

Imagine a world where no woman is denied her right to health- Seven propositions

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An old man's dream

A man at my age has two options: either to reminisce about a past of which he was a part, or to dream about a future in which he will not be a part. It is difficult to resist the temptation to talk about the past, and good old days. But I would rather dream about the future, and try to imagine a world where no woman is denied her right to health.

Our world of diversity

Diversity was the divine intent when, at the time of Babel, we were scattered all over the earth and our languages were confounded (Old Testament). Women in different parts of this diverse world may look different. But those of us who have been in the international field of women's health long enough know that women in this diversity share much more in common than what meets the eye. They share common aspirations. They have common concerns. They have in the present or had in the past their common grievances and injustices. And above all, they have common God-given entitlements, which many are still being denied. Women's health is often compromised not by lack of medical knowledge, but by infringements on their human rights (Cook *et al.*, 2003). One of these rights is their human right to health.

The human right to health

The human right to health was proclaimed in the international human rights treaty, The Economic, Social and Cultural Rights Covenant (Article 12), recognizing the right of *everyone* to the enjoyment of the highest attainable standard of physical and mental health (United Nations, 1996).

This right to health needed some clarification. It is not to be understood as a right to be healthy. As

clarified by the United Nations Committee, the right to health contains both freedoms and entitlements (United Nations, 2000). The *freedoms* include the right to control one's health and body. The *entitlements* include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.

As far as women are concerned, in many parts of our world, in our day, many women are still denied their right to health. They neither have the freedoms to control their health and body, nor the entitlement to a system of health protection which provides equality of opportunity for them, as women.

For the dream world where no woman is denied her right to health, seven propositions are submitted, related to the freedoms, or the entitlements or both, included in the right to health.

Let women have the freedom to control their health and body

While a woman can claim as her own, her head, her hair, her hands, her arms, her upper body, her legs and her feet, she cannot claim the same right to a remaining area of her body, which appears to belong more to certain males of the species, moralists, politicians, lawyers, men of religion, and others, all of whom claim the right to decide how this part of a woman's body can best be utilized. For a woman to enjoy her human right to health, her body, all her body, must be hers.

Women are entitled to be treated as ends and not as means

The attitude to treat women as means and not ends is still pervasive in the health sector in many parts of the world. Women are often treated as objects and not subjects. They are considered as means in the process of reproduction and as targets in the goal of

fertility control. Pregnant women may be taken care of largely as a means to get healthy children. Women are provided with family planning as a means to control population growth. Even saving mothers lives may be justified as important for the lives of children, because of the higher mortality of infants and children whose mothers have died. A case for girl education is made with a rationale that educated girls will make good mothers for our children in the future. It is regrettable when services are handed to women with a sense of veterinary quality.

Fertility control of women versus family planning by women is a case in point of women considered as means and not ends (Fathalla, 2001). Women have more at stake in fertility control than anyone else. Contraceptives are meant to be used by women to empower themselves by maximizing their choices, and controlling their fertility, their sexuality, their health and hence their lives. Family planning, however, has been used by governments and others to control rather than to empower women. Some governments were short-sighted, not to see that when women are given a real choice, and the information and means to implement their choice, they will make the most rational decisions for themselves, for their families, for their communities and ultimately for the world at large.

Women have a right to safe motherhood

Women's right to safe motherhood is not only a right to health; it is a right to life (Fathalla, 2006). It is a right to which governments are to be held accountable in monitoring the implementation of Human Rights Treaties. When States parties report on how they implement the right to life, they are required by Human Rights treaty bodies to "provide data on... pregnancy and childbirth-related deaths of women and to address deaths related to pregnancy and childbirth deaths as a matter of women's right to life" (United Nations, 2000).

Pregnancy is not a disease. Pregnancy is a bio-social function which women undertake to ensure the survival of our species. If women stop the noble function of childbearing, and they can, our human species will be extinct.

Pregnancy and childbirth are a risky business. A mother, in African folklore, tells her children "I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return." And she is right. Many do not return. The probability that a 15-year-old female will die eventually from a maternal cause is 1 in 31 in sub-Saharan Africa. In Afghanistan, the risk is 1 in 11. In developed regions, the risk is 1 in 4300. In Belgium, this lifetime risk is 1 in 10 900 (WHO, 2010). Belgium is

a mother-friendly country. In a report recently released on the State of the World's Mothers, 104 countries have been ranked according to a set of indicators (Save the children, 2011). Belgium came up among the top ten countries, with rank number 8, ahead of its neighbours: the Netherlands, France and Germany. Egypt in spite of some recent progress, came with the rank of 61.

According to United Nations estimates, every day about 1000 young women in the prime of their lives give up their life in the process of giving us a new life. And maternal deaths are just the tip of an iceberg of maternal morbidity and ill health. Each year, eight million of the estimated 210 million women who become pregnant, suffer life-threatening complications related to pregnancy, many experiencing long-term morbidities and disabilities (WHO, 2004).

Women do not have to give up their life in the process of giving us a new life. Maternal mortality has been eliminated or nearly eliminated in many countries in the world. Where the scandal persists, it is not because women are dying from disease we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving.

A call for equity

As voiced by women, in their Fourth United Nations International Conference in Beijing in 1995, a major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographic regions, social classes and indigenous and ethnic groups (United Nations 1995).

Health equity means the provision of equal health services for all those with equivalent needs, and the provision of more or enhanced services to those with greater needs. This is not what now happens in the real world. What happens has been described as the "inverse care law" (Hart, 1971). The availability of good medical care tends to vary inversely with the need for it in the population served. New public health interventions and programs initially reach those of higher socio-economic status, and only later, if at all, reach the poor. Where people are poor, women are the poorest of the poor. This inverse care law as described in 1971 was put more succinctly in just one sentence by Jesus Christ, when he said: "For him who has will more be given" (New Testament).

