

**IWRAW ASIA PACIFIC OCCASIONAL PAPERS SERIES
NO. 3**

**LACK OF ACCESS
LACK OF CARE:
A reference guide
to women's right to health
in the international trading system**

International Women's Rights Action Watch Asia Pacific



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International Women's Rights Action Watch Asia Pacific



International Women's Rights Action Watch Asia Pacific (IWRAP Asia Pacific) is an independent, non-profit NGO in Special consultative status with the Economic and Social Council of the United Nations (registered as IWRAP).

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This paper was written by Liz Sepper during her internship with IWRAP Asia Pacific in 2004. Liz is a law student at New York University School of Law.

Special thanks to:

Gigi Francisco, International Gender and Trade Network – Asia (IGTN-Asia) •
Caroline Lambert • Meg Satterthwaite, Center for Human Rights and Global Justice, New York University School of Law

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International Women's Rights Action Watch Asia Pacific
2nd Floor, Block F, Anjung FELDA
Jalan Maktab, 54000 Kuala Lumpur, MALAYSIA
Tel: 60-3-2691 3292
Fax: 60-3-2698 4203
Email: iwraw-ap@iwraw-ap.org
Website: www.iwraw-ap.org

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I. Introduction

Globalisation is a fact of life. But I believe we have underestimated its fragility. The problem is this. The spread of markets outpaces the ability of societies and their political systems to adjust to them, let alone to guide the course they take. History teaches us that such an imbalance between the economic, social and political realms can never be sustained for very long.

Secretary General of the United Nations, Kofi Annan¹

A trade agreement is signed in Uruguay. A year later, a woman in a country thousands of kilometers away goes to the market and finds that the price of rice has gone up. "Well," she sighs, "we'll just have to make do with less until prices go down". But prices continue to rise, and she begins to skip meals to provide her family with more. Finally, she decides that she must find work to supplement her family's income and feels lucky to find homework plaiting wires for an electronics company. But the work leaves her back sore, her fingers cramped and, because she cannot afford good lighting, her eyes strained. One day, she wakes up to find that she cannot see out of her right eye and hurries to the public clinic. "It will cost USD1 to see a doctor," the receptionist tells her. "USD1?" she asks. "How will my children eat?" And so she learns that the public clinics are no longer free, to see a doctor she must pay. She knows even such a small sum will leave her without money for food and water, so she goes home, hoping but not believing that tomorrow her eye will clear and a trip to the doctor will no longer be necessary.

This is a hypothetical woman but her life is not unlike the lives of many women around the world. Though the circumstances of her life, both good and bad, might be attributed to local policies and national problems alone, the truth of the matter is that the economic situation which affects her access to and enjoyment of rights is not national but international, for trade is now largely decided at the global and regional levels, with consequences not just for one or two trading partners but for the rights of individual men and women in all nations. This process of "globalisation", that is, the institution of a global trade market, is now a fact of life. Experienced largely first through World Bank and International Monetary Fund (IMF) policies and now through various aspects of international economic policy, in particular trade and investment

¹ Address of Secretary-General Kofi Annan to the World Economic Forum in Davos, Switzerland, on 31 January 1999. SG/SM/6881.

agreements between nations, globalisation requires that advocates engage in the process to control and limit its negative effects, particularly those effects that relate to human rights.

While not all results of globalisation are negative, globalisation has often had a negative impact on women's ability to claim the full scope of their rights, especially their economic, social and cultural rights. The burdens and benefits of liberalisation and global economic strategies are distributed unequally not only between nations but also between men and women. Women have often disproportionately borne the burdens of trade while seeing few of the benefits, with detrimental consequences for their enjoyment of their human rights. This disproportionate burden that trade agreements tend to place on women and their enjoyment of economic and social rights points to a conflict between international

Myth 1 about trade agreements - Trade agreements deal with trade not human rights

While the World Trade Organisation (WTO) purports to deal with trade and its dispute panels pretend to have no say over human rights or labour issues, WTO agreements affect economic life which in turn invariably affects essential dimensions of human rights implementation.

