

Human Rights and Social Equity Approaches to Reproductive Health in the United States

[Presentation by Catherine Albisa, NESRI Executive Director, to plenary at the American Public Health Association Conference on November 7, 2006]

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Thank you for this opportunity to speak today to all of you who represent the public health community, and who are in many ways the frontline in the struggle for realizing the human right to health for all people. The topic for this plenary is reproductive health, in preparing to speak to you today I pulled this text from the World Health Organization just a few days ago:

Future of sexual and reproductive health at tipping point

November 1, 2006 — The first-ever global study of sexual and reproductive health to be published in the medical journal *The Lancet* starting this week shows a picture of **declining financial support, increased political interference** and an **overall reluctance to tackle threats to sexual and reproductive health**. The evaluation shows that more than half a million women die as a result of complications in pregnancy and child-birth every year and an estimated 80 million women have unintended or unwanted pregnancies each year. That paragraph is troubling on so many levels that it is impossible to discuss all of them – but the first thing that struck me is that when I started out almost 20 years ago, idealistically and enthusiastically working as an attorney on reproductive rights in the United States I distinctly remember being concerned about:

1. Declining financial support;
2. Increase political interference; and
3. An overall reluctance to tack threats to sexual and reproductive health.

At the time, it seemed a simple matter to me, to educate judges and policy makers about what would improve reproductive health and ensure the well-being of women and their families. After all, once they saw that their misguided policies actually harmed, rather than protected health, it would only be a short time before all this nonsense was corrected. So, along with my colleagues, we went into courts and into the legislatures armed with facts and studies – which possibly many of you compiled, analyzed and published, utterly convinced that your voices, and your expertise and knowledge would carry the day.

I am desperately sorry to report that I was mistaken. Over time, I worked on the right to accurate sexuality information for adolescents, I worked on access to abortion for poor women, I worked on opposing the coercive use of reproductive technologies and the punitive policies against pregnant women, and I oppose the family cap that penalized poor women through the welfare program for choosing to have children. Today, we continue fighting the same battles while public health continues to suffer.

At some point, I was able to pause long enough to notice that in most of the arguments we were putting forward, health almost seemed an afterthought. We argued quite a bit about privacy, occasionally equality, and wherever it worked, the separation of church and state. Then we would say, and by the way, this is good for women's health – here are the studies.

Although all of the activists working in the field passionately believed in the value of health, we were trapped in a cultural, legal and political framework that divorced reproductive freedom issues from health. That framework persists today, and my view is that it is of paramount importance to tear it down, and build a new one where health is squarely at the center of the debate. That is a debate that we, as a progressive community committed to human rights, can ultimately win. It is hard to argue against health.

Yet, it is clearly not a simple debate. In order to win a debate you have to be able to define the terms, and this is where I think that approaches such as a health equity approach and social determinant theory that emerge from the public health community and human rights analysis can become mutually reinforcing and integrated tools that allow us to frame and ground public health messages in a way that can make them both persuasive and ultimately, with some translation, accessible and compelling to a wide audience.

First let us look at the parallels in these approaches and why they need each other. We must start by answering basic questions such as “what kind of entitlement is afforded by a human right to health?” Now, under the global standards each person is entitled to the “highest attainable standard of health.” But how do you determine what that is? Relying here on health equity experts, such as Paula Braveman and Nancy Krieger, you begin by examining differences in health status according to factors that reflect social advantage and disadvantage, and the “highest standard of health” is usually represented by the group with the greatest social advantage.

This analysis is important to reproductive health in two ways. First, it addresses inequities among groups of women and helps us unpack the role of race, class and other social exclusions in reproductive capacity and health. Second, using a different set of criteria it could help us unpack gender differences with regard to STD’s, healthy sexuality, etc. As Nancy Krieger writes: Accounting for, and being accountable to, the public’s health (or the human right to health) requires carefully documenting and analyzing social inequalities in health. Obviously, the question of discrimination – a central concern of human rights – is also raised by this analysis as it requires comparisons of social groups.

How does this translate into a solidly grounded position for a wider audience: everyone deserves to be as healthy as possible and your health should not depend on your income, race or gender. Most people would agree with that, but we need to monitor health equity to make it known when this basic principle is being violated. The evaluative framework can be provided by health equity approach and the value framework by human rights. As Braveman also writes, “although monitoring health equity is a scientific endeavor, its fundamental objective is guided by values.” Ultimately these are human rights values.

