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WOMEN’S HEALTH IS A HUMAN RIGHT

Maureen McTeer*

It seems fitting that in this International Women’s Week, when we mark women’s achievements in all areas, that we should meet here at the Washington College of Law to speak of women’s health and the legal and other challenges that still face women seeking care. We have a lot for which to thank the two founders of this law school. Ellen Spencer Mussey and Emma Gillett were not planning to make history when they began teaching three female students in their law offices in February, 1896.

They were realists and pragmatists, acutely aware that only they could ensure women had access to a legal education. They knew that if they did not act women would continue to be denied a chance to learn the law and to practice it as did men in their city and country.

Two years later, as their class prepared to enter their third and final year of legal studies, these two women again lead the way when another law school in the city refused to enrol their female students. Undaunted, they founded their own law school, whose letters of incorporation made it clear that this law school would be a place where women could learn the law as equals with men.

Two hundred and eleven years ago, the Washington College of Law made history, as the first of its kind to be founded by and for women, led by a woman Dean and celebrating the first and only all women graduating law class in America.

Thanks to their bold action, women in the U.S. and beyond enjoy the right to legal education and now form the majority of most graduating classes in law in North America.

In my country, four of the nine Justices of the Supreme Court of Canada, including the Chief Justice, the Rt. Hon. Beverley McLachlin, are women. It is a legacy of which you must be truly proud as we meet at the WCL today as part of this year’s health law symposium.

As a lawyer, a feminist, and a women’s rights advocate, I am pleased indeed to be here with you today, as part of the Founders Day celebrations, to speak to the topic of women’s health as a human right.

The whole concept of women’s rights and equality with men is a fairly recent phenomenon – beginning in earnest only after the Second World War. Of note, this post War era also marked the beginning of the most active phase of the modern women’s movement.

Since then, a tremendous amount has been achieved for women and there has been a sea-change in how women and girls are treated in most of the developed world.

One area where progress has been slow, however, is that of access to health care by women and girls – especially in the developing world.

Historically, your country and mine have played a leading role internationally to enhance the status of women. Our efforts have been both reactive and proactive; and our goals have been to end discrimination against women generally and to set new standards and definitions that ensure legal equality for women and girls, and guarantee them the power to exercise those rights through access to education and especially to health care and women’s health services.

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Seventy years ago, on Dec. 10, 1948, with Nazi atrocities barely ended, the Universal Declaration of Human Rights⁴ (UDHR) established fundamental human rights for all. It promised respect for the dignity and worth of the human person, and most important for our purposes today, it committed us to the guarantee of equal rights to both women and men.

The thrust of this and subsequent international human rights treaties was to entitle women to precisely the same protection as men. But as time progressed, it became clear that the “sameness principle” (as this treatment came to be called) was insufficient to ensure women would be treated as equals with men.

Fundamentally, the sameness principle ignores women’s biology and reproductive realities; and ignores discrimination against women due to religious and cultural biases throughout the world.

To quote Pierre Sané, the Secretary General of Amnesty International, in 1998, “International human rights law has been guilty of ‘gender-blindness’… For too long it focused on the ‘public’ arena largely populated by men and neglected the so-called ‘private’ sphere of home, family, and community in which women are traditionally enclosed.”⁵

And so the women’s movement in the 1960s and early 1970s began to lobby to move us beyond the sameness principle, urging world leaders to recognize the fact that women live their lives with different and additional responsibilities and demands than men do, and that the clustering of their lives in the private or domestic sphere of society left many vulnerable, indeed powerless, to control their own destiny or participate fully in its realization. Betty Friedan, years before, had spoken of this exclusion and the despair and desperation it engendered in women.

But it took until the 1980s, for the world to act at which time the United Nations took up the rallying cry for change for women and became the major catalyst for change. Its various agencies urged governments around the world to guarantee equity, equality, justice and fairness for women.

Perhaps because of their additional responsibilities as mothers and nurturers, the global UN context for action originally focussed on women’s sexual and reproductive rights.⁶

Between 1975 and 1995, the U.N. sponsored several international women’s conferences, building upon the change begun in affluent countries to revive the women’s movement in the 1960s and 1970s.

In 1975, at the Mexico City conference, The United Nations Convention on the Elimination of All Forms of Discrimination Against Women ⁷ (CEDAW) was passed. This international human rights treaty would seek to improve women’s status by focussing on women’s rights within the historical UN agreements already in place.

Twenty years later, the Cairo conference on Population and Development⁸ called on governments to raise the standards of living and quality of life for women.

