to implement Cairo's provisions on reproductive rights, which has had limited effects at best on quality and access to services for poor women in most states, has not really touched the more endemic violations of health and reproductive rights that *dalits* face as a result of poverty and discrimination.[14] These include no water or sanitation in rural villages, persistently high infant and maternal mortality, and a growing incidence of not only RTIs but now HIV, as more and more *dalit* women have become migrant workers and been recruited into the international sex trade.[15]

What's trade got to do with it?

As HIV/AIDS proliferates in South Asia, India is likely to be confronted with the same dilemma that has plagued sub-Saharan African countries, i.e. the lack of access to life-prolonging drugs (including antiretroviral therapy) because of their exorbitant cost on the world market and the corporate bias of the TRIPS (Trade Related Intellectual Property Rights) Agreement. The TRIPS Agreement was enacted by the World Trade Organization (WTO) in order to safeguard the intellectual property claims and exclusive patents of transnational corporations, thus preventing their products from being 'developed, sold or priced by anyone else, anywhere in the world'.[16] While the intricacies of global trade may seem remote from reproductive and sexual rights, in fact they stand precisely at the nexus where health, human rights and macro-economics meet. Not only do WTO actions enforcing TRIPS have the power to override national laws and international conventions on health (for example, prohibitions of trade in hazardous wastes and other environmental toxins). They also make it difficult, if not impossible, for poor countries to manufacture their own generic brands of patented drugs or to purchase such drugs from cheaper, non-patent-holding suppliers, without facing trade sanctions or other punitive actions.[17]

An integrative, human rights-based approach to health would recognise that:

'... intellectual property rights under the TRIPS agreements must not take precedence over the fundamental human right to the highest attainable standard of health care nor the ethical responsibility to provide life-saving medications at affordable cost to developing countries and people living in poverty'.[18]

This implies that the human right of people in all countries to have access to life-saving and life-prolonging drugs must take precedence over transnational corporate profits or the presumed right on the part of industry (implicit in intellectual property rights as currently defined) to establish prices based on what the wealthiest markets will bear.

The recent announcement by the World Bank, that it would commit large amounts of money to fighting HIV/AIDS, especially in sub-Saharan Africa, acknowledges a moral obligation on the part of the global economic system to make health care more widely accessible.[19,20] But it falls short of a human rights-based commitment insofar as it continues to take for granted the absolute control by private companies over prices, even of vital drugs. And it maintains intact the underlying structure of loans and private markets that sinks poor countries at the macro level – and poor women and their families at the micro level – further into debt. In other words, humanitarian gestures like those of the World Bank and other donors (whether Northern governments or private philanthropic foundations) will help to alleviate crises, but do not challenge the fact that health is treated as a commodity rather than as a basic human right.

Viewing the intersections of health, trade and human rights also raises questions about the devastating health impact on innocent civilians, especially women and children, of economic sanctions against so-called rogue states. The unilaterally imposed US embargo of Cuba, for example – extended in 1996 through the Helms-Burton Act to foreign companies that seek to trade with Cuba – has contributed to increases in maternal malnutrition, low birth-weight babies and premature births. This, in a country whose public health care provision has until recently been among the best, and whose infant and maternal mortality rates among the lowest, in the world. Because of blocked access to imported parts, the embargo has impaired the ability of Cuba's domestic pharmaceutical industry to release millions of contraceptive pills, so that

Cuban women are reliant on donated pills. The embargo's restriction on exports of x-ray film to Cuba has curtailed the availability of mammograms, formerly routine for all Cuban women over 35, to those considered at high risk, with all the implications of increased risk of breast cancer deaths.[21] In other words, the human rights aspects of trade policies are fully gender-specific.

Seeking alternatives: community organising for health and human rights

What can women's health activists do to advance a vision that links the principles of human rights, health rights and economic justice? While efforts to promote this linkage at the level of international conferences and national policies are necessary, such efforts are useless if they are not sustained through community organising to build popular support at the grassroots level. In Tamil Nadu, the Rural Women's Social and Education Centre (RUWSEC) seeks to implement women's and adolescents' reproductive and sexual rights through community organising, self-help and local empowerment. RUWSEC defines reproductive health broadly in terms of community health and women's well-being and operates through a democratic, non-hierarchical structure that employs local villagers (mainly *dalits*) and trains them in computer, administrative and other skills. Its many varied programmes include a clinic – run by community workers, not doctors – that provides a full range of in-patient and out-patient reproductive and primary health services. The clinic functions alongside literacy training; popular health education materials written in Tamil; domestic violence interventions at the village level; and workshops on gender equality and sexuality for *panchayat* (local council) members, women workers in export processing zones and adolescent girls and boys in the villages.[22,23]

RUWSEC's daily work in some 100 villages over more than 20 years contributes to building a popular culture of rights and a sense of entitlement among women and girls as regards their bodies and health and economic opportunities. Local organisers and programme coordinators report that, unlike a decade ago, today the women and girls they work with readily assert:

'Nobody can take control over my body but me, nobody can claim a right over it'.