Women have a right to benefit from scientific progress

The human rights treaty, The Economic Covenant, recognizes the right of *everyone* to enjoy the benefits

of scientific progress and its applications (United Nations, 1996).

Women, as part of their right to health, should have the right to enjoy the benefits of scientific progress and its applications in the field of health. But, do they? Let us look at infertility as a case in point. Scientific advances in the past few decades have opened the door of hope for infertile couples who were considered before beyond any medical help. With the technologies of assisted reproduction, women in the twenty-first century find it difficult to accept infertility as a fate. Challenges, however, remain in making these technologies available to women living in poor resource settings (Fathalla, 2007).

A recent study about infertility and the provision of infertility services in developing countries, reports that:

- Worldwide more than 70 million couples suffer from infertility, the majority being residents of developing countries.
- Bilateral tubal occlusion due to sexually transmitted diseases and pregnancy-related infections is the most common cause of infertility in developing countries, a condition that is potentially treatable with assisted reproductive technologies.
- New reproductive technologies are either unavailable or still very costly in developing countries. But there ways in which they can be made more affordable, and more adapted to low resource settings. (Ombelet *et al.*, 2008)

The first baby born with the help of new reproductive technology, Louise Brown, is now already herself a mother. But after a fascinating period of almost 30 years of IVF and 15 years of ICSI, only a small part of the world women benefits from these new technologies.

Infertility is a public health and social problem. Infertility management is an integral component of the reproductive health package (Fathalla and Fathalla, 2008). True, infertility does not threaten life or endanger physical health. But health is not merely the absence of disease or infirmity. It is a state of complete physical, mental and social well-being. Women do perceive the suffering from infertility as very real. In a moving passage in the Bible, Book of Genesis, Rachel, wife of Jacob, suffering from infertility, cries “give me children or else I die” (Old Testament).

In our world today, there are women dying *of* a baby, but there are also women dying *for* a baby. In developing countries, negative psychological and social consequences of childlessness are experienced to a greater degree than in Western societies (Ombelet *et al.*, 2008). This is particularly so, where

women are denied any other choice in life except childbearing and child rearing, and where children are considered the only goods that a woman is expected to deliver.

To some people it may seem odd that we talk about infertility as a public health problem in developing countries when the world urgently needs vigorous control of population growth. With the population problem on our hands, is it appropriate that we continue to worry about the problem of infertility? The answer is that we should worry even more. The adoption of a small family norm, through voluntary infertility, which is a desired goal at country and at global level, makes the issue of involuntary infertility more pressing. If couples are asked to adopt a responsible reproductive behaviour and are urged to postpone and to widely space pregnancies, it is imperative that they should be helped to achieve a pregnancy when they so decide, in what will be a more limited time they have available.

A warning: beware of the Homo dogmaticus

The Homo dogmaticus is a vocal minority subspecies of the Homo sapiens. It is not confined to any continent, country, race or religion. The diagnostic clinical triad is a tunnel vision, a sense of exclusive ownership of the truth, and a self-given mission to force own vision on others. Women’s right to health is often a target for the Homo dogmaticus. A little story from the past in our profession is instructive. It may sound funny today, but it shows how dogmatic views can interfere with women’s health care. When the Scottish obstetrician James Young Simpson introduced obstetric analgesia (pain relief during labor) in the nineteenth century, there was uproar from the clergy, all of whom are men. Misinterpretation of the biblical scripture “in sorrow thou shalt bring forth children” resulted in denial of pain relief to women, as suffering in labour was believed to be consistent with the divine intent. It was only after Queen Victoria needed and used the analgesia in the birth of her eighth child that the resistance was dropped. (Camann, 2005).

A universal prescription for women’s health.

Women need “power” to secure their right to health. Powerlessness of women is a serious health hazard (Fathalla, 1997). Women need power because they are suffering from a power deficiency syndrome. As of 2011, only 28 countries have reached or surpassed the 30 percent mark for women’s representation in parliament (UN Women, 2011). In times of armed conflict, women are still systematically subjected to violence. Sexual violence against women is being

used as a tactic of war. Even behind closed doors, home is not safe (Fathalla, 2005). Most of the women infected with HIV in developing countries were infected by their husbands or long term- partners (UNAIDS, 2009). Women’s risk of infection is increased by their lack of decision-making power, including asking their partners to wear a condom.

Here are the instructions that go with a “power” prescription. As to the dose, the advice is to take as much as you can get. There is no risk of over dosage and there are no reported side effects. The problem, however, is that there is no pharmacy that can supply it over the counter. Women have to struggle to get it, and to keep a sustainable supply of it

A dream can come true

Women in many parts of the world have made good progress (UN Women, 2011). In other parts of our diverse world women still have some steep mountains to climb, but women are not for turning, and what women have done women can do. There are grounds for hope that no woman will be denied her right to health. But hope is never enough to realize one’s dreams. Francis Bacon once said: “hope is a good breakfast, but it is a bad supper” (Brainyquote, 2011). Hope is good when you have it and go to work on it. Hope is bad when you have it and go to sleep on it. Dreams can come true, but only if we work hard on them. The health profession has a moral and social responsibility to stand behind and beside women to secure their right to health.

SEVEN PROPOSITIONS

- Let all her body be hers
- Women are ends and not means
 - Women have a right to safe motherhood
 - Equity please
- Women have a right to benefit from scientific progress
- Beware! The Homo dogmaticus
 - A universal prescription for women’s health

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