Trade agreements can lower government revenues, thereby reducing public funds available for education, social security and healthcare. Though they may create jobs, trade agreements can also drive certain sectors out of business.

With trade agreements inevitably some goods, most significantly food stuffs, and some services such as health and education, become more expensive while others, sometimes the ones that people depend on for their income, become less expensive.

The benefits and disadvantages of trade also may be unevenly spread so that marginalised groups, particularly those living in poverty and belonging to minority communities – indigenous, migrant, elderly, disabled, etc. – are further deprived of basic social and economic rights.

trade rules and human rights. Yet, such conflict is not inevitable. It is possible for new trade agreements to be formulated in a way that encourages the enjoyment of human rights and gender equality.

Therefore, while this paper is not meant to be a comprehensive study of the effect of trade agreements on human rights, hopefully it will motivate advocates to begin thinking about the issue of trade and to pressure states to harmonise human rights and international trade obligations. While this paper focuses on trade and women's right to health, it is intended to serve as a more general framework of analysis that advocates can apply to trade and any number of social and economic rights. Ultimately, we hope that women's human rights advocates will be able to connect international trade to consequences (both positive and negative) for economic and social rights and then draw their governments into discussions of how trade and human rights can coexist. In our view, human rights treaties should be given primacy over trade agreements.

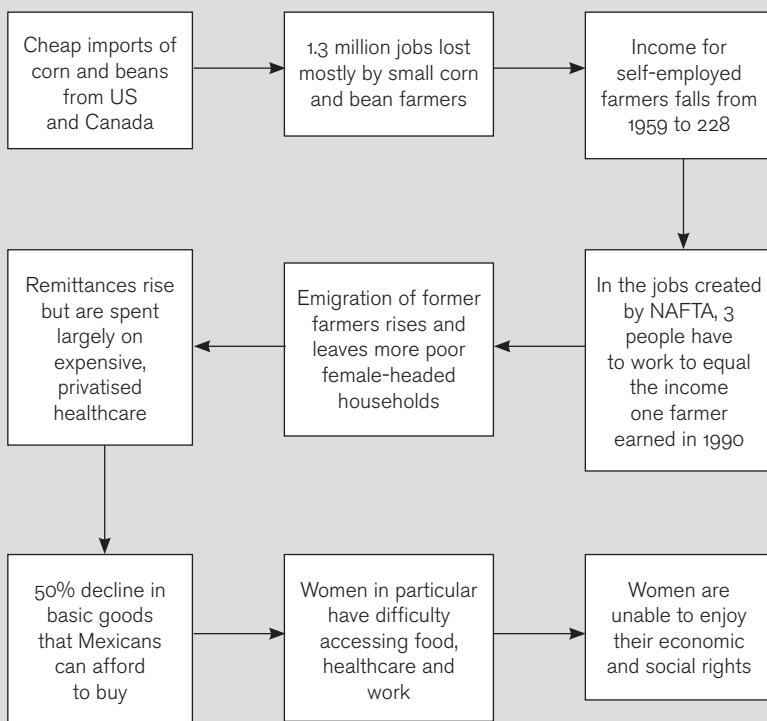
To provide a framework to begin to work towards these goals, this paper will: first, make the connection between trade agreements and women's right to health; second, establish the basis for the right to health and the importance of social and economic rights; and third and most importantly, provide women's human rights advocates with tools to hold their national governments accountable for the discriminatory effects of trade policies that impair women's enjoyment of economic, social and cultural rights.

Since trade agreements and health may seem initially unrelated, this paper will begin by showing the connections between them and the impact of trade on women's full enjoyment of the right to health. The right to health² should be understood not as a right to be healthy but rather as conditions under which one can control one's health and body and use "a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".³ Regrettably but understandably, trade agreements are usually

² Using CESCR General Comment No. 14 and other sources, IWRAP Asia Pacific has formulated a definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is not confined to health care, but includes socio-economic factors and extends to the underlying determinants of health, such as resource distribution, gender, food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment".