This translates into gender and generational changes: women no longer wait for men to accompany them to the hospital but go on their own; adolescent girls expect more from life than just marriage and are refusing to marry early or sometimes at all; and children of both sexes are 'thinking more for themselves' and thinking in terms of justice, rights and wrongs. The organisation's coordinator of adolescent programmes says that the most important reason for this change – even more important than the impact of television and the increase of jobs for women outside the village – is that a whole generation of mothers (and fathers) has now gone through RUWSEC's training programme and strongly supports a rights-based vision of gender equality, reproductive/sexual health and economic independence for its daughters.

The Asmita Resource Centre for Women in Secunderabad is another grassroots organisation that is working to embed reproductive health in the larger context of human rights and economic justice. Like RUWSEC, Asmita works mainly among *dalit*, tribal and other marginalised groups. Its networks extend throughout the state of Andhra Pradesh, promoting a holistic programme and popular education across a wide range of sectors: gender violence, economic development and workers' rights, legal and cultural literacy, bridging communal and language divisions, promoting the work of women writers and artists from both Muslim and Hindu communities, and strengthening the access of women and girls to health services, including reproductive and sexual health services. Asmita's 'Self-Help in Health' programme culminated in the publication of *Nâ Shariram Nâdhi* (India's version of *Our Bodies, Ourselves*) and a programme to train rural traditional birth attendants. The group's campaign against sexual harassment in the workplace helped to influence an important judgment and guidelines for employers on sexual harassment issued by the Indian Supreme Court in 1997.[24,25]

Asmita connects the principle of 'my body is mine' to a critique of dominant population and macro-economic policies and a vision of a more equitable distribution of power, resources and information across the sexes, castes, classes and age groups. Its core team systematically invokes the provisions of the Beijing Platform, the Cairo Programme and the Women's Convention (CEDAW) in its work with grassroots urban and rural

women, seeing these documents as sources of legitimacy for ASMITA's empowerment agenda. As the principal NGO responsible for disseminating the Beijing Platform in South India, Asmita has distributed thousands of posters and documents and created a cloth scroll, emphasising the intersection between women's right to livelihoods, literacy, control over their bodies, political participation and health, and the link between all these and debt cancellation, full employment, a minimum wage, equal wages for women, enhanced social sector budgets and land reform.[26,27]

Significantly, the 13th International Day of Action for Women's Health (28 May 2000) is dedicated this year to reviving the Alma Ata vision through a campaign for 'Health for Women, Health for All NOW!' This campaign involves a critique of the gross inequities in resources for health between rich and poor countries as well as among classes and between men and women within countries (including the highly industrialised countries of the North). It questions the renewed emphasis on user fees and cost recovery schemes that seem to have made health care even further out of reach for millions of poor, elderly and marginalised people (especially women and children). It condemns World Bank and other 'health sector reform' economists for abandoning Alma Ata's principle of universal access ('health care for all') in favour of 'targeted approaches' (a euphemism for reduced public sector expenditures).

Above all, this campaign grounds its usual calls for enforcement of women's reproductive rights, gender equity in health care, access to comprehensive services and actions against gender-based violence in a number of critical demands for structural and economic change, including:

- that national budgets reallocate funds away from militarism and toward 'health and other human development priorities';
- that 'rich countries and international financial institutions...substantially reduce the debt burden of poor countries';
- that fair trade should replace protectionist policies as well as the loans and foreign aid that perpetuate dependency; and
- that 'transnational corporations that profit from health' be subjected to international human rights standards to assure that 'profit-maximising practices' such as patent monopolies do not override 'the life-and-death concerns of people'.[28]

The statement for the International Day of Action for Women's Health 2000 recognises that enforcement of these demands will require new mechanisms for international accountability, ones that are far more democratic and responsive to human needs than those currently followed by the international agencies that currently govern global health and development policies.

The 'Health for Women, Health for All NOW' campaign signals a growing attention among transnational women's health movements to the kinds of broad structural transformations that will be necessary to achieve women's reproductive and sexual rights in reality, not just in words. Of course, this is not happening in a vacuum. It is occurring in the context of recent mass protests in Seattle and Washington DC, and outside the USA, against the inequitable impact of globalisation and prevailing trade policies. At the same time, women's groups have brought to these protests an awareness of the links between a gender perspective and a human rights perspective and the relevance of both to international trade. The International Day of Action campaign – and like it, the upcoming World March of Women Against Poverty and Violence, scheduled for 17 October 2000 – signals a moving away from 'issue compartments' towards a more unified vision. It is the vision that groups like Asmita and RUWSEC have been trying, against formidable odds, to implement in their work with grassroots communities. And it suggests the revolutionary potential of a human rights framework that is linked both to economic justice and to gender justice.

