ARROWs For Change

Women's and Gender Perspectives in Health Policies and Programmes

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Women's Rights to Health

The most serious obstacles to women's health and their health rights are cultural, religious and social biases against women. These lead to barriers in accessing quality health information, education and services and the inadequate allocation of governmental and donor resources. Lack of medical knowledge, for example, cannot be used to explain why women in developing countries in particular, continue to die unnecessarily from pregnancy and childbirth (estimated 580,000 global deaths annually) and from reproductive cancers for which sufficient scientific knowledge on prevention and treatment exists.

United Nations Population Fund, *Population: Gender Equality and the Girl Child.*

A Rights Approach

The basis of a rights approach is the affirmation that human well-being and health is influenced by the way the person is valued, respected and given the choice to decide on the direction of her/his life without discrimination, coercion or neglect of attention. Human rights express basic values on the way people are entitled to be treated socially and provide an ethical basis for guiding action to redress any imbalance between society's privileged and unempowered members. The fact that these principles are called human rights denotes that the entitlements are equally applicable to all human beings irrespective of their differences due to identities of nationality, ethnicity, religion, sexuality, class, gender and so forth.

In relation to women's health, the basic human rights of women include the rights to life; to liberty and security of the person; to equality before the law; to the highest attainable standard of physical and mental health; to safe conditions of work; to found a family; to privacy and confidentiality; to medical information; to informed consent, choice and decision-making in health care; to reproductive and sexual health; and to the benefits of scientific progress. These health rights have been agreed to by governments in various international covenants, in the Women's Convention and in UN conferences as fundamental to the well-being of people.

Violation of Rights

States which have ratified the human rights covenants, and the Women's Convention, and endorsed the Cairo and Beijing documents, have strong obligations to ensure that women's health rights are not violated. The three broad categories of violation are: 1) Direct action on the part of States which includes for example, coercion in the practice of contraception and abortion ("the right to liberty and security of the person"); 2) States' failure to meet the minimum core obligations of human rights such as neglecting to reduce maternal mortality rates, and meeting other reproductive health needs (HIV/AIDS, STDs, contraceptive services, etc.) through the provision of essential health services ("the right to life and survival"); 3) Discrimination on the part of States in terms of access to health services which result in disadvantage to the health of specific groups such as adolescents, the unmarried, older women, migrants, and indigenous people.

Other important violations include: inaction on eliminating violence against women and female genital mutilation; neglect to include women in properly controlled medical research and clinical trials; inadequate attention to the elimination of harmful or unnecessary medical intervention and medication; inaction on eliminating hazardous work environments; existence of spousal consent for

medical care or procedures for women (such as sterilisation and hysterectomy); non-enforcement of minimum age for marriage; and inattention to female infanticide, prenatal sex selection and son preference. Violations at health service delivery level include: refusing to provide reproductive health services (such as contraception, legal abortion, etc.) requested by clients due to the providers' own morality; lack of client's privacy and confidentiality; inadequate provision of information on medical procedures, medication and options available; and lack of respect for women's choice of medical treatment options.

Obstacles and Action Required

Monitoring Progress: Assessment of the extent to which either State or health service providers are currently fulfilling their obligations in relation to women's rights to health is difficult. One of the main obstacles is the lack of practical and reliable indicators by which progress can be assessed and a data collection and monitoring system which would produce the timely information required.

In the absence of agreed upon indicators of access, standards for quality services and convincing data, critiques by women's health activists and researchers are not taken seriously. Government, health professionals' associations and women NGOs need to continue to work together nationally and internationally to agree on a basic set of indicators to monitor implementation of the Women's Convention and the Cairo and Beijing agreements.

Health Professionals: Health professionals and their respective associations, need to continue to work on incorporating women's rights into the ethics or charters of their health practices, and then on improving their interaction with women clients and women's access to health information and gender-sensitive services, as well as advocacy with the government. Linking up with relevant women NGOs to assist in planning and monitoring/evaluation is an important strategy.

Government Obligations: Human rights are viewed narrowly by governments as primarily political and civil (and therefore seen as threatening) rather than as entitlements towards improving well-being in all aspects of human life—socially, culturally and economically. With a more open mind, Governments need to reassess their viewpoints and acknowledge the benefits of a rights approach to women and to their health status. More dialogue between governments, NGOs, health professionals, and UN agencies on human rights, women's rights and health, has to be initiated, particularly at a regional level, which will help to expand national perspectives. Nationally, governments need to swiftly develop detailed plans to implement the Women's Convention and the Cairo and Beijing recommendations in consultation with women NGOs, health NGOs, and health professionals. Existing plans should be reviewed to assess the extent to which women's rights to health are clearly expressed and operationalised.

Women NGOs: Women NGOs need to have a clear framework on women's rights to health and develop their advocacy and networking strategies with government, health professionals and human rights lawyers and activists. They also need to be in touch with and then communicate grassroots women's experiences of health services and obstacles faced in acquiring their health rights. Together with other health NGOs, they can then spearhead discussion on a national assessment of women's health needs and entitlements, and the extent to which State and health service provider obligations to women are being met within the framework of rights.