³ CESCR. General Comment No. 14. para. 8.

The relationship between trade and human rights The North American Free Trade Agreement and Mexico's corn imports



Statistics taken from: White, Marceline, Carlos Salas and Sarah Gammage. 2003. NAFTA and the FTAA: Gender analysis of employment and poverty aspects in agriculture. Women's Edge Coalition. November.

seen as separate and apart from the right to health. After all, to most people, trade simply means economic transactions between countries, including trade in goods and services and payments for foreign patents, while trade agreements are seen as mere contracts between states which aim to reduce tariffs and non-tariff barriers to trade. To most, trade concerns market access not rights. Yet although trade tends to impair the exercise of human rights by its very

nature, equitable fair trade could create enabling conditions for the realisation of human rights. For example, by causing prices of essential food items to rise or by promoting the privatisation of healthcare, international trade agreements can make women's enjoyment of the right to health more difficult and costly to attain. On the other hand, fair and equitable international trade agreements have the potential of creating jobs, lowering prices of commercial goods, and expanding access to medical technology, all of which positively affect women's right to health.

As the most influential trade body in the world, the nine-year-old World Trade Organisation (WTO) has great power to either impair or encourage the enjoyment of the right to health. Charged with administering a revised General Agreement on Tariffs and Trade (GATT) and more recent treaties such as the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the General Agreement on Trade in Services (GATS), the WTO includes 147 of the world's countries as at April 2004. By setting the standards for all international trade agreements negotiated bilaterally, regionally and multilaterally, the WTO impinges on a wider range of sectors than were previously involved in trade agreements and thus increasingly affects women's enjoyment of economic and social rights worldwide. Consequently WTO trade agreements and the enjoyment of the right to health have become inextricably linked.

Myth 2 about trade agreements - Trade is gender-neutral

While most trade agreements contain no language pertaining to gender, they may have a disparate negative impact on women. Because in most countries the majority of women have less access to resources and bear a heavy burden of reproductive work, they may be unable to attain any benefits of liberalisation or free trade.

Most importantly, trade theory presumes some groups and people will "lose" under free trade. These tend to be the poor, of whom 70 per cent are female. By not evaluating who is disadvantaged by trade agreements, trade representatives allow the repercussions of trade to continue to be borne by the poor and specifically poor women.

To explain the connection between legal obligations under WTO trade agreements and legal obligations under international human treaties, the second section of this paper will discuss the human rights basis for the realisation of women's right to health and State obligations in this regard. While we have chosen to focus on women's right to health, many human rights are implicated in the discussion around the highest attainable standard of health, for the right to health informs and is determined by a variety of other rights. Certainly, the determinants of health like water, housing and food can create the conditions necessary for women to enjoy, access and claim the right to health. The extent to which these and all other civil, cultural, economic, political and social rights are respected will prejudice or enable the realisation of women's human rights. Indeed, since human rights are indivisible and interdependent, the right to health bears upon other rights including the right to life, privacy and self-determination. In the same way, to the extent that international trade rules encroach on a state's ability to protect human rights and to develop economically, they impair the state's right to development.

Precisely because all rights are interrelated whether civil, cultural, economic, political or social, it is most essential that women's human rights advocates bring economic and social rights into discussions and challenge the tendency of trade policies to perpetuate a hierarchy of human rights in which civil

Myth 3 about trade agreements – Trade is an international not local issue

Trade agreements are negotiated on an international level, but their results are felt nationally and locally. The local impact of trade can be seen in the opening or closing of factories that provide employment for entire towns; a rise in the price of food staples like rice or beans; user fees at local health clinics; or the feminisation of certain sectors of the economy.

