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Thematic Section

Gender, Health and Globalization: A critical social movement perspective

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ABSTRACT *Manisha Desai looks at the international women's health movement (IWHM). She argues that changing gender relations have engendered the discourse of global health and raised the particular concern of women's health to the forefront of discussions about health. At the same time, because of IWHM the globalization of health and disease have also become pathways to changed gender relations that have led to community level changes in norms and practices that reproduce gender inequalities.*

KEYWORDS *peoples' health movement; international women's health movement; international conference for population and development; primary health care; alma ata declaration; WHO*

Introduction

The attention to gender in the global health arena is primarily a result of women world wide connecting their community activism around health issues to the transnational level, first via the International Women's Decade from 1975 to 1985 and then in the 1990 s through 'linkage politics' via the various UN world conferences on human rights, population, social development, and the environment.

The international women's health movement (IWHM)[2], however, has not been as successful in engendering national and local policies and in raising expenditures on women's health. This is primarily a result of an unfortunate historical conjunction. Ironically, the engendered global health discourse coincided with the worldwide adoption of neoliberal policies, via Structural Adjustment Programs (SAPs), all through the 1990s that undermined its effectiveness in terms of women's well-being and health.

The international women's health movement

Health has long been considered a cross-border issue and attempts to protect the health of subjects and citizens within certain territories also have a long history from the quarantines during the plague epidemic of the middle ages to the various colonial health policies that in its civilizing mission disciplined or destroyed various 'native' healing and health practices (Prasad, 2003). But health as an international issue began to take shape first with the League of Nations and then more specifically with the

development of the United Nations and its specialized agencies such as the World Health Organization (WHO) and the United Nations Fund for Children (UNICEF).

Initially, the international health focus was on developing norms and standards of technical knowledge and spreading the expertise about prevention and cure around the world and developing programs geared towards the needs of developing countries. These international efforts followed one of two approaches, either they focused on specific diseases and its eradication like small pox, polio, and other such efforts or they supported general health care (Gomez-Dantes, 2001). Both these approaches saw gender only in terms of women's reproductive health, primarily as targets of population control policies.

The international health regime was state-centered and top-down focusing on the role of the medical experts and as far as women were concerned, the role of contraceptive technology. As Manderson and Whiteford (2000) argue, too often the international health regime developed plans as though there is a level playing field around the world which led to obstacles in its implementation. Gendered and cultural local realities were rarely given any primacy in this regime.

These realities of the international health regime's attention (or lack of) to women's health were first challenged by the second-wave of the feminist movements that were emerging in all parts of the world. In the US and the West, radical feminists sought to reclaim women's bodies and sexualities and self-help groups emerged in which women learned to perform self-examinations. The Boston Collective and its publication of 'Our Bodies Our Selves' was one of the landmark developments in the women's health movements. They also challenged the andocentric medical establishments and their appropriation of women's skills and knowledge, which were devalued when performed by women but valued when professionalized and institutionalized.

Most scholars see the emergence of the IWHM in these radical feminist groups in the US and western Europe (Higer, 1999). However, there were also women in other parts of the world who were in parallel developing a critique of the dominant health perspective based on their participation in community health and development projects as well as their activism in the liberation theology movements in Latin America and other radical student and peasant movements in India, China, and the Philippines. Upon independence in 1947 India had embarked on an innovative model of mixed economy and had developed primary health care centers in all rural areas as part of its community development project. In China, the bare-foot doctors were also a response to meeting the people's needs in rural areas.

And it was this work in Asia that inspired the 1978 concept of Primary Health Care (PHC) presented in the Alma Ata Declaration of the World Health Assembly. PHC was seen as the key strategy for achieving Health for All (HFA) by the year 2000. This strategy was based on the understanding that basic health care needs policies and programs have to address the underlying economic, political, and social disparities that lead to poor health. The principles that it encompassed were: 'universal access and coverage on the basis of needs; comprehensive care with an emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action for health; and appropriate technology and cost-effectiveness in relation to available resources' (Sanders and Chopra, 2003:105). These principles reflected the basic needs approach of development in the 1970 s.