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ARROWs **For Change** is published three times a year and is a bulletin primarily for Asian-Pacific decision-makers in health, population, family planning, and women's organisations. It provides: ♦ Women's and gender perspectives on women and health, particularly reproductive health ♦ A spotlight on innovative policy development and field programmes ♦ Monitoring of country activities post-ICPD, Cairo and post-FWCW, Beijing ♦ A gender analysis of health data and concepts ♦ Resources for action.

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IPPF's Charter on Sexual and Reproductive Rights for All

The International Planned Parenthood Federation (IPPF) now has a *Charter on Sexual and Reproductive Rights* which is an integral activity of Vision 2000, IPPF's Strategic Plan. The Charter provides an ethical framework within which IPPF carries out its mission, setting out what the Federation considers sexual and reproductive rights to be, that is, rights and freedoms pertaining to invididuals as well as to couples. It also makes the connection clear between human rights language and service delivery realities in the field of sexual and reproductive health. For example, IPPF's commitment to the Right to Liberty and Security of the Person entails recognition by all of the member FPAs that all persons have the right to be free from forced pregnancy, sterilisation and abortion, and it involves their commitment to take action, in association with other groups, to ensure that this right becomes a reality for the women and men in the countries where they work. The Charter is legal in character as it is based on recognised international human rights law (UN charters, conventions, etc.), which refers to relations between the State and its population and to state obligations to the population.

The Development Process

The first drafts of the Charter were created by a small group consisting of IPPF's Legal Counsel and the Executive Director of the Federation's member association in Denmark, both of whom are lawyers, with programme support from within IPPF's Europe Regional Bureau. The Charter was discussed by IPPF's main policy-making body, the Central Council, in 1995, having been subject to an exhaustive review process into which all member associations had direct input. An inter-regional consultation brought together participants from within IPPF, and international human rights experts Rebecca Cook (Canada) and Mona Zulficar (Egypt), with a view to ensuring different cultural inputs. The Charter was approved by the 1995 Central Council meeting, and was subsequently endorsed by the 1995 Members' Assembly of more than 140 associations. Twelve rights have been identified, all of which appear in international human rights instruments, including the Universal Declaration of Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; and the Convention on the Rights of the Child.

Objectives of the Charter

The Charter has two key objectives:

- To raise awareness of the extent to which sexual and reproductive rights have already been recognised as human rights by the international community in internationally adopted UN and other declarations, conventions and covenants.
- To make clear the connection between human rights language and key programme issues relevant to sexual and reproductive rights—to make the link between, for example, the right to privacy, and the right to confidentiality when seeking sexual and reproductive health care services.

Operationalising the IPPF Charter

Guidelines on how to use the Charter effectively are being drafted. The guidelines will explain how FPAs can advocate and implement reproductive health and rights within each of the twelve rights. Basically, they lay out the practical aspects of the three key issues necessary for people to exercise each right, and for FPAs to monitor: How is the legislation? Is there any, and if so, is it facilitating or at least not prohibitive? Do people get the necessary information, education and communication about reproductive health issues? And do they have the necessary options in order that they can choose?

The IPPF-ESEAO (East, South East Asia and Oceania) Regional Office and Regional Council Members had also held a panel discussion in July 1997 on the Charter in Malaysia, inviting women activists, experts on sexual and reproductive health, academics and others to share their views on specific rights in the Charter and how to apply them. This effort, a first of its kind globally, was aimed to officially introduce the Charter to the region and to raise the awareness of sexual and reproductive health as a human right; to explain the legal aspects of the Charter, how it can be applied by family planning associations (FPAs) and to come up with recommendations on what can be done to further advance sexual and reproductive rights in the ESEAO region. The challenge remains in actualising the Charter.

■ For more information, contact the IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom. Tel: (44-171) 4860741; Fax: (44-171) 4877950; E-mail: <ippfinfo@ippf.attmail.com>; IPPF website: <http://www.oneworld.org/ippf/>. The Charter is available in English, French, Spanish and Arabic. It will also be available in Korean, Chinese, Thai, Malay, and the native languages of Samoa, Tonga and Vanuatu.

Grassroots women have their say...

The **International Reproductive Rights Research Action Group (IRRRAG)** was based on the premise that until more is known about the local context and ways in which women conceptualise reproductive health and sexual matters in their everyday lives, it cannot be postulated that reproductive health rights and needs are universal to women as women have different life experiences.

IRRRAG was born out of a great concern among women activists, health advocates, and academics that population policies and programmes were not considering women's perception of their own health needs. Consequently, women were being disregarded in the greater plan for social and economic empowerment. This in itself constituted a violation of women's human rights. Thus, the movement of "reproductive rights" gained momentum which affirmed the critical importance for women to have control over their reproductive health as well as their reproductive roles.

IRRRAG Research

IRRRAG was established in 1992 as a collaborative international project to explore the meanings of "reproductive rights" for grassroots women in diverse national and cultural settings. The research, co-ordinated by Rosalind Petchesky, involved seven countries, namely, Brazil, Egypt, Malaysia, Mexico, Nigeria, Philippines and the United States.