Furthermore, both the WTO and the UN are composed of member states and their policies do not exist independently of those states. Therefore, it is the national governments of member states who must be targeted for advocacy and whose obligations at both the WTO and under UN human rights treaties must be consistent.

and political rights are to be protected while social and economic rights are neglected. Therefore, though focusing on the right to health, this paper provides a framework through which to examine the interaction between trade agreements and women's human rights generally. Also and most importantly, this paper contends that, in order to ensure the right to health and to end the conflict between free trade and human rights, states must be encouraged to take these human rights obligations into account during trade negotiations.

Therefore, the last section of this paper will discuss the importance of advocates' understanding trade and human rights and engaging with national governments. As the WTO and trade agreements grow in importance and influence, it is essential that women's human rights advocates understand the effect of globalisation on their economic and social rights. In particular, advocates must understand that international trade agreements translate into and change national policies, often irreversibly, and that any effort for the implementation or claim of women's human rights must be undertaken with an awareness of the links to globalisation and international trade in particular. And so, while thus far women's NGOs have focused their advocacy on the UN, women's voices are also needed at national levels to influence trade agreements, hold their own governments accountable and prevent unintended repercussions of seemingly gender-neutral trade policies. In fact, the most important point of this paper with respect to advocacy is the necessity for strong national-level advocacy on trade and the introduction of a human rights perspective to trade and economics at a national level.

II. Trade agreements and their effect on women's right to health

International trade agreements affect women's right to health disproportionately, but they do not operate in a vacuum; nor are they the first economic policies to have a negative impact on women's health. Already, the implementation of structural adjustment programmes promoted by the World Bank and the IMF have reduced the meaning of the enjoyment of the right to health to only basic healthcare for the most vulnerable groups. These trade policies and World Bank plans have led to a decline in expenditures on public health as governments promote market-based health services, in line with their international trade commitments. Consequently, today, public health worldwide suffers and the health of entire populations, male and female, is impaired. Women are affected not only as members of the population generally but also as women specifically

and thus experience the compounded effects of discrimination. It is within this context that trade agreements operate to affect and sometimes obstruct women's enjoyment of the right to health. And it is within this context that advocates must work for implementation of trade agreements that facilitate greater enjoyment of women's rights.

Generally speaking, women's right to health is disproportionately impacted by trade agreements that reduce access to healthcare due both to biological differences (sex) and sociological factors (gender). Worldwide, women bear heavier burdens of work than do men. Combining reproductive work and employment outside the home, women tend to work longer hours and have much less leisure time than do men.⁴ In addition, carrying water, laundry, children, etc., in the course of their reproductive work causes them to suffer more frequent stress and strain-related injuries. Hard work and lack of leisure time consequently makes women even more susceptible to malnutrition, infection and diseases, especially during pregnancy and childbirth.⁵ When health services are available, because of their biological and reproductive functions, women also tend to have a greater need for health services and use them more often. Therefore, when access to healthcare is reduced, the opportunities for women to achieve substantive equality with regard to the right to health are further prejudiced.

Moreover, in all societies men and women differ in their access to both public and private resources, and usually the position of women with respect to those economic and physical resources is more tenuous. Traditionally, women's role as primary caregivers to the young and the sick restricts their access to paid employment and any paid employment they do assume is generally devalued.⁶ As a result, women constitute 70% of the world's poor, suffer the worse health that comes with poverty and may be more easily dragged into poverty through ill health. Overall, even within wealthier families, many women lack decision-making ability with regard to the family's resources. In developing countries which spend less than USD21 per person per year on healthcare, women's lack of access to resources causes routine health and reproductive services to be inaccessible for the majority of women.⁷

⁴ Whited, Melissa, Abraham, Minety, Fosse, Farah and Spieldoch, Alexandra. 2003. "Gender, Health and Trade". International Gender and Trade Network. August. pp1-2.

⁵ *ibid.*

⁶ Montréal Principles on Women's Economic, Social and Cultural Rights. 7-10 December 2002. <www.equalityrights.org/cera/docs/Mont_Prin_ENG.doc>

⁷ Whited. *op. cit.* p2.

