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Gender Politics, Gender Paradox: Establishing and Implementing Global Standards for the Promotion and Protection of Women's Health

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GENDER POLITICS, GENDER PARADOX: ESTABLISHING AND IMPLEMENTING GLOBAL STANDARDS FOR THE PROMOTION AND PROTECTION OF WOMEN'S HEALTH

David P. Fidler[*]

The Global Gender Paradox

The organizers of this conference have provided us with a rich assortment of issues to consider in the relationship between policy, law, and women's health. I have been asked to focus my remarks on conceptual concerns associated with establishing and implementing global standards for promoting and protecting women's health, with a particular eye on the challenges these objectives face in developing and least-developed countries. Thomas Murray said yesterday that generalities are the refuge of scoundrels, so perhaps I am the designated scoundrel given my mandate to focus on conceptual issues rather than on-the-ground practicalities.

Thinking about my assigned task in relation to the issues addressed at this conference raised for me two implications. First, as we learned from yesterday's proceedings, women's health around the world faces serious problems. As one leading expert argued in 2006, "The great dreams of the international conferences in Vienna, Cairo, and Beijing have never come to pass. It matters not the issue: whether it's levels of sexual violence, or HIV/AIDS, or maternal mortality, or armed conflict, or economic empowerment, or parliamentary representation, women are in terrible trouble. And things are getting no better."[1]

Second, these problems raise the need to implement existing standards for women's health more effectively and, where necessary, to develop more and better promotion and protection standards. Thus, the formulation and implementation of global standards for women's health are key challenges for gender politics in the early 21st century.

In thinking about these challenges, a paradox of sorts appeared in my mind. In my work on international law and global health, I frequently find gender-specific analysis of public health problems, and this analysis is tied to existing normative standards about women's health, most frequently emanating from international human rights law. In fact, these gender-informed analyses typically do the following: (1) they describe empirical data showing that a health problem significantly, and sometimes disproportionately, affects women; (2) they analyze this data in ways that connect it to political, economic, cultural, or medical problems women face; (3) they apply existing norms or standards that support betterment of women's health; and (4) they propose recommendations, principles, or guidance for improving the health of women. These gender-informed analyses appear with sufficient frequency that I have heard them referred to as the "gender boilerplate."

The paradox that I want to unpack is this: We perceive that problems concerning women's health worldwide, but particularly in developing and least-developed countries, are growing at the same time that gender-informed analysis of global health issues has become more pervasive. Now, immediately, two explanations for this paradox jump to mind, neither of which is comforting. First, our heightened awareness of women's health problems flows from the increased use of gender-informed analysis of public health problems. Put another way, we are only now beginning to understand how bad things are for women in many parts of the world. Second, the increased application of existing norms and standards on women's health reflects a worsening situation for women's health in many parts of the world. In other words, reality on the ground bears little resemblance to the standards found in policy and legal documents.

Many presentations at this conference highlight this gap between norms and reality with respect to specific health problems, such as maternal health, domestic violence, cultural discrimination, and sexual trafficking. I am going to focus conceptually on the challenges the effort to improve women's health faces in terms of standard development and implementation. I want to break down the conceptual components that go into the formation of standards for women's health, map the development of such standards using these components, and finally consider the difficulties standard-setting for women's health faces in the current context of global health governance. Through these steps I hope to communicate something about the structure and dynamics of gender healthcraft in the early 21st century and probe the difficulties gender healthcraft will face in the foreseeable future.

Behind the Gender Boilerplate

This audience needs no education in terms of the seriousness and sophistication of gender-informed analyses of global health problems, but let me connect this important phenomenon to my conceptual mandate. The depth and breadth of gender-aware examination of both specific disease threats, such as HIV/AIDS and malaria, and social determinants of health, such as education and poverty, that we see today is historically unprecedented and is the result of the development of the process through which standards for women's health form.   In analysis and advocacy for improvements in women's health, standards emerge from the combination of three things: the development of epidemiological or empirical evidence, the application of human rights principles, and the process of gender mainstreaming.