The study focussed on women's sense of entitlement and strategies in making decisions on reproductive and sexual matters, and how they negotiated real and perceived opposition from parents, husbands, religious authorities and medical health providers. The research focus was also to go beyond contraception, family planning and abortion and to include other reproductive issues, the recognition of women's reproductive rights and to look into commonalties as well as differences in reproductive health needs among countries, cultures, ethnicity, class and religions.

Conceptual Framework

The research was organised around four conceptual matrices: i) concept of entitlement: what are the circumstances and beliefs in which women felt a sense of entitlement in regards to reproduction and sexuality; ii) reproductive decision-making: how do women make decisions throughout their life-cycle regarding childbearing, contraception, abortion, marriage, motherhood and sexuality including sexual identity; iii) resistance and accommodation: what are the kinds of resistance and accommodation women practice and think as possible in relation to self-identity and reproductive decision-making; and iv) social, political, legal and economic conditions: according to women's experience and knowledge what are the social, economic, legal and political conditions and services that affect women's decisions over their reproductive life and rights.

AIMS

- To give voice to women (on their reproductive rights), particularly poor women, whose voices were least likely to be heard in national and international policy making arena.
- To provide information that will advance recognition of reproductive rights as international human rights.

Methodology

IRRRAG's research was a predominantly qualitative ethnographic study. The research findings were supported by quantitative data where relevant to validate and reinforce the findings.

The research method involved in-depth interviews with relatively small numbers of low-income people from diverse backgrounds that represented the local context of each country. Country research teams chose a number of interview techniques, i.e., group interviews, in-depth individual interviews, role-playing, etc. Each country included at least one rural and one urban site. Most countries adapted the conceptual framework into their respective country research applicable to the local setting as well as carried out background research relevant to the economic, social, cultural, legal and health status of women and integrated this information into their findings. In addition to this, some countries went as far as interviewing health providers; community, union or religious leaders who often included men; and conducting life histories, focus groups or using role-play.

Cross-country Outcomes

The findings of the study revealed significant patterns of similarity despite various differences among and within the seven countries. Overall difference was found in women's expression and sense of sexual and reproductive entitlement. Their decision whether to leave a marriage or not to marry at all seemed strongly dependent on practical outcomes or if it would lead to social stigmatisation. For example, "not marrying at all" was unthinkable to respondents from Malaysia, Nigeria, Egypt and the Philippines because culturally, it was unacceptable for these women to have children outside wed-lock,

as well as considering options like divorce or separation. However, for respondents from Brazil, Mexico and US, not marrying at all or being single mothers is a more realistic option.

Women from all seven countries have aspired to control their own fertility, childbearing and contraceptive use irrespective of social, institutional and legal barriers. For example, in Brazil, Malaysia, Mexico, Nigeria and the Philippines, women were using contraceptives or getting abortions without the knowledge of husbands and parents, by using traditional or drugstore methods. Furthermore, the women felt that they earned the right to make these decisions based on having responsibilities of childbearing and childrearing.

"I am the one to make the decisions where family planning is concerned...After I decide then I tell him that we should not have so many children or that we should not space them so closely...Childrearing is not by him...He does not suffer, the suffering is done by me" - Lai Yin, Malaysia

A stronger sense of entitlement concerning sexuality and reproduction was found among the young, unmarried women as well as older women who have passed the time and test of motherhood. For example, young unmarried respondents from Egypt, Malaysia and urban Nigeria were found to be more willing to choose their marriage partner, work outside the home, decide freely on contraception and abortion; and in the case of Nigeria and Malaysia, some unmarried respondents were also abandoning premarital virginity. Furthermore, mothers from Brazil, Nigeria and USA have strong desires for their daughters to experience more education as well as more freedom than they had.

Women's empowerment to act on their sense of entitlement to reproductive and sexual decisions was significantly enhanced by their earning capacity. This was a crucial factor for a number of the women to fend off violence from their partners in their homes, and if the situation got worse, to leave and support their children on their own (Philippines, Malaysia, Brazil and the US).

"It's better to work after marriage. If you stay at home your husband may bully you. If you are working you are not afraid, you are supporting yourself" - Malaysia

In asserting women's rights to sexual pleasure and satisfaction, it was found that in the Philippines, Mexico and Nigeria, sexual accommodation was viewed as the wife's duty and sexual pleasure as a man's prerogative. However, women were found more forthright in their opposition to dangers involving sexuality than they are in expressing any right to sexual pleasures.

"If a man is infected with AIDS or any other STD, his wife should be free to refuse to sleep with him in order to protect herself" - Marietu, Nigeria

There was great consistency across countries in respect to complaints about the poor quality, inaccessibility and high cost of health and family planning services, especially demeaning and inhumane treatment received from medical health providers. In Nigeria, Egypt, Philippines and Malaysia, women seemed less likely to protest against clinical abuses, and would refuse to return to the clinic even if this jeopardised their own health. At the same time, many respondents found it easier to articulate a sense of injustice and entitlement towards public institutions than towards those with whom they live.

USEFUL OUTCOMES

- A unique qualitative methodology for doing research across country, cultural and political borders in a way that engages research subjects as active knowers and participants.
- A set of national and international publications that document IRRRAG's findings, to be disseminated around the world and in several languages.
- Active efforts by IRRRAG's research teams to make the findings available as advocacy tools for the communities where the research took place and for local and international organisations devoted to changing women's health and social conditions.

