I I. Conclusion: Reproductive Health and Human Rights in the Real World

It is both a privilege and a challenge to summarize an important discussion of reproductive health, gender and human rights. Those engaged in this dialogue laid before us their knowledge and thoughts for our reflection. I am taken by the range of experience represented and by the continuing commitment—reflected here to grapple with the relationship of human rights and reproductive health as we move beyond Cairo.

We have learned in rich detail how women’s status, rights and empowerment act as determinants or risk factors for women’s health. We have learned how policies, gender relations and other socioeconomic factors can hinder or promote information and access to desperately needed health care. These factors can reduce or increase people’s vulnerability to disease and infection, and promote or retard their efforts towards self-determination and opportunity. At the same time, we have learned how personal health and the means to control reproduction are preconditions to negotiating power, asserting rights and making choices. Our contributors addressed issues of health and rights from the standpoint of both the individual and the public. Where these two perspectives intersect, daunting challenges emerge and the rights framework must then recognize and accommodate ethical complexity and the fact that in many circumstances—from a policy standpoint—there is no single right answer and no one solution that meets the needs of all individuals.

I am struck by the consensus among us. We are all searching for ways to embrace and understand human rights in relation to other sectors as a transforming idea. We have discovered it is possible to find circumstances in which norms have been changed, or old norms overcome, when confronted by both the need and the mandate to improve the lives of women within the context of linking health and rights together.

Asha Mohamud and Elaine Murphy gave an instructive overview of sex and sexuality and how one’s sexuality is often distorted by social environment, cultural, economic and political factors. Although few programs have gone beyond the “plumbing” to address sex and sexuality in the context of gender and human rights, those that have find that such awareness-raising changes people forever.

Allan Rosenfield, in looking at maternal mortality from a gender and human rights perspective, reminded us of the short history of human rights—

1 Formerly AVSC International
I am struck by the consensus among us. We are all searching for ways to embrace and understand human rights in relation to other sectors as a transforming idea.

conceptually—in the world, and of just how recent many of the important universal declarations and treaties setting out these rights really are. He made the point powerfully and from many angles that maternal mortality is undeniably a human rights matter and that the human rights perspective has to move forward. Ensuring the human rights approach may bring progress that has not been heretofore seen in providing access to services for households and communities in developing countries.

Jim Shelton emphasized that tensions arise around the more basic needs of coverage. Lack of resources—physical, human and financial—is not the only problem, but is a real constraint. We are unlikely to ever see equal distribution of wealth and financial resources. Therefore, we must find ways to get the “what” and the “how” correct. The public health community must be concrete, in terms of stating goals and objectives, so that we can focus on how to allocate resources. Using Disability Adjusted Life Years (DALYs) is an attempt to bring this together for the better; however, DALYs do not meet the human rights test.

Regan Ralph explained why a rights perspective is needed in promoting access to and quality of reproductive health care and traced the history of rights activism, highlighting intersections between reproductive health and rights. She provides compelling evidence that without awareness of their human rights, women’s health is at grave risk. With such awareness, women have the tools to begin to fight for their right to health.

Anika Rahman reviewed many of the treaties that specifically define rights in relation to family planning and reproduction. She explained that human rights address both access to services and those treatments and choices afforded individuals by service providers and service sites. She also addressed gaps in the treaties that affect, and often hinder, their effective implementation. On abortion and human rights, Anika reminds us that advances have been made to decriminalize abortion, but that the controversy surrounding this aspect of reproductive health and rights is far from being resolved. Interestingly, it seems that precisely because family planning, and especially abortion, are so controversial in some national, religious or cultural contexts, these reproductive health services have in fact been examined from a rights perspective more than any other.

Geeta Rao Gupta made almost tactile the urgent need to look at health and rights together in the real context of societal complexity. She stressed that individual behavior cannot be viewed as entirely volitional, as in the case of sexual risk-taking. Instead, individual behavior is often the outcome as much as the cause of social, cultural and political determinants—forces generally outside individual control. She urges us to move beyond a traditional public health model. She speaks to women’s powerlessness and poverty and the need to address and change both. Geeta touches on the complex ethical conundrum in relation to HIV drug availability for women in pregnancy, especially in poor Southern countries or as
part of clinical trials, reminding us in this context how much power and economic status affect rights and health. As always, she asks us to look broadly at larger socioeconomic circumstances, such as gender inequality and the distribution of power, factors that have an impact on all aspects of individual health, behavior and rights.