By empirical evidence, I mean the data that provides insight into how a particular disease, threat to health, or social determinant of health affects the health of women. By human rights principles, I refer to the rules and norms found mainly in the international law of human rights.   By gender mainstreaming, I mean the processes of "assessing the implications for women and men of any planned action, including legislation, policies or programmes, in all areas and at all levels" with the ultimate goal of achieving gender equality.[2]

Let me illustrate how these three things developed sequentially to work together in terms of the development of standards for women's health. My example is maternal health, one of the oldest international health issues focusing specifically on women. Epidemiological data on maternal morbidity and mortality have for decades been indicators of deficiencies in many countries concerning women's health.   After World War II, translating epidemiological data on maternal health into policy involved the application of newly emerging international human rights principles.   Initially, maternal health fell within larger human rights concepts, such as the principle of non-discrimination and the right to health.

For example, the WHO Constitution provides that the enjoyment of the highest attainable standard of health is a fundamental human right without distinction of race, religion, political belief, economic, or social condition.[3]

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[2] *See* Official Records of the General Assembly, Fifty-second Session, Supplement No. 3 (A/52/3/Rev.1), chap. IV, para. 4.

[3] Constitution of the World Health Organization, pmbl., July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185.

Interestingly, the WHO Constitution did not single out non-discrimination on the basis of sex.[4] To help countries fulfill the right to health, however, the Constitution made one of WHO's functions the promotion of maternal health and welfare.[5] Later, the International Covenant on Economic, Social, and Cultural Rights, adopted in 1966, included sex in its non-discrimination principle and required States parties to ensure the equal rights of men and women in the enjoyment of all economic, social, and cultural rights[6]—but it does not specifically list maternal health in its right to health provision.[7]

In terms of the UN human rights treaties, not until the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) do general principles of international human rights law protecting women connect directly to maternal health.[8] In addition, CEDAW was more specific about the rights-based requirements for maternal health, obligating governments to provide appropriate services during pregnancy, at birth, and in the post-natal period.[9] This specificity helped expand rather than narrow perspectives on women's health because to achieve what CEDAW prescribed would require governments to go well beyond the delivery of health services during birth. CEDAW's comprehensive focus on non-discrimination against women provided opportunities to move beyond specific health issues, such as maternal health, and towards grappling with social determinants of women's health through human rights concepts.

This move set the stage for the next phase in the development of standard setting for women's health—the strategy of gender mainstreaming, which appeared in the latter half of the 1980s but accelerated in the 1990s, especially after the Beijing Women's Conference in 1995. Through gender mainstreaming, experts developed specific standards for women's health improvement across multiple policy sectors. The detailed standards in so many realms of political action aimed for transformative social consequences that would hopefully produce, iteratively, gender equality. Gender mainstreaming, in turn, created opportunities for new gender-informed empirical analysis because advocates and policy makers assessed gender

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[4] *Id.*

[5] *Id.* art. 2(1).

[6] International Covenant on Economic, Social and Cultural Rights, arts. 2-3, Dec. 16, 1966, 993 U.N.T.S. 13.

[7] *Id.* art. 12.

[8] Convention on the Elimination of All Forms of Discrimination Against Women, art. 12, Dec. 18, 1979, 1249 U.N.T.S. 13.

[9] *Id.*

effects not previously considered in conventional approaches, such as the traditional concern with maternal health.

The combination of epidemiological evidence, human rights principles, and gender mainstreaming has produced a powerful dynamic for the formulation of standards for protecting and promoting women's health. The impact of this dynamic can be sensed by comparing the single mention of maternal health in the WHO Constitution with how the Millennium Development Goals (MDGs) seek to improve maternal health, reduce specific disease burdens that significantly affect women, such as HIV/AIDS and malaria, and empower and educate women so that they are in more control of their lives and therefore their health.

Behind the Gender Paradox

My description of the conceptual components of the dynamic that generates standards for women's health does not, of course, explain the paradox I mentioned earlier. In fact, I have only told one part of the story, the part about the formulation of standards. Experts at this conference have repeatedly noted the failure of countries to live up to responsibilities established through binding and non-binding standards on the protection and promotion of women's health. Therefore, I need to add additional elements to the picture. Unfortunately, what I will describe is something familiar to many areas of international law and global health because it focuses on the failure of effective implementation of international norms and standards at national and local levels.

Conceptually, after formulation, a standard or norm must be incorporated into policy and then implemented in the politics of a society. The formulation stage is really about framing a problem, and I have already described how governments and non-governmental actors have used human rights principles to frame understandings of epidemiological evidence concerning women's health. The use of human rights produces norms or standards designed to guide future action. These norms then have to be incorporated into policy and law. Gender mainstreaming has been adopted as a strategy to achieve incorporation. The final step is implementation, putting the incorporated standard into actual practice in the lives of people in society. The incorporation and implementation phases are, thus, key challenges for gender politics with respect to women's health.