Conclusions

The IRRRAG study showed that overall, low-income women often manifest a strong sense of entitlement when it comes to decisions concerning childbearing, contraception, abortion, marriage and sexual relations. They accommodate to traditional practices or expectations which they find demeaning in order to secure their needs under conditions of limited resources, lack of a supportive and social environment or unresponsive institutional mechanisms to translate their sense of entitlement into effective rights.

"Listening to what grassroots women have to say" has far-reaching consequences in terms of policy change pertaining to reproductive health, as well as in transforming societies' views towards women's reproductive rights.

■ Sources:

The above article is a summary based on the Introduction and Conclusion to IRRRAG, *Negotiating Reproductive Rights*.

International Reproductive Rights Research Action Group (IRRRAG); Petchesky, R. and Judd, K. (eds.). forthcoming 1998. *Negotiating Reproductive Rights*. London: Zed Books.

For more information on IRRRAG, please contact: IRRRAG. Hunter College, 695 Park Avenue, New York, NY 10021, USA. Tel: 1-212-772 5682; Fax: 1-212-772-4268 E-mail: <irrrag@ igc.apc.org>

Malaysia

■ The Malaysian Medical Association conducted a one-day seminar on the 15th of June 1997 on "Women's Health", which was planned in collaboration with women NGOs. The seminar was aimed to sensitise participants to factors affecting women's health, and to the Cairo International Conference on Population and Development (ICPD) Programme of Action and the Beijing Fourth World Conference on Women (FWCW) Platform for Action. The seminar was also aimed to identify and prioritise major issues in women's health in Malaysia.

It was proposed that MMA develop a women's health agenda that would provide interventions at both community and provider levels. The MMA Centre Committee on Women's Health, with the help of invited members from the Ministry of Health and the NGOs including ARROW, will develop a service guideline or criteria for MMA members in both the public and private medical sectors to help promote gender-sensitive practices and guidelines on management of women's health issues such as domestic violence, rape and sexual assaults, issues related to sexuality among female adolescents, and health screening for women. It will also identify data needed for gender-sensitive women's health programmes, develop data collection procedures, as well as set out indicators and criteria that can be used by MMA medical practitioners in providing services to women and for future research and evaluation.

■ A workshop on the Socio-Legal Status of Women in Malaysia was held on 31 July 1997 to explore, among others, issues based on constitutional and civil rights, as well as secular family law, Islamic family law and criminal law on violence against women. Organised by the Gender and Development Research Centre (GADREC), Universiti Putra Malaysia (UPM), the one-day workshop was held to present the findings and the recommendations of the Malaysian Study and to obtain feedback from representatives of relevant government ministries, academicians and lawyers, and non-governmental organisations. Part of the Asian Development Bank (ADB) study on the socio-legal status of women in selected countries (Thailand, Malaysia, Indonesia and the Philippines), the Malaysian Study was aimed to: 1) review the socio-legal status of women; 2) assess the legal constraints; 3) identify areas of legal reform, institution-building, and training; 4) develop legally-based strategies; and 5) identify strategic entry points for ADB. The workshop was co-sponsored by the Women's Affairs Division (HAWA) of the Ministry of National Unity and Social Development, and the ADB. The Malaysian researchers highlighted five main areas of the law pertaining to women which needed to be reviewed. These were the Islamic family law, the Domestic Violence Act 1994, rape and incest, labour and employment, and land. Some of the main research findings highlighted included the need: 1) to standardise Islamic Family Law among all the states in Malaysia and to ensure that enforcement of these laws are uniform in nature with clear procedural guidelines to ensure consistency, and that the enforcement of such laws is carried out without male bias; 2) to increase women's awareness of their legal rights and legal literacy, and how to make use of the system to protect these rights; 3) to provide gender-sensitisation training to the staff of relevant agencies at all levels; 4) for legal reform—for example, that there be a separate law for incest rather than have it subsumed under rape; and 5) for legislation to ensure proper protection and due benefits to part-time workers.

Pakistan

■ Pakistan Voluntary Health and Nutrition Association (PAVHNA) is a consortium of 30 Pakistani NGOs working in the areas of health, nutrition and family planning. Its focus is mainly on training of its own staff, of community development workers in other NGOs, and doctors and paramedics.

Their biggest challenge so far has been raising fees from services, and in improving reproductive health care services, as well as informing the community about reproductive rights which is seen as essential. Reproductive health issues are considered a delicate matter in Pakistan. PAVHNA has found that doctors and physicians lack contraceptive knowledge due to inadequate information in the medical curriculum. Currently, PAVHNA has trained 1,200 doctors and 600 paramedical personnel. They are also working in collaboration with doctors to help change attitudes, beliefs and value systems pertaining to reproductive health as well as supply and exchange the latest information on the subject. For example, a workshop was held recently for doctors on HIV/AIDS and STDs, and more are planned for the future. Furthermore, PAVHNA has developed a new curriculum for screening women, and providing back-up care, with emphasis on check-ups, and building referral systems via associated clinics and hospitals. PAVHNA believes women's attitudes towards contraception is slowly changing. Women are beginning to acknowledge their own needs for contraception.