A history of activism

Feminists, both radical and liberal, in the US and Europe were not as familiar with these development discourses as they were oriented towards the developing countries. But this was to change with the declaration of the International Woman's Year in 1975 and subsequently the International Women's Decade (IWD) from 1975 to 1985. This is the first time that women activists, not just governmental representatives, from different countries met at the NGO Forums that were held simultaneously with the three Women's World Conferences at Mexico City in 1975, Copenhagen in 1980, and Nairobi in 1985. The Forums were where activists and grass-roots workers contested

and shared meanings and strategies. These contentious events became more accommodative in Nairobi, partly because of its location there were more Third World women than western women; white women were critiqued in the US by women of colour and had become more class and race conscious; and the interactions over the decade meant that all women were developing knowledge about women's issues in other parts of the world and becoming less provincial and more open to other perspectives (Desai, 2002). Violence against women was the key issue around which consensus developed.

It was in this process of interaction with Third World Activists that the IWHM in the West, which had primarily been about reclaiming sexuality and abortion rights, began to consider population issues. This focus was facilitated by the scandals of the 1970s when contraceptives such the Dalkon Shield and Depo Provara that were banned in the US were dumped in the Third World, and sterilization abuses in India and China rationalized by the state as population policies came to light (Higer, 1999).

In these early years the IWHM in the West and the Third World focused on consciousness-raising and mobilizing outside traditional policy channels, primarily creating linkages with women's health groups around the world and sharing information and learning about women's health issues (Higer, 1999). Groups like ISIS International and the International Women's Tribune Center were formed in 1974 and 1975, respectively, to act as avenues of gathering and disseminating information and holding workshops and linking groups. In 1978, Women's Global Network for Reproductive Rights was formed with similar aims.

At this initial stage, the IWHM did not have much impact on reproductive policies as they worked outside the population policy framework and very few groups attended the first two population conferences sponsored by the UN in 1974 and 1984. This changed in the mid-1980s as a result of the transnational networks that had developed during the IWD and the IWHM was becoming more transnational than just western. In addition to the networks developed during the IWD, the IWHM activists also gained valuable knowledge and understanding of how to influence the UN system and policy debates. Most importantly, the IWHM formed epistemic communities, transnational networks of policy professionals and activists who shared common values and causal understandings and can exert significant influence on how issues are perceived, framed, and solutions are proposed.

Also, the 1980s were a decade of right wing governments in the US and Europe and many of women's rights were under attack. During the Reagan years, there was a cut in the US funding for the International Planned Parenthood and the UN Population Fund. Thus, the international arena became a more attractive site of action. Furthermore, the UN conferences and foundations provided resources for prep-coms where women from different regions could meet before hand to shape the agenda of the conference. All this meant that the IWHM became very active in the UN arena in the 1990s.

The 1990s were also the decade of several important UN conferences around human rights, environment, social development, and the fourth World Conference on Women in Beijing. The women's lobby was the most visible and vocal at these conferences as they planned innovative strategies to gain visibility for their issues. But the most important gains of this period were the linking of women's rights to human rights, redefining human rights to include rights violated by nonstate actors such as violence against women (Desai, 1999; Joachim, 1999), and broadening the definition of reproductive rights from family planning and 'safe motherhood' to including issues of sexuality, gender relations, and economic status. Also new institutional actors emerged such as the International Women's Health Coalition in 1984 and the International Network on Feminist Approaches to Bioethics (FAB) in 1992.

Women's linkage politics

Thus, the Cairo declaration linked the social and economic empowerment of women to their reproductive rights. This success of women's issues is tied to what Mayhew and Watts (2002) call 'linkage politics'. They sought credibility and funding

for women's issues by linking them to issues already high on the international agenda such as peace, human rights, and economic development. For example, in Nairobi gender violence was seen as an obstacle to peace as it was seen as an obstacle to human rights for all in Vienna. This, of course, highlights how secondary women's issues are in themselves that such linkages are necessary.

Based on 22 projects in 18 countries, Haberland and Measham (2002) illuminate the efforts of policy-makers, program managers, health workers, advocates, and clients in translating the Cairo declaration. Despite such gains in many countries, in the 1990 s the SAPs have wrought havoc on women's health.