Discriminatory practices with regards to women further exacerbate differences in access to healthcare. In many cultures, during hard times, women and girls are expected to reduce their caloric intake and avoid seeking medical care. Even in good times, girls typically receive inadequate reproductive counseling and less attention in the prevention of diseases than boys do.⁸ This discrimination against women in medical care and particularly in the treatment of sexually transmitted infections (STIs) greatly hinders the ability of many women to protect themselves from HIV and other STIs.⁹

Cause and effect? The difficulty of establishing the effect of trade on health

Proving the causative effect of trade policies on the deterioration in women's health is difficult to do. An initial difficulty arises because data on the effects of trade is often not sex-disaggregated. Even where sex-disaggregated data is available, showing a direct cause and effect relationship can be extremely difficult because trade is such a complex subject. Furthermore, certain policies such as trade in health services are going on regardless of GATS and while the WTO provides the legal framework for policies of, for example, liberalisation, such policies began before the WTO was organised. Often, however, there are intuitive links. For instance, women's access to healthcare may be affected by a new government policy which is a result of decreased government revenue which in turn is the result of liberalisation of trade in goods under a trade agreement. WTO rules can be shown to bind and perpetuate the current conditions.

⁸ *ibid.*

⁹ Report of the Special Rapporteur on the Right to Health. E/CN.4/2004/49. para. 34.

Additionally, cultural bias often prevents women from having the authority to negotiate safe sex and reproductive practices. For example in Kenya, research has shown that many communities discourage the use of the female condom not because women do not want to use it but because they are concerned that it “may allow women too much freedom, enabling them to ‘move around’ on their husbands”.¹⁰ As a result of this type of cultural bias, women often experience higher levels of exposure to STIs than do men. In all of Africa, the AIDS crisis is hitting women hardest; almost 60% of AIDS victims are female, and they often do not have the option of abstinence or condom use.¹¹ For these reasons, in Zambia, for example, women aged 15-19 are five times more likely to be infected with HIV than men of the same age.¹²

Therefore, even where empirical evidence of the impact of trade policies on health has yet to be compiled and analysed, any policies that impede enjoyment of the right to health will likely be borne disproportionately by women. Because women lack economic resources and decision-making power and experience the reproductive function, greater work burden and discrimination, their right to health must be expressly protected and reckoned for in the international trade process. Accordingly, the Special Rapporteur on Health has argued that women would benefit most if the right to health were taken into consideration in negotiating trade agreements.¹³ Indeed, analysis of several trade agreements and policies indicates both that there is a pressing need to consider the right to health when negotiating trade agreements and that women’s enjoyment of the right to health is impaired more than men’s when trade agreements are executed without consideration of health issues.

¹⁰ 2003. “Lessons from a Female Condom Community Intervention Trial in Rural Kenya”. Family Health International Research Briefs on the Female Condom. No. 7.

¹¹ Boseley, Sarah. 2004. “AIDS defeating world’s best efforts as record numbers are infected”. *The Guardian*. Wednesday, 7 July.

¹² Nanda, Priya. 2000. “Health Sector Reforms in Zambia: Implications for Reproductive Health and Rights”. Center for Health and Gender Equity Working Papers. August. p14.

¹³ Report of the Special Rapporteur on the Right to Health. Mission to the World Trade Organisation Addendum. E/CN.4/2004/49/Add.1. para. 57.

Some trade agreements with consequences for women's health

- *Agreement on Sanitary and Phytosanitary Measures (SPS)* which allows for challenges of domestic regulations that protect health.
- *Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS)* which gives pharmaceutical companies patent protection for drugs for 20 years, slowing the introduction of generics and raising prices. It also allows companies to take intellectual property rights over traditional medicines and practices of indigenous peoples.
- *Agreement on Technical Barriers to Trade (TBT)* which does not permit domestic health regulations that are more trade-restrictive than “necessary”.
- *General Agreement on Trade in Services (GATS)* which requires continuing and irreversible liberalisation of services which can include healthcare, water and sanitation. It also permits challenges to health regulations and encourages the transfer of skilled labour from developing to developed countries.
- *General Agreement on Tariffs and Trade (GATT)* which can cause a rise in prices of health necessities such as staple food items and requires that countries permit the importation of unhealthy products such as tobacco.