Besides the need for contraceptive technology in Pakistan, there is also a need for counselling, interpersonal communication skills and management training pertaining to reproductive health. Meanwhile, two other groups, Key Marketing and Green Star are working in parallel to popularise family planning by

marketing contraceptives with effective distribution systems and personalised counselling augmented by audio cassettes. With these new initiatives as well as improved reproductive health care and growing client demand, positive results are beginning to emerge. PAVHNA is hoping in future to also conduct training on fertility and gender issues.

New Zealand

■ In light of the recommendations of the Beijing Platform for Action (PFA), and the Government of New Zealand's commitment towards achieving equity for its women, the New Zealand Ministry of Women's Affairs in 1996 produced a set of guidelines for gender analysis to increase opportunities and advance the status of women in the country. The guidelines will provide public and private sector organisations with a framework on how to apply gender analysis in the development and implementation of policies and services. This is the first attempt in New Zealand to describe the principles and practice of gender analysis. The Ministry has plans to update the guidelines once gender analysis becomes more widely used in the country, and further publish case studies to document its use. Initially, the guidelines will apply to women in New Zealand. However, it will be made available to other countries who wish to adapt the guidelines into their policies and services.

Source: *Ministry of Women's Affairs. 1996. The Full Picture: Guidelines for Gender Analysis. Wellington: Ministry of Women's Affairs.*

Papua New Guinea

■ East Sepik Women & Children's Health Project is a grassroots women's health programme implemented through partnership between East Sepik Council of Women, a local NGO, and Save the Children/PNG, as well as with the Provincial Division of Health, Church Health Services and local government. It is based on the initiatives taken by the East Sepik Council of Women in 1983–85 to address the needs of its rural members for greater access to information, services and choices in family planning and primary health care. A major re-development of the programme took place in 1995 with the first two years spent setting up basic primary health care/first aid services and family planning in 162 villages. The first phase of the project has been established and sustained through well-developed management and supervision systems based on past experiences.

Currently, the organisation is into its second phase which includes major training of volunteer village women to become the service providers and a refocussing on maternal and reproductive health. The aim is to build a project framework reflecting grassroots women's understanding, status and control over their own health. The organisation is also working closely with regional experts and utilising materials for trainers and volunteers which take gender, reproductive rights and reproductive health as fundamentals for education and service provision.

International Women's Rights Action Watch (IWRAW) Asia Pacific

■ International Women's Rights Action Watch (IWRAW) Asia Pacific, a regional NGO based in Kuala Lumpur, Malaysia, recently conducted a South East Asia workshop in Kuala Lumpur on IWRAW's project "Monitoring the fulfillment of State obligations towards Gender Equality". The objectives of the project were namely to i) contribute to the implementation of the Women's Convention and the Beijing Platform for Action; ii) achieve equality for women and the realisation of their rights; and iii) strengthen the capacity of women and NGOs to actively engage in national advocacy and to intervene in CEDAW processes. Greater awareness of the Convention and its potential uses was also expected to be generated in the course of and beyond project implementation. The project was intended primarily for NGOs and other institutions for advocacy at national level or for intervention processes and venues to pressure their respective governments in fulfilling the latter's obligations and commitments to promote women's rights under the Convention and Beijing PFA.

So far, IWRAW has achieved three of its workshop's objectives, i.e., it has developed a tentative framework for effective NGO monitoring of state fulfilment of obligations and commitments under the Women's Convention and the Beijing PFA; validated a baseline collection format; and secured tentative commitments of partnership between IWRAW and prospective focal points. A follow-up meeting has been arranged.

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From the Documentation Centre

Clearinghouse on Infant Feeding and Maternal Nutrition. 1996. *Women's Rights to Maternity Protection: Information for Action.* Washington, D.C.: The Clearing House on Infant Feeding and Maternal Nutrition. 85 p.

This source book is intended as a catalyst for action: information is presented on maternity protection for employed women in a framework which can be easily applied by communities. Its purpose is to help women's groups to advocate for maternity protection review laws in their own countries and compare them with provisions in their workplaces. The book is divided into four parts. In part 1, issues on maternity protection, existing provisions, and breastfeeding are discussed. The second part contains possible action to amend and monitor the situation. After a brief introduction on what can be done and how, emphasis is given on legislation (e.g. legal awareness, training, and legal reform); support for women (e.g. child care); advocacy (e.g. strategic action); and call for action (e.g. collective action). The third part contains country data in table form which includes among others information on the country's maternity protection law, who is covered, maternity leave duration, benefits period, and CEDAW ratification. In the last part are lists of useful resources which include names and contact details of organisations working on women's issues; references and education materials that address gender and development, breastfeeding and child care, labour or legal issues, and advocacy and communications; and World Wide Web sites that are sources of information on the issues addressed in this source book.

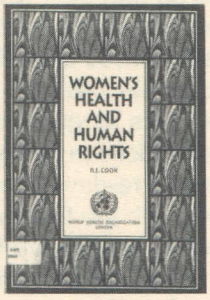
■ **Source:**
a) The Clearinghouse on Infant Feeding and Maternal Nutrition, American Public Health Association, 1015 Fifteenth Street NW. Washington D.C. 20005, USA.
b) World Alliance for Breastfeeding Action (WABA), P.O. Box 1200, 10850 Penang, Malaysia.

