

# WOMEN'S RIGHT TO HEALTH AND THE BEIJING PLATFORM FOR ACTION: The Retreat from Cairo?

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## **The United Nations World Conferences on Women**

Women's health, particularly women's reproductive health, was given short shrift when the first of the UN World Conferences on Women, held in Mexico City in 1975, ushered in the UN Decade for Women (1976-1985). Although health was then singled out, together with education and employment, as one of three areas requiring particular attention at the Second World Conference (Copenhagen, 1980), it received far less attention than the other two areas at the Third World Conference (Nairobi, 1985), when the so-called Nairobi Forward-Looking Strategies for the Advancement of Women were adopted.<sup>1</sup>

Nevertheless, throughout the UN Decade for Women special attention was paid to the need for women to have access to family planning, and for couples and individuals to be in a position to reach informed decisions about the number and spacing of their children. The Nairobi Forward-Looking Strategies developed this further by dealing with the effects on women's health of having too many children, too young, too old, and too frequently.

But it was not until 1987 that full recognition was given to the plight of the half million women (nearly all of them in developing countries) who die each year from pregnancy-re-

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lated causes including childbirth, and to the millions of other women who suffer the rest of their lives from the consequences of inadequate contraception, unsafe abortion, obstetric complications, and poor pre-and post-natal care. The occasion was the 1987 Safe Motherhood Conference, also held in Nairobi, and co-sponsored by the World Bank, World Health Organization (WHO), and United Nations Population Fund (UNFPA).<sup>2</sup> It set the target of reducing maternal mortality by 50 percent before the year 2000, which is known as the Safe Motherhood Initiative.

In view of all the evidence available about the appalling health status of women in developing countries, it is astonishing that so little attention has been paid to it in the international arena, beyond the need for family planning and safe motherhood. In fact, the attention that has been given is directed more to its effects on the process of development, than on the consequences for the women concerned.

This may have resulted from the lack (and in many cases, the complete absence) of expertise on health matters within most government delegations, and to a lesser extent, among nongovernmental organizations (NGOs) participating in these conferences. In fact, governments and NGOs have both tended to show far more interest in the education and employment of women and their role in development than in their health. Nor has much emphasis been placed on women's human rights to health. Indeed, it is safe to say that although the health content of the draft Platform For Action of the Fourth World Conference on Women, to be held in Beijing in September 1995, is far more substantial than at previous conferences, there are ample grounds for believing that there has been little change in the situation.<sup>3</sup>

Other problems that have beset the fate of women's health at previous conferences may be summed up as follows: disagreements about priorities between various NGOs concerned with women's health; the fragmentary manner with which the subject has been considered, evidencing a lack of understanding of the need for women's health to be approached comprehensively, so as to cover the whole of a woman's life span; failure to adopt a gender-sensitive approach, i.e. to deal with those adverse health conditions affecting women because they are women; and last but not least, a reluctance to accept

that women have any right to the enjoyment of reproductive health, especially sexual health.

Fortunately, there has been recognition of the importance of women's health at the three most recent UN inter-governmental conferences, namely the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development (ICPD) (Cairo, 1994), and the World Summit on Social Development (WSSD) (Copenhagen, 1995, commonly known as the Social Summit).<sup>4,5,6</sup>

The Vienna Human Rights conference recognized that women have the right to the highest attainable standard of physical and mental health throughout their life, and to accessible and adequate health care including the widest range of family planning services. The Cairo conference went further. It not only recognized, but defined, the concept of reproductive health, emphasizing that it includes sexual health, "the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted disease." The Social Summit, of course, could hardly have failed to acknowledge the adverse effects on women's health of its three main themes of poverty, unemployment, and social disintegration, although its treatment of the worsening reproductive health status of young people in developing countries was notably weaker than at Cairo.

### **Advocacy for Women's Health**

Meanwhile, the Commonwealth Medical Association (CMA), aware of the importance of promoting a consensus on women's health issues at all four conferences to be held before the end of 1995, convened a group known as Advocacy for Women's Health. The group consists of associations of health professionals, reproductive health organizations, women's organizations, and women's networks with European headquarters. The main planks of the group's policy on relevant issues were settled at a Roundtable held at the Rockefeller Centre in Bellagio, Italy, chaired jointly by Fred Sai, later chair to the main committee at ICPD, and by Laetitia van den Assum of the Netherlands government.<sup>7</sup>

The group decided at the Roundtable to adopt three ap-

proaches to women's health issues at the conferences: (1) a comprehensive approach covering the whole of a woman's life span; (2) a gender-sensitive approach concerned with health conditions that affect only women; and (3) a human rights approach concerned with a woman's right to health, and more especially, to reproductive and sexual health.