References and Notes

1. Swarns R L, 1999. Health care for South Africa's poor imperiled by lack of funds. *New York Times*. 16 November. pA9.
2. Capoor I et al, 1999. Survey of 10 PHCs in Gujarat and Rajasthan. In: Ramachandran V, Visaria L (ed). *The Community Needs-Based Reproductive and Child Health in India: Progress and Constraints*. Health Watch Trust. Jaipur, p49.
3. Poor health and expensive health services in Dhaka, 1999. In: Round-Up, *Reproductive*

Health Matters. 7(14):179-80, summarising Nahar S, Costello A, 1998. The hidden cost of 'free' maternity care in Dhaka, Bangladesh. *Health Policy and Planning*. 13(4):417-22.
4. See United Nations, 1994. Programme of Action Adopted at the International Conference on Population and Development, Cairo, Egypt, paras. 7.2 & 7.3.
5. United Nations, 1995. *Platform for Action*, Fourth World Conference on Women, Beijing, China, paras. 92 & 95.
6. Copelon R, Petchesky, R, 1994. Toward an interdependent approach to reproductive and sexual rights as human rights: reflections on the ICPD and beyond; and Butegwa F, International human rights law and practice: implications for women. In: Schuler M (ed). *From Basic Needs to Basic Rights,* Women in Law and Development International, Washington, DC.
7. See Koivusalo M, Ollila E, 1997. *Making a Healthy World: Agencies, Actors & Policies in International Health*. Zed, London.
8. See also Elson D, Evers B, 1998. Sector programme support: the health sector – a gender-aware analysis. Graduate School of Social Sciences, University of Manchester (Unpublished), p5.
9. Corrêa S, Petchesky RP, 1994. Reproductive and sexual rights: a feminist re-vision. In: Sen G, Germain A, Chen LC, 1994. *Population Policies Reconsidered*. Harvard University, Cambridge.
10. Corrêa S, 1994. *Population and Reproductive Rights*, Zed, London.
11. Petchesky R, Judd K, 1998. *Negotiating Reproductive Rights*. Zed, London.
12. Mukherjee V N, 1999. Gender dimension of basic needs: women's access to menstrual hygiene and RTIs, MacArthur Foundation Fellowship for Population Innovation. (Unpublished)
13. WEDO, 1999. *Risks, Rights and Reforms: A 50-Country Survey Assessing Government Actions Five Years After the International Conference on Population and Development*. WEDO, New York, p11.
14. See Ramachandran V, Visaria L (ed), 1999. The Community Needs-Based Reproductive and Child Health in *India: Progress and Constraints*. Health Watch Trust, Jaipur.
15. Interview with D L Jaya of VEDIKA, Amal Charles of the Society to Train and Educate People's Participation in Development, and R Girija of SHARADA Women's Organisation.
16. Women's Environment & Development Organization, 1999. *Primer: Women & Trade – A Gender Agenda for the World Trade Organization*. WEDO, New York, p10.
17. See Silverstein K, 1999. Millions for Viagra, pennies for diseases of the poor. *Nation*. 19 July: 13-19. The South African government briefly tried to get around such sanctions by allowing the import of less costly drugs or 'compulsory licensing' of local manufacturers to produce their own version of drugs such as AZT. But hostile threats by US-based pharmaceutical companies quickly squelched this rights-minded policy. Global economic inequities make such resistance highly problematic for most developing countries – they would risk the loss of foreign investment and export markets for the sake of their citizens' health.
18. This language was proposed by the NGO Women's Caucus in its efforts to influence government delegations negotiating the World Summit for Social Development + 5 'Further Initiatives' document at the United Nations in April, May and June 2000.
19. This commitment and a more recent suggestion by some transnational pharmaceutical companies that they might lower the price of AIDS drugs for Africa (announced as this journal issue was going to press) came in response to pressure from AIDS activists, the UN Secretary-General, UNAIDS and others. See *New York Times*, 24 April 2000, p10 and 12 May 2000, pA1.
20. See also Wolfensohn JD, 2000. Free from poverty, free from AIDS. Speech at UN Security Council, 10 January. www.worldbank.org
21. American Association for World Health, 1997. Denial of food and medicine: the impact of the US embargo on health and nutrition; and www.madre.org 1999.
22. Subramanian Sokhi S, 1998. *Rural Women Take Reproductive Health Matters into Their Own Hands: Rural Women's Social Education Centre*. International Council on Management of Population Programmes, Selangor, Malaysia.
23. Interviews with TK Sundari Ravindran, RUWSEC's honorary executive director, and its field organisers and staff, March 2000.
24. Sabala & Kranti, 1995. *Nâ Shariram Nâdhi* is Telegu for *My Body Is Mine*. Puni.
25. See also National Alliance of Women (NAWO), 1997. *Supreme Court Judgment on Sexual Harassment at Workplace*. Landmark Judgment Series 1. NAWO, New Delhi.
26. Interview with Kalpana and Vasant Kannabiran, 26-3-2000.
27. Asmita Resource Centre for Women, n.d. *Towards Building a Gender Just Society: Review of Activity 1991-1998*, Hyderabad. pp23-24.
28. *Health for Women, Health for All NOW!* (pamphlet), 2000. Women's Global Network for Reproductive Rights, Amsterdam. Prepared by Likhaan, Philippines.