Commonwealth Medical Association (CMA). 1996. *International Roundtable on A Woman's Right to Health, Including Sexual and Reproductive Health, 26-29 September 1996, Toronto, Canada: Organised by the Commonwealth Medical Association on Behalf of Advocacy for Women's Health.* London: CMA. 37 p.

The main objectives of the roundtable were to prepare a report that can assist members of the Committee on the Elimination of Discrimination Against Women (CEDAW) in detecting violations of the Convention on the Elimination of All Forms of Discrimination Against Women which have adverse effects on women's health, and to provide concerned NGOs with guidance on the use of the convention to deal with health-related violations. The roundtable brought together human rights experts, health professionals, lawyers, and representatives of interested UN organisations, who dealt with the three broad areas of sexual and reproductive health, the health needs of women in waged and unwaged work, and the health needs of women according to life's course and life's circumstances. Among the areas looked at are the Convention itself, the reporting process, reservations, procedures before the committee, workload, NGO participation, complaints to CEDAW about violations, and information gathering. The roundtable also discussed the formulation of general recommendations based on reports sent to the committee, measures to invoke the convention to protect women's right to the enjoyment of health, as well as addressing government violations of the convention. The promotion of and obstacles to women's rights to the enjoyment of health are then presented, followed by the role of indicators in monitoring women's health, including a very useful list of indicators of women's health status, health service provision, and women's empowerment relating to health. Throughout the booklet, examples of organisations and programmes are included which can serve as "best practice" examples. The last part of the booklet includes practical advice to health professionals, NGOs, and health professional associations at national and international levels. This is a very informative booklet for women's and health organisations to base their work on the Convention.

■ **Source:** *Commonwealth Medical Association, c/o BMA House, Tavistock Square, London WC1H 9JP, UK.*

Cook, Rebecca J. 1994. *Women's Health and Human Rights: The Promotion and Protection of Women's Health Through International Human Rights Law.* Geneva: WHO. 62 p.



This booklet was originally prepared as a contribution by WHO to the World Conference on Human Rights in 1993. As such, it approaches the subject of women's health from the perspective of international human rights law. It includes six chapters: 1) The evolution of international human rights relevant to women's health; 2) Pervasive neglect of women's health (overview, health risks in infancy and childhood, of adolescence, and of women at work, reproductive health, VAW, other health concerns); 3) Measuring State compliance with treaty obligations; 4) International human rights to improve women's health (the right of women to be free from all forms of

discrimination; rights to survival, liberty and security; rights to family and private life; rights to information and education; the right to health and health care; the right to the benefits of scientific progress; rights regarding women's empowerment); 5) Human rights mechanisms for protection of women's health (international, regional and national protection); 6) Conclusion. The author suggests that every effort should be made for a vigorous and sustained scrutiny of women's health status at all levels and to use many types of resources for advancement, including the education of health professionals in human rights law and education of human rights advocates in how to acquire and interpret health data and extract the elements that are legally significant. The implementation of principles for the promotion and protection of women's health would address health status factors, health service factors and conditions affecting the health and well-being of women; and based on the principles, specific guidelines for the legal promotion and protection of women's health could be developed.

■ **Source:** *Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland.*

Correa, Sonia; Petchesky, Rosalind. 1994. "Reproductive and sexual rights: a feminist perspective", in Sen, Gita; Germain, Adrienne; Chen, Lincoln C. (eds). *Population Policies Reconsidered: Health, Empowerment, and Rights.* Boston: Harvard University Press. pp. 107–123.

The authors' intention with this article is to define the terrain of reproductive and sexual rights in terms of power and resources: the power of women to make their own, informed decisions about fertility, childbearing, childrearing, gynaecological health, and sexual activity, as well as the resources to carry out such decisions safely and effectively. After reviewing the epistemological and historical concept of women's relationships to children, partner, family and community, the authors address several fundamental problems which were raised in connection with the "reproductive and sexual rights" discussion, like the individualist bias and the presumption of universality. They review the ethical content of reproductive and sexual rights by defining such concepts as bodily integrity, personhood, equality, and diversity, and show with their analysis that the individual and the social dimensions of rights cannot be separated, as long as resources and power remains unequally distributed. They argue that rather than abandoning the rights discourse, it should be reconstructed so that it both specifies gender, class, cultural and other differences, as well as recognises social needs. The main point made is that sexual and reproductive rights, understood as private "liberties" or "choices", are meaningless, especially for the poorest and most disenfranchised, without enabling conditions through which they can be realised. These conditions constitute social rights and involve social welfare, personal security, and political freedom.

■ **Source:**
a) Harvard Center for Population and Development Studies, 9 Bow Street, Cambridge, MA 02139, USA.
b) International Women's Health Coalition (IWHC), 24 East 21 Street, New York, NY 10010, USA.

Freedman, Lynn P. 1995. "Reflections on emerging frameworks of health and human rights". *Health and Human Rights* Vol. 1, No. 4. pp. 315–348.