Unfortunately, the world of women's health displays an unstable, upside-down triangle effect, where we have lots of standards, less incorporation, and

even less implementation. The standard setting dynamic described earlier has proved robust in terms of formulating standards and increasingly active, through gender mainstreaming, in trying to incorporate gender-informed standards in many policy areas affecting women's health. Incorporation and implementation of gender-informed policy in international, national, and local politics is, however, considered sub-optimal by most experts. Here, for example, is the assessment of the implementation impact of gender mainstreaming by the former UN Special Envoy on AIDS in Africa, Stephen Lewis:

> The original idea was intended to use gender mainstreaming as a transformative' strategy . . . that is to say, there would be a radical transformation in gender relationships. It has not happened, least of all within the United Nations itself. There is not a single assessment of gender mainstreaming that I have read . . . that is fundamentally positive. Every single one of them ranges from the negative to an unabashed indictment.[10]

The contrast between the fertility of standard formulation and the barrenness of implementation seen in women's health is a reality all too familiar to those who study and practice international law, particularly human rights. Clearly, finding ways to improve implementation is a key challenge, but, at least conceptually, identifying potentially effective strategies is proving difficult, especially with respect to improving women's health in developing and least developed countries. To understand why the difficulties with implementation are increasing, we need to look at gender politics in the context of contemporary global health governance.

Gender Healthcraft and Global Health Governance

The dynamic I described that produces standards for women's health developed over time and came more fully into form in the 1990s, when gender mainstreaming grew in influence and use. But, it was precisely in the 1990s, particularly the latter half of that decade, that the politics of global health began to change dramatically. In other words, just as this standard-setting dynamic found its feet, the ground began to shift in ways that posed problems for advocacy for women's health. These political changes are often discussed in the literature on global health governance, which is a complex development that I do not have time to analyze comprehensively. Key aspects of this

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[10] Remarks by Stephan Lewis, *supra* note 1.

phenomenon are the increasing involvement of non-state actors in global health politics and the changing nature of state interests in global health problems. What I want to address is how the transformation in global health politics has affected the formulation, incorporation, and implementation of standards for women's health.

In terms of the formulation of standards, the last decade has seen dramatic changes in how states and non-state actors conceptualize global health problems. Rather than framing health issues in human rights terms, we have seen such issues increasingly framed as challenges to security and economic interests. This transformation of the conceptualization of global health has complex implications for standard setting for women's health. On the positive side, appeals to security and economic interests have been frequently used to bolster arguments for more attention on women's health. Women's health as an issue has, thus, become ammunition for arguments for human security and development strategies—just think, for example, of the MDG's that directly or indirectly touch upon women's health concerns. Security and economic arguments for more attention on women's health conveniently fall back on the guidance and recommendations for action developed through the traditional standard-setting dynamic, creating some level of synergy.

On the negative side, this synergy on standard-setting exacerbates the existing top heaviness developed through the traditional dynamic. In other words, the problem is not the lack of standards for women's health—the problem is the failure to incorporate and implement those standards.

Another problem linking health to security and economic interests creates is heightened competition for political attention and economic resources in developed countries for global health—and this competition often comes from new initiatives in which neither women nor human rights are the main motivations. Think, for example, of the significant emphasis now placed on health security as a national interest of states. The new initiatives may benefit women's health, but they are neither specifically for women's health nor the product of gender-informed analysis. This observation reinforces the new complexity that women's health as a policy objective faces.

Another effect of seeing women's health as a security or economic matter has been, at least in my experience, questions about what health and health-specific human rights concepts actually add to the pursuit of security and economic interests. I have increasingly heard skepticism about why it is necessary to frame large-scale sexual violence against women in war or in

peace as a violation of the right to health when, morally and legally, such violence is first and foremost a shocking violation of civil and political rights. This approach retains a human rights angle but privileges civil and political rights over economic, social, and cultural rights with respect to human security for women.   Beneath this skepticism of health-specific rights is perhaps opposition to the mantra of international human rights law that all human rights are interdependent and indivisible and an assertion that civil and political rights are the true keys to the political and economic empowerment of women.