For the first time, it was officially recognized that women’s equality, education and health were crucial to development and that indeed without them, international development as a goal would be unattainable.

Governments came to realize that investing in women and girls was essential to their country’s future success and prosperity, and reproductive health was firmly established within the context of human rights, with women’s empowerment now the key to the protection of those rights.

The Cairo commitment paved the way for national governments to tackle long-standing reproductive health problems; and to create a legal and social culture globally that would ensure reproductive health and rights for women and girls.

The Cairo meeting was followed closely by the Beijing conference in 1995. This Fourth World Conference on Women adopted the Beijing Platform for Action⁹ which remains the internationally agreed upon template for advancing women’s status today.

The Platform reconfirmed that women’s human rights included their right to decide on matters concerning their sexuality “including sexual & reproductive health, free of coercion, discrimination & violence…” It further stated that women’s second class status contributed to their ill health in areas of reproduction and sexual health.

By the 1990s, then, women’s reproductive health and the many factors which determine it throughout their life cycle – referred to as the “social determinants of health” were defined and monitored through the lens of human rights.

Yet despite all this effort, women’s health and the systemic changes needed to ensure our full equality with men lagged behind.

In 2000, unhappy with progress towards achieving the goals of these major international women’s conferences, then U.N. Secretary-General, Kofi Annan pushed for the passage of the Millennium Development Goals (MDGs)¹⁰. Ironically, none mentioned sexual and reproductive health as a specific goal.

But at the World Summit in 2005, the UN explicitly reaffirmed that universal access to reproductive health is critical to achieving the MDGs.¹¹

The Millennium Project Report¹² that year called for bold action on women’s health and rights – especially sexual and reproductive rights - insisting that one of the seventeen “Quick Win Solutions” was the expansion of access to sexual and reproductive health information and services worldwide.

This despite the “gag-rule” in place under the previous American Administration, which had such a profound effect on women’s lives in the developing countries of the world. Still, little has changed since 2005.

To quote the 2008 U.N. Millennium Development Goals Report

Maternal mortality remains unacceptably high across much of the developing world. In 2005, more than 500,000 women died during pregnancy, childbirth or in the six weeks after delivery. Ninety-nine per cent of these deaths occurred in the developing regions, with sub-Saharan Africa and Southern Asia accounting for 86 per cent of them. In sub-Saharan Africa, a woman’s risk of dying from treatable or preventable complications of pregnancy and childbirth over the course of her lifetime is 1 in 22, compared to 1 in 7,300 in the developed regions.¹³

So where are we in terms of women’s health and access to care today? Will we meet the MDG targets by 2015? According to the 2008 U.N.’s
Millennium Development Goals Report, greater effort is required. A bit of an understatement given the enormity of the challenge we face.

No one has described more accurately the challenge that lies ahead for all of us than SHA ZUKANG, the U.N. Under-Secretary-General for Economic and Social Affairs, who said:

Ensuring gender equality and empowering women in all respects – desirable objectives in themselves – are required to combat poverty, hunger and disease and to ensure sustainable development. The limited progress in empowering women and achieving gender equality is a pervasive shortcoming that extends beyond the goal itself. Relative neglect of, and de facto bias against, women and girls continues to prevail in most countries. As an indispensable starting point for women’s betterment in later life, all [113] countries that failed to achieve gender parity in primary and secondary enrolment by the target year of 2005 should make a renewed effort to do so as soon as possible. Improved support for women’s self-employment, and rights to land and other assets, are key to countries’ economic development. Above all, however, achieving gender equality requires that women have an equal role with men in decision-making at all levels, from the home to the pinnacles of economic and political power.

And so what can we do to help?

You and I are fortunate women, blessed with both affluence and influence. We live in the Capitals of two of the world’s great countries. We are educated. We are free. We have food. We have medicines. We have health care options second to none.

Most of us share the view that we achieve more by working together than we can ever achieve on our own. This concept of community is at the heart of the women’s health movement. But the stark reality is that our good fortune is not shared by most of the women in the world.

Today, in our world, almost half a million women die each year from the preventable complications of pregnancy and birth. Half a million women, year in and year out whose potential and contributions are lost to the world forever. Almost all of these women live in poor and developing countries, the vast majority in Africa and Asia, where other diseases, especially HIV/AIDS increasingly have a woman’s face.

Responding to such tragic statistics of loss of women’s lives is not simply a question of extending health care. It is more basic. It requires us to reconfirm that women’s health is a human right, not a special interest, and to recognize that women’s health and wellbeing are affected by a wide range of factors – the so-called “social determinants of health”. That is a deliberate health policy choice that our governments must make.