Meetings of the group have continued to be held regularly, at which commentaries on the drafts of documents for the various conferences have been agreed to and circulated by members of the group to their affiliates. Workshops have been organized on behalf of the group during the parallel events (e.g., NGO fora) associated with meetings of the Preparatory Committees (PrepComs) for the conferences and the conferences themselves. In addition, statements have been made on behalf of the group to the main committees of the conferences.

Wherever possible, funding has been obtained to enable female doctors from developing countries to participate in workshops and roundtables organized by the CMA at PrepComs and regional meetings for the conferences. These women have provided delegates with much needed information, based on personal experience, about the actual status of women's health in their own countries.

The roundtables organized on behalf of the group at regional meetings for the Beijing conference did manage to have a significant effect on the health content of the regional Platforms for Action.<sup>8,9</sup> At the beginning of 1995, an inter-regional roundtable including government delegates was held in London in order to coordinate the regional Platforms for Action and to prepare for the meeting of the Commission on the Status of Women (CSW) that functioned as the final PrepCom for the Beijing conference.<sup>10</sup> The roundtable was re-convened at the end of June 1995 to review the final draft of the Beijing Platform for Action as put forward by the CSW.

### **Bracketing of Text**

The draft of the Platform for Action of the Beijing conference,<sup>11</sup> hereinafter referred to as 'the document,' is the product of two previous meetings of the CSW. As is the practice during the preparatory process for a UN conference document, those parts of the text that delegates decided they were un-

able to agree on, or would have to be left for agreement until the conference itself, are placed in square brackets. They are, therefore, regarded as controversial statements and proposals that individual or grouped government delegations are unable to accept. The deliberations which occur at the actual conferences will focus primarily on reaching consensus around bracketed text.

What has been surprising in the past several years is the extent to which delegates, committed to certain views about reproductive and sexual health, are prepared to insist on bracketing text. In preparations for the Cairo conference, brackets were placed around all references to safe motherhood (apparently because it was felt that it could include abortion); reproductive health; contraception (including family planning); abortion (including abortion induced on accepted medical and legal indications); fertility control (even though the text stated specifically that it did not include abortion); and sex education (to which objection was taken on grounds that it encourages promiscuity, although all evidence shows that it has precisely the opposite effect).

Predictably, many of the brackets were removed, or alternative language substituted, in the final Cairo document. Nonetheless, the parties concerned went on to insist that text dealing with the same issues in the draft document for the Social Summit also be bracketed, the consequence of which was not dissimilar to that which occurred in Cairo. Undaunted, they have repeated the same exercise with the draft of the Beijing document. The document to be discussed in Beijing arrives with approximately 40 percent of the relevant text in brackets, including all references to gender, apparently because certain delegates at the PrepCom suddenly discovered that they did not understand what the term means.<sup>12</sup> There is, of course, a whole chapter devoted to gender in the ICPD Programme of Action (Chapter IV). It should be noted that a substantial proportion of this bracketing exercise has been instigated by the Holy See (Vatican State), aided and abetted by countries sympathetic to its views, including a number of Islamic States and NGOs committed to what is termed the 'right to life.'

The document begins with a draft declaration called the Beijing Declaration, which has been proposed by the G77 (a

group of developing countries now numbering well in excess of 100), followed by amendments proposed by the United States and Canada. Although the draft Declaration and its amended versions contain some worthy intentions toward women, more to the point, none of them even mentions women's health. In addition, women's health does not appear anywhere in the one-page "Mission Statement" that follows it.

The following examples are given to illustrate the problems that the text creates in the field of reproductive health.

#### **A. Adolescent Health**

It is no exaggeration to say that the single most important task for those delegates at Beijing concerned about the appalling health status of women in developing countries is to protect the language contained in the Cairo document from assaults being made to it in the Beijing document. This is of particular importance given that the text concerning adolescent health in the Social Summit's document was noticeably weaker than it had been in the Cairo document.