Structural adjustment undermining women's health

In the 1980s and 1990s, despite the gains made by the IWHM there was a big shift in the international perception of health from a humanitarian issue to an issue of economic growth and security (Gomez-Dantes, 2001). This has meant the emergence and importance of new political actors in the international health arena such as the World Bank, the International Monetary Fund (IMF), and the World Trade Organization (WTO). These new actors have completely redefined the discourse on health as evident in World Bank's 1993 report titled, 'Investing in Health Care.'

The report emphasizes two strategies, 'introduction of market forces into the health care sector and the allocation of public resources according to criteria of technical and instrumental efficiency' 'The practical outcome of this orthodox neoliberal logic is health care reorganization that implies state withdrawal from the financing and provision of health services and a reorientation of public institutions toward selective assistance' (Laurell and Arellano, 2002: 194).

So we have two contrasting developments, on one hand health is defined by health activists and the IWHM as an issue of rights while the governments, pressured by the World Bank and IMF, define it as an issue of security linked to economic and political development (Kickbusch, 2003).

The main recommendation of World Bank's health reforms was privatization of health care to be understood as: introduction of user charges in state health facilities, especially for consumer drugs and curative care (the rationale was that the rich would be made to pay, thus leaving the government free to pay for community services and public health for the poor); promotion of third party insurance such as sickness funds and social security; promotion of private facilities and clinics; and decentralization of planning, budgeting, and purchasing for government health services.

One of the impacts of privatization of health reforms in Third World countries has been a cut in public health services, particularly primary care, and the increased use of nongovernmental and private voluntary organizations to deliver services. In Africa, NGOs provide between 25 and 94 per cent of health services. For example, 25 per cent of hospital care in Ghana is private, in Zimbabwe 94 per cent of services for the elderly are privatized, and in Uganda and Malawi 40 per cent of all health services are privatized. Privatization has greatly reduced government funded primary care, thus limiting the poors', particularly women's, access to health care. In some cases, health care is completely inaccessible to poor women. When poor women have to pay for health care from their meager earnings, they do so for their children but not for themselves.

Thus health reforms have made women even more vulnerable healthwise. In the United States, the linking of health care to employment has meant that women who are unemployed or work part-time have no health care. The UNICEF-sponsored Moner Report found that, in 16 of the 23 countries in the region, life expectancy had declined. In Russia, women lost 3.2 years. In addition to life expectancy, the maternal death rates in these countries are higher than in Europe generally.

In the mid-1990s, the World Bank came under severe criticism from governments and health movements around the world. It now advises governments to provide some health care and in low-income countries it recommends at least a clinical package consisting of perinatal and delivery care,

family planning, sick children's care, and care for diseases like tuberculosis and sexually transmitted diseases.

Thus, women's right to health is limited to their reproductive health during their child-bearing age and not at all stages of their lives. Violence against women, which affects women's and girls health at all ages, while recognized by the World Bank as a threat to their health, has received very little attention. Despite the focus on child-bearing years, women's reproductive rights have been curtailed.

Given this global effort to compromise women's health, despite the engendering of the global health discourse, the IWHM has sought a new strategy of going back to its movement roots and using the networks made during the IWD and the 1990s to launch a campaign for Health For All by collaborating with the People's Health Movement.

The people's health movement

While the above realities and the inequalities in the global health arena are being acknowledged by everyone, including the World Bank, 'Missing from this literature are analyses of how and why the social inequalities within and among our societies are generated and reproduced, and how the socioeconomic and political forces responsible for this situation are affecting the quality of life of our population' (Navarro, 2002: 1). The aim of the People's Health Movement is to highlight this analysis and to recommit to Primary Health Care and Health For All.

The People's Health Movement (PHM) is an 'international network of organizations and individuals that came together in 2000 to reignite the call for Health for All Now!' (www.phmovement.org). The goal of the PHM is 'to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities.' Its main aim is to begin with the work done by people's health movements around the world to develop long-term and sustainable solutions to health problems.