This article discusses the ways in which the analytical tools of public health (e.g. epidemiology and demography) can be applied to develop theories to place the right to health within the human rights framework. These tools help to identify and describe health issues as socially constructed human rights issues. With the emerging theories, effective advocacy strategies can be developed which focus particularly on women's reproductive health and reproductive rights. Public health research, although often presented as an objective scientific inquiry, is actually a value-laden and therefore, highly political endeavor that should be used by advocates to elucidate the connections between women's health and the wider social, economic, and political conditions in which they live. This is necessary as public health seeks to understand health and disease not only as a function of self-contained biological systems of the human body, but as patterns of health in the populations. Such research can then inform theory and practice in the dynamic field of women's human rights. It not only can help us to understand how particular health phenomena are socially produced, but also, what implications particular human rights phenomena have for health. This article suggests an approach to health and human rights collaboration that views women as committed, indispensable members of the communities in which they live. The suggested approach seeks to identify and implement social structures and cultural configurations that promote and support women's dignity and autonomy and thus, their health and well-being, in that social context.

■ **Source:** *Lynn P. Freedman, Columbia University, 60 Haven Avenue, B-3, New York 10032, USA.*

International Women's Rights Action Watch (IWRAW); Commonwealth Secretariat, Women's and Youth Affairs Division. 1996. *Assessing the Status of Women: A Guide to Reporting Under the Convention on the Elimination of All Forms of Discrimination Against Women. 2nd ed.* Minneapolis: IWRAW; London: Commonwealth Secretariat. 89 p.

This manual is designed to serve as a framework for monitoring the implementation of the Convention on the Elimination of All Forms of Discrimination Against Women. Its main purpose is to assist individuals, women's human rights and other groups, and non-governmental organisations to assess the status of women and to determine the extent to which the Convention is implemented in the countries that have ratified or acceded to the Convention. Guidance is given for:
1) monitoring the implementation of the Convention and for reporting; and 2) assessing the legal and actual status of women when reporting. The manual has eight parts: 1) Introduction; 2) Commentary on the articles of the Convention; 3) The Convention; 4) Consolidated guidelines for the initial part of state party reports; 5) The Committee guidelines regarding the form and content of initial reports of states parties; 6) The Committee guidelines for the preparation of second and subsequent periodic reports; 7) General recommendations adopted by the Committee; and 8) Declaration on the Elimination of Violence Against Women.

The Convention contains articles on the definition of discrimination against women, obligation to eliminate discrimination, the development and advancement of women, acceleration of equality between men and women, sex roles and stereotyping, suppression of the exploitation of women, political and public life, international representation and participation, nationality, education, employment, equality in access to health care, social and economic benefits, rural women, equality before the law and civil matters, and equality in marriage and family law. The text of each article is followed by a brief comment. Finally, a list of questions to ask on accountability and implementation provide a useful tool for monitoring action.

■ **Source:** *The International Women's Rights Action Watch (IWRAW), Humphrey Institute, University of Minnesota, 301-19th Avenue South, Minneapolis, MN 55455, USA.*

OTHER RESOURCES

■ **Cook, Rebecca J.** (ed.). 1994. *Human Rights of Women: National and International Perspectives.* Philadelphia: University of Pennsylvania Press. xiv, 634 p.

■ **François-Xavier Bagnoud Center for Health and Human Rights (Harvard School of Public Health).** *Health and Human Rights: An International Quarterly Journal*. Cambridge, MA: Harvard School of Public Health.

■ **Human Rights Watch Women's Rights Project.** 1995. *The Human Rights Watch Global Report on Women's Human Rights*. New York: Human Rights Watch. xxi, 458 p.

■ **Peters, Julie; Wolper, Andrea** (eds.). 1995. *Women's Rights Human Rights: International Feminist Perspectives*. New York; London: Routledge. 372 p.

■ **United Nations.** 1995. *The United Nations and Human Rights: 1945–1995*. New York: United Nations Department of Public Information. 536 p.

■ **United Nations.** 1996. *The United Nations and the Advancement of Women: 1945–1996*. New York: United Nations Department of Public Information. 845 p.

■ **American Association for the Advancement of Science (AAAS), Science and Human Rights Program: Directory of Human Rights Resources on the Internet**
<http://shr.aaas.org/dhr.htm>

■ **WomenWatch: the Internet Gateway on the Advancement and Empowerment of Women** (a joint initiative of DAW, UNIFEM, INSTRAW)
<http://www.un.org/womenwatch/>

ARROW'S PUBLICATIONS

ARROW. 1997. *Gender and Women's Health: Information Package No. 2*. Kuala Lumpur: ARROW. v.p.

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ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific. Health Resource Kit.* Kuala Lumpur: ARROW. v.p.

■ *Differential pricing. For more information, please contact ARROW.*

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p.

■ *Price: US$10.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

ARROW. 1994. *Reappraising Population Policies and Family Planning Programmes: An Annotated Bibliography.* Kuala Lumpur: ARROW. 101 p.

■ *Price: US$5.00 plus US$3.00 postal charges. Payment accepted in bank draft.*

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Human Rights of Women

The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on the grounds of sex are priority objectives of the international community.