Inequalities in health care and related services are listed in the Beijing document as one of the 11 critical areas of concern on which "governments, the international community and civil society, including NGOs and the private sector, are called upon to take strategic action" (para. 46). But the seemingly reasonable statement which follows soon after that "the lack of sexual and reproductive education has a profound impact on women and men" (para. 76), is in brackets—notwithstanding the consensus reached in Cairo about the urgent need for adolescents to have unrestricted access to reproductive and sexual information and services (paras. 6.15 and 7.45-48). While the statement that "adolescent girls need, but too often do not have, access to necessary health and nutrition services as they mature" (para. 95) has not been bracketed, the factual statement accompanying it, that "Counseling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking completely, and a young woman's right to privacy, confidentiality, respect and informed consent, is often not considered, taking into account the parent's responsibilities" has,

inevitably, been encased in brackets. In addition to being potentially harmful to the health of young girls, the brackets threaten to undermine the agreement reached in Cairo.

The phrase, “taking into account the rights, duties, and responsibilities of parents and other persons legally responsible for children and consistent with the Convention on the Rights of the Child,” appears 23 times in the document. The intention is, presumably, to try to ensure that adolescent girls are unable to access reproductive health information or services without the knowledge and consent of their parents—which is, of course, why girls so rarely take advantage of such services. In this context, it is important to note that Article 15(1) of the Convention, which is set out in full in the document (para. 259), requires parents “to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance, in the exercise by the child of the rights recognized in the present Convention.”<sup>13</sup> One of those recognized rights is the right to privacy. It can, therefore, be argued that parents should respect the privacy of adolescents who are sufficiently mature to understand the nature and consequences of accessing reproductive health information and services.

### **B. Inequalities in Access to Health and Related Services**

The rights of women to “enjoyment of the highest attainable standard of physical and mental health,” defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,” is reaffirmed (para. 91). However, reference to “the limited power many women have over their sexual and reproductive lives” and the statement that “the right of all women to control their own fertility is basic to their empowerment” have both been placed in brackets (para. 94).

The text of paragraph 92, referring to the “different and unequal access” that women have to primary health services “for the prevention and treatment of childhood diseases, malnutrition, anaemia, diarrhoeal diseases, communicable diseases, malaria and other tropical diseases and tuberculosis, among others,” displays little understanding of women’s health issues and their relative priorities. The text omits any reference to sexually transmitted diseases and implies that,

apart from malnutrition, the diseases named are non-communicable. Although this paragraph recognizes that health service policies and programs often perpetuate gender stereotypes and that “women’s health is also affected by gender bias in the health system and by the provision of inadequate and inappropriate medical services to women,” the term “gender” has been bracketed on each occasion.

While recognizing that women have little access to information and services for prevention and treatment of HIV/AIDS (para. 99), the references to women not often having “the power to insist on safe sex;” to their being “not able to insist upon responsible sexual behavior on the part of their partners” and to “obstacles to negotiating safe sex,” have all been included in brackets. If these brackets are not taken off, the document will have succeeded in avoiding any mention of the main reasons women are so vulnerable to HIV/AIDS. Meanwhile, it should be noted in passing that WHO has estimated that one million women were newly infected last year.

The need to “ensure that all health services and workers conform to human rights, and to ethical standards in the delivery of women’s health services aimed at ensuring responsible and voluntary and informed consent” is affirmed in paragraph 107(g). The paragraph goes on to declare that “Nothing, however, in the Plan of Action is intended to require any health professional or health facility to provide, or to refer for, services to which they have objections on the basis of religious belief or moral conviction as a matter of conscience.” This sentence was introduced by the Holy See, probably as a result of the papal encyclical that was published during the PrepCom.

The effect of this is that a health professional who has a conscientious objection to carrying out any procedure necessary to save the life, or to prevent serious damage to the health of a female patient, need not even refer her to a colleague who is prepared to take the necessary action. Such professional conduct (misconduct would be a better description) is contrary to all universally accepted principles of medical ethics. Significantly, conscience clauses in legislation permitting abortion will often specifically exclude emergency procedures.