In terms of the incorporation of standards for women's health, we again see the transformation in the politics in global health creating competitive pressures from the new norms and interests forcing women's health to play on the turf of security or economics or pushing gender approaches down the political agenda.   These competitive pressures tend to make the standard-setting dynamic of women's health I described earlier less germane.   Let me give you an example that comes from a February 2007 speech by the new WHO Director-General. Margaret Chan.   This speech addressed the hot topic of health diplomacy in the 21st century.[11]   In the speech, Chan mentioned women's health only once, as a sub-topic under the linkage of health and development, and she spent most of her remarks on health security, which she did not connect to women's health issues, not even sexual violence against women.   This example illustrates how the terrain has shifted in women's health in ways that mean that standards for women's health face heightened competition for incorporation attention from the new conceptualizations of how we should frame global health issues.

In terms of implementation, let me briefly highlight four issues that I think standards for women's health face today.   First, the unprecedented increase in global health activities we see today has led to an increase in the so-called vertical programs and initiatives—much to the frustration of public health experts who want horizontal, system-wide health capacity built in developing and least-developed countries.   The intensification of these vertical initiatives, seen especially in the context of HIV/AIDS, also confronts the comprehensive, horizontal ambitions of gender mainstreaming. The transformative impact gender mainstreaming seeks to achieve faces, therefore, an accelerating disaggregation of governance in developing and least-developed countries.

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[11]   Margaret Chan, Director-General, World Health Org., Health Diplomacy in the 21st Century: Address to Directorate for Health and Social Affairs, Norway (Feb. 13, 2007), http://www.who.int/dg/speeches/2007/130207_norway/en/index.html.

The gender perspective is not the victim of divide and conquer but rather of divide and dissipate the impact empirical evidence, human rights norms, and gender mainstreaming could have across all levels of governance and societies.

Second, accelerating verticalization produces a rational preference for technical or technological responses to women's health problems, such as access to anti-retrovirals, sanitation systems, vaccines, and maternal hospitals, rather than socially transformative political, economic, and cultural changes advocates for women's health believe are necessary to address effectively the root causes of gender health disparities.

Third, implementation of standards for women's health has also been challenged by some political and religious push-back from various conservative forces in developed and developing societies. For various reasons, these forces have explicit or implicit issues with what they perceive is a radical agenda of social change pushed through activities on women's health.

Fourth, among those most concerned about protecting and promoting women's health, anger, frustration, and disillusionment are growing with the implementation failures at national and international levels. Stephen Lewis noted, for example, his surprise at the number of women's health advocates "who have expressed an almost venomous skepticism about the UN's capacity to perform. They have noted the miserable sidelining of women and women's issues and are close to writing off the entire UN on that basis . . . . I had not fully realized how much the United Nations is at a crossroads in the minds of so many."[12] This anger, frustration, and disillusionment are causing a rather soul-wrenching but urgent search for new, more effective ways to implement existing standards for women's health—but the search is not, at present, going well.

These various challenges at the formulation, incorporation, and implementation stages have produced some of the interest that is growing to one particular proposed solution to the crisis faced by women in the world today. I am referring to the proposal, endorsed recently by the new UN Secretary-General, for the creation of a new UN organization for women.[13] This proposal to create new global gender governance architecture is aimed at

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[12]	Remarks by Stephan Lewis, *supra* note 1.
[13]	Press Release, General Assembly, Secretary-General Urges General Assembly to Consider High-Level Panel's Proposals to Make Organization More Coherent, Efficient, Accountable, U.N. Doc. GA/10586 (Apr. 16, 2007), *available at* http://www.un.org/News/Press/docs/2007/ga10586.doc.htm.

establishing a mechanism that can produce effective country-level implementation of global standards protecting and promoting women's rights, including health.[14] Interestingly, support for new governance architecture for women's health mirrors the growing interest in new architecture for global health governance more generally. But, in order to escape the existing stagnation on implementation, this new gender governance mechanism will need to have power to make national governments act and financial resources on a scale required to help women, especially women in developing and least-developed countries.

One immediate reaction to this proposal has been, "Are you kidding me?" This reaction draws on the deep disappointment and disillusionment already caused by an existing, high-profile reform effort at the UN that has, so far, disappointed just about everyone. I am referring, of course, to the new UN Human Rights Council. But, in keeping with my role as a scoundrel interested in generalities, let me explain two important conceptual problems that stand as significant obstacles to the hope that a new, powerful, and well-resourced international organization will be created to implement standards on protecting the rights and interests of women.