United Nations. 1994. [Part I, para 18]. *World Conference on Human Rights: Vienna Declaration and Programme of Action.*

United Nations. 1994. [Principle 4]. *International Conference on Population and Development.*

Women's Health Rights

The World Conference on Human Rights recognises the importance of the enjoyment by women of the highest standard of physical and mental health throughout their lifespan . . . on the basis of equality between women and men, a woman's right to accessible and adequate health care, and the widest range of family planning services, as well as equal access to education at all levels.

United Nations. 1994. [para 41; The equal status and human rights of women]. *World Conference on Human Rights: Vienna Declaration and Programme of Action.*

Women have the right to the enjoyment of the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

United Nations. 1995. [para 89; Women and health]. *Fourth World Conference on Women: Beijing Declaration and Platform for Action.*

Discrimination

Discrimination against women means any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil, or any other field.

United Nations. 1979. [Article 1]. *Convention on the Elimination of All Forms of Discrimination Against Women.*

Governments' Obligation to Women's Rights

The Universal Declaration of Human Rights states that "everyone has a right to a standard of living adequate for the health and well-being of himself(sic) and of his family(sic), including food, clothing, housing and medical care and necessary social services . . .". Although the Declaration states a comprehensive set of rights to which all persons including women are entitled to, a separate legal and binding instrument was needed to accord the recognition that gender discrimination has adverse effects on women's health and well-being, as well as to guarantee women the protection of their rights.

Thus the **Convention on the Elimination of All Forms of Discrimination Against Women** sometimes referred to as the Women's Convention, was adopted by the General Assembly of the United Nations in 1979, and came into force in 1981. The Convention's basic principle states that governments are obligated to abolish all forms of discrimination against women. This is outlined in broad terms in Articles 1 to 4 which includes the definition and appropriate measures to be taken to guarantee women their rights on the basis of equality without discrimination[1]. Articles 5 to 16 refer to the different areas in which governments are obligated to eliminate discrimination through such measures. In relation to health, governments are obligated to maximise their resources to progressively achieve the realisation of women's rights to health, including reproductive health and sexual health, and to appropriate health care for women (Article12).

Governments sign the Convention to indicate they agree in principle with its content, whereas those that ratify the Convention are obligated to comply with its articles. They are also permitted to make reservations to the Convention[2]. Governments that ratified the Convention have to present progress reports at the end of the first year of ratification followed by every four years, to the **Committee on the Elimination of Discrimination Against Women (CEDAW)**, a United Nations treaty body established to monitor countries' compliance with the Convention. In 1997, three countries in the Asia-Pacific region, namely, Philippines, Australia and Bangladesh submitted their fourth periodic country report to the Committee, while Indonesia will do so in 1998. Local NGOs can participate in CEDAW's monitoring process as well as request copies of these reports for their own perusal.

To date, 160 countries globally have ratified or acceded the Convention[3]. At the time of the Nairobi Forward Looking Strategies for the Advancement of Women Conference in 1985, only five countries in the Asia-Pacific region ratified or acceded the Convention. By the time of the Asia-Pacific Regional Conference in Jakarta in 1994, 18 countries ratified or acceded the Convention. To date post-Beijing, approximately 25 out of 36 countries in the region have ratified or acceded the Convention. The remaining countries in the region are not even signatories to the Convention (see Table 1).

Table 1. Asia-Pacific Governments that have not signed or ratified the Women's Convention (1997)

Brunei Darussalam	New Caledonia
Cook Islands	Palau
DPR of Korea	Rep. Marshall Islands
Kiribati	Solomon Islands
Myanmar	Tonga
Nauru	Tuvalu

Source: Derived from the CEDAW website (see ref. no. 3 below).

Ratifying the Convention does not necessarily mean women's rights are being promoted and protected. Most Asia-Pacific countries still have a moderate to high rate of maternal mortality which reflects inadequate access to health services and low levels of education[4]. Furthermore, the human rights track record in countries like Cambodia, China, and Indonesia who signed the Convention as early as 1980 are considered relatively poor.

Much work is still needed to ensure that governments are implementing measures according to the Convention to improve the lives of women. The failure of governments to fulfill their obligations in relation to women's health and health rights will constitute discrimination against women under the Convention. Women from community-based organisations to governments and NGOs can play a more decisive role in redressing the neglect of women's rights by mobilising at national and international levels for a swifter and effective implementation of the Convention. This would help ensure that women's rights will be achieved.

References:

[1] **Commonwealth Secretariat**. 1988. *The Convention on the Elimination of All Forms of Discrimination Against Women*. London: Commonwealth Secretariat. pp. 3–6.

[2] Reservations/the right not to comply to certain parts of the articles, does not mean that governments may behave in a manner contradictory to the rights of women; this allows time for governments to introduce the necessary measures later.

[3] Latest figure of States that have signed, ratified, acceded or succeded to the Women's Convention. 22nd July 1997. **CEDAW** website: <gopher://gopher.un.org:70/11/ga/cedaw>

[4] Bhutan a signatory of the Convention in 1980 has recorded the highest mortality rate (1,600 per 100,000) in Asia-Pacific closely followed by Nepal, Papua New Guinea and Cambodia. **UNDP**. 1996. *Human Development Report 1996*. New York: Oxford University Press. pp. 154–155.

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