Attention should also be drawn to paragraph 110 (e), that action should be taken to “inform women about the data that



shows hormonal contraception, abortion and promiscuity increase risks of developing cancers and infections of the reproductive tract, so that they can make informed decisions about their health." In fact, all evidence points to the fact that hormonal contraception reduces the risk of cancers of the cervix, the endometrium, and the body of the uterus, and that evidence of increased risk of breast cancer is, at best, equivocal. The point should also be made that what constitutes promiscuity is very much a value judgement. It is sexual activity that is the determinant.

### **C. Complications of Unwanted Pregnancies**

The comprehensive definition of violence against women (para. 114), which includes examples, makes no mention of unsafe abortion, which is one of the most important causes of adverse health status of women in developing countries. On the other hand, references in the following paragraph (115), which sets out "other acts of violence against women," refers to "forced pregnancy," "forced abortion," "female foeticide (sic) /prenatal sex selection," and "female infanticide." As far as pre-natal sex selection is concerned, no exception is made in favor of amniocentesis for the purpose of avoiding the transmission of genetic disease, nor is there any exception stated in paragraph 225(i), which calls for legislation to be enacted against it.

The loose use of language throughout the document in referring to terms such as "infanticide" and "feticide" serves only to cause confusion. The terms "abortion" and "feticide" are used interchangeably throughout, and the words "at conception" have been added after "infanticide" in paragraph 41. The terms "abortion" and "feticide" should not be used in relation to a fertilized ovum (embryo) before it has implanted in the uterus, at which point it becomes a fetus. The term "infanticide" should be used only in the context of a child that has been born alive.

The term "feticide" is not an established medical term and presumably applies to a fetus until the onset of labor. However, the use of this term fails to take into account whether the fetus is viable (capable of maintaining an independent existence upon being born alive) or non-viable, and should, therefore, be avoided. The term "abortion" (whether

or not criminal) is usually reserved for termination of a pregnancy when the fetus is non-viable. The criminal destruction of a viable fetus is usually referred to as "child destruction." Whatever views delegates may have about "the beginning of life" or "ensoulment," the above terms should be used correctly in the draft document, and not distorted to make special points.

## **Conclusion**

It is unlikely that there will be another UN World Conference on Women for at least 10 years, during which time millions of women, the majority of them adolescents in developing countries, will remain at risk of dying of or suffering permanent damage to their health from complications associated with unwanted pregnancies, and from sexually transmitted diseases, in particular HIV/AIDS.

The situation calls for urgent re-enforcement and implementation of the consensus reached by governments in Cairo last year, on the provision of reproductive health information and services, and for a commitment by governments to protect women's rights to the enjoyment of health.

Unfortunately, at this late stage in the preparatory process for the Beijing Conference, it has proved impossible for governments to agree on the text in the draft Programme of Action that supports the consensus reached in Cairo.

The situation is compounded by restrictions that the text seeks to impose on the freedom of health professionals and facilities to provide essential reproductive health services, and by the lack of adequate expertise on women's health issues within most of the government delegations to the Conference.

## **References**

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  5. United Nations Population Fund, *Report of the International Conference on Population and Development*, Cairo, 5-13 September 1994, UN Doc.A/CONF/171/13, 18 October 1994.
  6. United Nations, *Declaration and Programme of Action of the World Summit on Social Development*, Copenhagen, 6-12 March 1995.
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  8. Commonwealth Medical Association, *Report of Roundtable on Reproductive and Sexual Health for the ECE Region*, Vienna, 15 October 1994.
  9. Commonwealth Medical Association, *Report of Roundtable on Reproductive and Sexual Health for the ECA Region*, Dakar, 14 November 1994.
  10. Commonwealth Medical Association, *Statement of the Roundtable on Women's Health*, London, 5-7 January 1995.
  11. Commission on the Status of Women, see note 3.
  12. EDITOR'S NOTE: This resulted in the forming of a Gender Contact Group, established to resolve questions regarding use of the word "gender." The Group reports directly to the Conference in Beijing. Chaired by Selma Ashipala of Namibia, the Contact Group meeting was attended by about 60 representatives of interested nations. The Contact Group agreed to reaffirm that the word "gender" as used in the Platform for Action is intended to be interpreted and understood as it is in ordinary, generally accepted usage. Consensus was reached, with Guatemala alone preferring that gender be specifically defined in the Platform for Action.
  13. United Nations General Assembly, *Convention on the Rights of the Child*, adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989.