I want to argue that what we face today in global health generally and women's health specifically are two anarchy problems. Now, when I say "anarchy," I use the term as international relations theory uses the term, as an analytical concept that simply means the absence of any recognized, common, and superior political authority. Global health happens in the condition of anarchy that characterizes international relations. We are familiar with the problems that this condition of anarchy creates for relations between states. In this context of what I call old-school anarchy, we know from long experience that states resist creating international organizations that have real authority over sovereign states or independent discretion over serious financial resources. Why this long-standing resistance would disappear when the issue is women's health is not clear. Thus, the old-school anarchy problem poses significant barriers to the creation of a new women's organization within or outside the UN that would have real power and large-scale financial resources.

But we also face another anarchy problem—what elsewhere I have called the open-source anarchy problem. Very briefly, the problem of open-source anarchy focuses on the difficulties that non-state actors and their involvement

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[14] *See id.*

in global health causes for the need for better global health governance. Traditionally, anarchy was the province of state actors and was largely closed off to significant non-state actor participation. Anarchy, especially in global health, is now, however, open source, to make an analogy to the world of software, meaning that non-state actors can access and effect anarchy in ways historically denied to them under old-school anarchy.

Now, let me connect the reality of open-source anarchy to the expansion of global health activities by non-state actors seen in the past decade, which aggravate the problem of vertical health initiatives expanding at the expense of needed horizontal, system-wide health sector reform and capacity building. Non-state actors are playing a growing role in the verticalization phenomenon. But what architecture or governance mechanisms do we realistically have to centralize, harmonize, and rationalize the global health activities of both state and non-state actors simultaneously? Opposition to such architecture will come not only from states but also non-state actors. Non-state actors do not want to be brought under intergovernmental or public control because they prize their independence and the influence they have now gained in open-source anarchy.

In addition, NGOs and foundations know that their limited financial resources and personnel can only really be tasked to more vertically inclined activities because they are more manageable compared to the political, economic, cultural, and technological transformations that gender mainstreaming insists must be done to protect and promote women's health.

The combination of the problems of old-school anarchy and open-source anarchy spell real trouble for not only the desire for new global gender governance architecture but also women's health in developing and least-developed countries. The political dynamics these two anarchy problems create stand directly in the path of the kind of significant, radical governance transformations that many perceive are critical to advancing implementation of standards for the protection and promotion of women's health in developing and least-developed countries.

Conclusion

It is time for me to conclude. I argued that the combination of empirical evidence, human rights norms, and gender mainstreaming has been impressive in its ability to generate global standards for women's health. Although impressive, this system of standard setting is, in the opinion of many, showing

serious design flaws and is in danger of being overshadowed by other developments in global health. The problems have sparked a search for the next "big idea," one of which is the new global gender architecture of a new UN women's organization. This "big idea" faces not only searing skepticism about the ability of the UN to reform itself effectively but also the two anarchy problems I described, which produce political dynamics such that neither states nor non-state actors have rational interests that support a powerful, well-financed women's organization that can centralize, rationalize, and harmonize their efforts in global health.

Paul Farmer once argued that if you want to prevent a Haitian woman from getting HIV, then you should find her a job.[15] This argument takes the debate in the opposite direction from the proposal for new global gender architecture at the UN. It takes us back to the woman living in poverty who needs more control over her body, livelihood, and dignity. Find her a job. It sounds so simple, particularly against the sobering obfuscation produced by generalities that are the refuge of those who do not have any answers. But, unfortunately, the combination of empirical evidence, human rights principles, and gender mainstreaming teaches that "find her a job" is, indeed, no easy matter. Fortunately for humankind, women continue to demonstrate resilience, perseverance, and hope that, paradoxically, that should fill us simultaneously with profound awe and deep shame.

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[15] *See* Paul Farmer & Laurie Garrett, *From "Marvelous Momentum" to Health Care for All: Success is Possible with the Right Programs*, COUNCIL ON FOREIGN RELATIONS, July/Aug. 2006, http://www. foreignaffairs.org/20070301faresponse86213/paul-farmer-laurie-garrett/from-marvelous-momentum-to-health-care-for-all-success-is-possible-with-the-right-programs.html.