For we know that when women are poor their health suffers. When women eat little and eat last, their health and therefore their families’ suffer. When women die in childbirth, die from easily preventable causes, their babies die too; and then too often, another woman, usually no more than a child herself, takes her mother’s place – and continues the cycle of women trapped in illiteracy and poverty and often abuse, with no real hope of ever breaking free.

We have to help change that reality, break those cycles of poverty, build new hope and opportunity for women. That is the challenge that awaits us – you and me – lucky women who are truly committed to ensuring that women’s health is indeed a human right.

Female Participant:

I previously worked on a study of gender parity systems within Sub-Saharan Africa and found that, regardless of the number of women that were participating in the legislative systems, there was a disproportionately small amount of pro-women’s rights legislation actually passing through. This would suggest that it really is up to the developed world to push for these rights. What is your best suggestion for advancing that cause?

It is a little bit more difficult to do by giving the money to governments who are not pushing through the amount of legislation necessary. Is it necessary to put more money into private organizations and look toward development ventures that will promote women’s health issues, especially now that there’s been a change in the administration?

Maureen Meteer:

My background is politics. My husband was a Foreign Minister, so we had an opportunity to travel the world extensively, including in Africa, and remain very involved in Africa. It is against that backdrop that I answer your question. I am not pretending to be an expert, but offer my personal view, limiting myself to Africa, because that was your focus.

There are several elements to aid and health, and the first is attitudinal. We should try not to always be the ‘expert’ arriving with all the answers. We have to recognize that most of the solutions have to be home-grown in order to really be effective. Indeed, the Non-Governmental Organizations (NGOs) had a tremendous role in convincing governments that this was the way to proceed. We hope to “train the trainers”. It is within our tradition of aid in Canada. Sooner or later the trainers will go home. The women in Africa are very dynamic and involved in their communities. They are its natural leaders and have achieved change against the backdrop of their daily lives and cultures. For instance, there was a tribal law that prevented women from holding land. The world responded with what seemed at the time a very small step, by starting a system of micro-credit. Groups and governments began to provide small loans, usually no more than $100 each, directly to women who had no other access to credit. It became such a wonderful success story and all but .01% of these loans were repaid.

I mentioned previously the need for a solid public system of health care. If you live in a society where you have to pay to deliver your baby in a hospital or clinic with a qualified midwife, nurse, or doctor, then you will likely have to pay for all types of care. Further, pregnant women who are buried in their own village with no money, whose husbands decide whether to pay for a doctor or midwife, have a diminished chance of getting care at delivery. Serious labor troubles require obstetric care, such as a caesarian or some kind of intervention, which a birthing attendant cannot provide. First, the doctor and surgery are going to cost money. Second, there is likely no transportation to the clinic or hospital. Finally, if you die in the clinic, your husband and family must pay to transport you home for burial. For these reasons, women often reason it is better to deliver at home. Most women (53%) give birth without any professional help. These elements have to be
dealt with at the grassroots level. On the other hand, you have to work at the government level to look at the policy issues, as we are doing through White Ribbon Alliance. The two working hand-in-hand are absolutely essential. If we cannot succeed the way we are trying now, so fewer women die each year from preventable causes, then we will try to achieve it some other way.

Female Participant:

I would like to comment about the preventable causes of death in childbirth. One hundred and twenty to 150 years ago, the gender of the child who was born was not recorded, just whether the mother survived. We did not even pay attention to whether the baby survived. The preventable causes of death in childbirth are infection and hemorrhage, which are treatable in the United States and Canada. The number one health intervention is, singularly, and by far the education of women. Educated women educate their children, boys and girls, and it is the sons who will change things. The key issue is providing education to women by financing small community schools. As long as women’s education is prohibited by social, cultural, and religious rules, we are not going to start saving their lives.

Maureen McTeer:

Primary education for women and girls is so important that it is one of the Millennium Development Goals. A tension exists in achieving the eight Millennium Development Goals. The money goes to whichever goal has the largest voice. As an example, in September 2008, hundreds of women went to New York City as part of the White Ribbon Alliance for Safe Motherhood. We had a commitment that MDG #5 would be highlighted by world leaders at the U.N. General Assembly. Yet, despite solid commitments, both the photo ops and the money went to the Bill Clinton Foundation for AIDS. While it is true that that AIDS in Africa has a woman’s face now, the focus was not on women and AIDS, maternal health, or saving women’s lives. We have to be careful not to play one Millennium Development Goal against the other. Without education none of the other goals are going to fall into place.