Towards this end, in December 2000 it held a People's Health Assembly (PHA) in Bangladesh. This PHA – the first of its kind – was a unique gathering. Unlike the WHO Health Assemblies this one involved people in village meetings, in district meetings, in national events, and in regional workshops to prepare for the global gathering in Bangladesh. The purpose of this Assembly was to bring together policy-makers, activists, and professionals to develop a People's Charter For Health and to strategize about ensuring that Health For All would be reality rather than a laudable goal. The Assembly took place in a community health centre in Bangladesh where the accommodations were modest and where people had a chance to talk about their concerns regarding health. Over 1400 people from 92 countries attended this inspiring assembly.

The preamble of the resulting People's Charter For Health, which drew upon the Alma Ata Charter of Health For All, reads as follows: 'Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence, and injustice are at the root of ill-health and the deaths of poor and marginalized people. Health for all means that powerful interests have to be challenged, that globalization has to be opposed, and that political and economic priorities have to be drastically changed. This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organizations and corporations' (www.phmovement.org).

What is crucial about this movement is that women's issues are central to its charter and women's networks and activists are key actors and decision-makers in it. This is a direct result of the successes of the IWHM during the 1980s and 1990s. Following the Assembly, the PHM has launched two important campaigns. The first campaign, coordinated by the Women's Global Network for Reproductive Rights, is the Women's Access to Health. From 2003 to 2005 the campaign will centre on primary health care for all people everywhere, 'taking into account, in theory and practice, women's reproductive and sexual health

needs.' May 28 2003, has been declared the International Day of Action for Women's Health. The 3-year campaign's slogan is 'Health for All – Health for Women'. In 2003 the Campaign will be primarily directed at national governments: 'Governments Take Responsibility for Women's Health.'

In order to celebrate the 25th anniversary of the Alma Ata Health For All Declaration and to remind the international health community of its commitment PHM launched in 2003 a year long global campaign to revive Alma Ata's vision of a holistic approach to healthcare which addresses the social, economic, and political determinants of health, rather than the World Bank's selective and privatized health care for a few. The campaign will be undertaken in over 92 countries from where delegates came to attend the first People's Health Assembly in Bangladesh. A focus of the campaign will be to promote the worldwide adoption of the People's Charter for Health (PCH), which they claim constitutes the largest consensus document on health since the Alma Ata declaration of 1978.

Conclusion

If globalization is understood as changes in spatial, temporal, and cognitive boundaries then all these have an impact on health (Lee, 2003). We have new spatial configurations of health and disease in all countries; temporally as the SARS epidemic demonstrates microbes travel faster across the globe as does information about monitoring, reporting, controlling, and treating diseases; in terms of the cognitive dimension there are contradictory effects, more knowledge is shared as shown by the PHM and there are more possibilities of adopting standards of health and workplace and environmental safety but at the same time messages of consumption based on US lifestyles and standards of beauty also become global which have devastating health effects around the world.

In this global context, as Garrett (2000 cited in Kickbusch 2003: 203) notes, the international players in the health arena, especially the World Bank and the IMF have 'betrayed the trust' on an unparalleled global dimension. This calls for a renewed focus by the IWHM on primary health for all based on people's needs and involving them in decisions that affect their lives. As Anne Donchin (2001) concludes, '…we need to hear stories of transformative strategies that have worked – stories by women near the centres of power and by those at the margin. Only through such continuing dialogue can we hope to interject feminist concerns into the dominant discourses and practices that define the norms of medicine and health care delivery services' (Donchin, 2001: 9).

Notes

1 This article is based on a paper prepared for a 'Gender, Health, and Globalization' Conference at Yale University, 20–22 June 2003.

2 See Melucci's (1999) definition of a social movement. For him movements are ongoing constructions of collective action and identity, always in progress. They are fragmented, heterogeneous constructions including a diverse set of organizational forms, ideologies, and identities. They are continually reconstructed through diffuse, decentralized subterranean networks. They aim to bring about social change based on myriad strategies and ideological positions. What makes such fragmented heterogeneous activity a movement is the self-identification with a larger web of feminist activism.

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