Lori Heise and Mary Ellsberg powerfully portray the relationship between human rights and violence. They note that women constitute 70 percent of the world’s absolute poor and that being poor is a risk factor for domestic violence and abuse. They raise the question of norms of behavior that can permit or even encourage wife-beating as an acceptable act within a particular social context. I was overwhelmed by their data on violence, sexuality and health, as I have never before seen such a comprehensive analysis of the many ways that the denial of women’s basic rights to equality and security of the person can work to condemn them to ill health and a life of restricted choice. As someone who long ago worked in public clinics where as many as 65 percent of the clients had been sexually abused, I have long been familiar with these connections, but I have never seen the whole picture woven together with such force. Lori and Mary concluded by encouraging work at the grass roots where real change must begin. But, there must also be a commitment at national levels…and what of men as a target of change?

Jodi Jacobson illustrated that some government reproductive health services and donors are beginning to integrate rights- and health-based policies as they respond to the mandate to change historically demographic approaches to service delivery. Traditional programs have largely focused on numbers of contraceptive users rather than on quality of care at the client-provider level and have ignored women’s risks of STIs and sexual coercion. Jodi cautions us, however, that policy change may not necessarily mean real change, and that researchers and activists must monitor the situation.

Naisiadet Mason’s personal story reminded us just how desperate is the need for the public health community to address cultural norms and to move beyond efforts to “address risky sexual behavior.” She shared with us her own history, which illustrates that we must embrace multi-sectoral approaches in order to begin to have a meaningful impact on power dynamics, especially those between partners and within families.

In 1971, I was in rural India. Health services were scarce. I watched a woman bleed to death in childbirth in the presence of her husband and children. They wailed with gut-wrenching agony. Have you ever seen a woman die in childbirth? I cannot describe for you a much more horrible event. It is war individualized. In the final moments it is two hearts and two souls exposed in death. It is, in at least three-quarters of the cases, preventable and therefore, simply put, it is one of society’s greatest failures ….When you have been there as a participant in this failure, or as a witness, a part of those souls remain with you for your lifetime.
put, it is one of society’s greatest failures…in one little room somewhere… as the life of one more woman slips away. When you have been there as a participant in this failure, or as a witness, a part of those souls remain with you for your lifetime.

Earlier this year I visited the region of Kaolack, in Senegal. There is a health center where many women come for delivery because they are told that it is safer than delivery at home. Picture this if you can. The building is in decay. The ceiling is falling down. In the room where women deliver, the beds are all rusted with broken springs and bits of yellow mattress, blood stained. There are no window screens. There are flies, lots of flies. There is no sign of running water. In the back of the room there is screaming. A woman is lying on a wooden palette. Her legs are held up by another woman. She is having a D-and-C (dilation and curettage) procedure without anesthesia. In Kaolack, in the area served by this health center, anywhere from 850 to 1,300 women die in childbirth for every 100,000 live births.

As an obstetrician and gynecologist, I relate this picture of reproductive health services because it is the part of the equation with which I am most familiar. What does it really mean to talk about the rights framework in this context? The right to safe services? The right to information, to informed choice? The right to be empowered to minimize the preconditions of life, gender inequity, political, economic and sociocultural inequity that make it impossible to be an individual with rights?

As a physician, I struggle to see beyond the most immediate cause of my distress—the tangible horror of bad health services. What I am looking for is common ground in the search for the policy commitment, services and life circumstances that will support the right of individuals to have and choose services that are the best possible, given the constraints, but without neglecting the one for the many or the many for the one.

For me, the rights framework creates a check and balance for the sometimes overly utilitarian and paternalistic thinking of policymakers and health professionals. This framework helps us screen for what is clearly unacceptable, even if it fails to answer all the hard questions for us. The rights framework gives health professionals and advocates a common language for assailing the unacceptability, for example, of substandard and inhumane maternity wards. It helps us focus on the fact that decent and acceptable services, which prevent maternal death and treat women with dignity, are entitlements because they are fundamental to what it means to be human. But we need the framework to accommodate both policy ideals and real constraints and to bend when the rights and needs of different individuals are at odds. There is no “one size fits all” solution.

I have a reputation for dealing with controversial issues in reproductive health so I would like to conclude by quoting a controversial author. This should serve as food for thought regarding the magnitude and significance of the Cairo Agenda and what we as advocates are striving for: “There is nothing more difficult to carry out nor more doubtful of success nor more dangerous to handle than to initiate a new order of things” (Machiavelli).