In addition to objectives and values, human rights also addresses the question of accountability – governments are required to progressively implement a national plan of action to realize the human right to health. But how do you measure and evaluate that obligation to progressively implement it? From a health equity approach you ask how social disparities in both health and its major determinants change over time, whether the gaps are diminishing, and whether progress is sufficiently rapid.

Human rights instruments also take the position that rights are “interdependent” – which is the simple recognition that if your right to housing is violated, your right to health is also compromised. Social determinant theory would say that the denial of health care services is a “proximate/downstream determinants” of health, and that the failure to ensure adequate housing is a “distal/upstream determinants” of health –but both frameworks recognize the interdependence of these issues.

This is an important concept for an accurate analysis of reproductive health concerns, particularly how broader issues of gender discrimination impact on reproductive health through these “distal or upstream” determinants. As just one example, we know very well how the threat of homelessness, or losing custody of one’s children due to homelessness coerces women into accepting higher risk sex with unreliable, and at times, violent partners upon whom they rely for economic security – and how women’s less privileged economic position creates this vulnerability. Both social determinant theory and human rights recognizes the complex and often indirect web of violations that threaten public health.

The various pieces that make up the human right to health are too varied to detail in one talk – but I wanted to just raise a few of these basic human rights concepts that have clear parallels in public health discourse. I tend to think of human rights as the software and rigorous health equity evaluation tools as the hardware to create a health system that is truly directed at preserving and ensuring public health. And for obvious reasons, the software and the hardware of any system must be aligned so that they can work well together.

Let us go back and look at the threats identified on the WHO website – and while this was a global report, a list made for the US would look very similar. First, let us look at declining financial support. We see this threat in attacks on the Medicaid program and clear strategies to limit funding, decreased financial support for immigrants, etc. When it comes to reproductive health issues for the poor, this is one of the gravest threats. And declining financial support is linked to the second threat of “political interference” because funding it is often the first venue where reactionary forces attack the availability of a particular health service – be it contraception, abortion, etc.

The threat of political interference is usually an attack on women’s autonomy – you see this in threats to limit the legality of reproductive health services or to use funding streams to deprive women of accurate information to make informed health decisions.

And the third, an overall reluctance to tackle threats to reproductive and sexual health. In the United States, I would suggest this manifests itself as a reluctance by policy makers to even acknowledge such threats at times – certainly this is the case with LGBTQ youth and that population’s need for services and support. Additionally, the needs of women without immigration papers are severely under-addressed. Finally, the needs of pregnant women at high risk generally seem to fall into that category, except when policy makers choose to take a punitive approach and it appears more like a political interference with public health objectives.

These three threats all emerge from the combination of the commoditization of health care and gender hierarchy. As a community, reproductive health advocates and experts should develop a broad strategy of addressing these trends within a human right to health framework, buttressed by health equity evaluation tools and analysis. This puts health at the center for the debate, and links the reproductive health struggle strongly to other struggles for health equity.

Too often, as reproductive health advocates in the United States, we have fought for our issues without considering how they fit in with the broader public health effort. We argue that women should receive a fair share of funding, for example, without adequately considering whether the resources allotted to the health budget are equitable to start. To build a strong health movement the latter approach must start to dominate our efforts or we will continue climbing the same hill for decades without appearing to make progress.

Again, to win a debate you must be able to define the terms. The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” This approach is also reflected in human rights instruments. Physical and mental well-being requires access to services and protection from coercion. Social well-being requires equitable social policies that address the marginalization of communities.

That definition has been criticized by some as idealistic. It seems we are at an unfortunate moment in history where to have ideals is somehow suspect and inherently problematic. Better – some argue – to be realistic and accept that health is a commodity and part of a broader market where it can be bought and sold depending on individual’s level of financial resources and social power. We can then, those voices argue, work to make the market as “efficient” as possible, which is the best we can do.

But health is a core aspect of equality, dignity and freedom, and human rights requires a clear commitment to universal access to quality services for all people, regardless of geography, wealth, gender, race, sexual orientation or other status. This commitment from the public health and advocacy community must never waver and we must build strong solidarity relationships between us to achieve social justice in health in the United States and around the world.