Challenges for Advocates

- Develop case studies and research to discover direct links between trade and women's health.
- Prepare fact sheets to make intuitive links between trade policy and women's rights clearer.
- Provide information on the effect of trade on women's health to national level officials .

Five ways trade agreements affect women's right to health and what advocates should know about them

1. The agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)

At first glance, intellectual property rights do not seem to be related to women's right to health or to human rights at all. However, intellectual property rights can and do directly affect women's enjoyment of social and economic rights. First and most obviously, patent protection has allowed large companies to patent natural processes and medicines that have long been used by indigenous peoples. This means that indigenous people no longer have a right to profit from these medicines or to determine to what use their traditional knowledge will be put. This has particularly dire consequences for women who are the healers and possessors of traditional medicinal knowledge in many cultures. For example, in Peru, a medicinal herb known as cat's claw, used by women healers to treat women's cramps, has been patented by a pharmaceutical company. This affects both the rights of female healers and the rights of women to access traditional medicine. Seeds used by indigenous peoples are also being patented and altered, affecting indigenous rights to use the seeds and to sell their products on the market.

Secondly, intellectual property patents do not allow for a decrease in prices and the resulting greater access to products. This does not present a problem when it comes to the latest cell phone technology. But, where the product is necessary for people to enjoy the right to life and health as in the case of malaria, HIV or birth control drugs, patent protection obstructs enjoyment of these human rights. Drugs simply become too expensive to buy even when they are necessary for life.

What are intellectual property rights?

Intellectual property rights are a way of providing legal protection for inventions or ideas as if they were physical property. In the same way that property laws punish and prevent others from stealing, borrowing or destroying a person's car, intellectual property laws prevent others from stealing or borrowing ideas. To attain intellectual property rights, a person must register the invention, artistic work or name with the national government. Such registered intellectual property falls into three basic categories: trademark (registered mark to identify a certain product or service), patent (for inventions), and copyright (for literary, musical and artistic works). The purpose of intellectual property protection is to encourage creativity and reward innovation; the idea is that without the possibility of financial recompense, a person will not dedicate time to research and invention. The theory of intellectual property law, however, involves a delicate balance between encouraging creativity, which

Preserving traditional knowledge in a TRIPS system

For thousands of years, Indians have been using saffron powder to heal wounds and cuts. Yet, in 1995 the US Patent Office granted exclusive ownership of the method of promoting the healing of a wound by administering saffron to two researchers from the University of Mississippi. Though the Indian Council of Scientific and Industrial Research challenged the patent in US court, two years passed before the researchers' monopoly was cancelled. Unfortunately, because advocates lack the resources to mount legal challenges, no other challenges have been made to thousands of "pirated" patents of traditional knowledge.

However, developing countries are attempting to protect their ancestral knowledge in new ways. Kenya, for example, intends to introduce the protection of "indigenous knowledge" into its laws. In India, where 7,500 medicinal plants are recorded, civil society is pressuring the government to introduce the concept of "prior art" when it amends its intellectual property law to conform to TRIPS. Further, some primary healthcare practitioners have taken the initiative of drawing up "registers of common property" as evidence of the indigenous people's ownership of the knowledge.

Source: <<http://mondediplo.com/2001/03/13health>>

provides society with the benefit of innovation, and fostering competition, which benefits society through lower prices and greater access to invention.

An introduction to TRIPS and its flexibilities for the protection of health

Implemented in 1995, the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) represents the first time intellectual property rules were introduced into international trade agreements. Under TRIPS, upon joining the WTO, each state must bring its intellectual property rules into conformity with TRIPS articles; least developed countries, however, are given a ten-year grace period from application to the WTO to bring their laws into line (this was later extended to 2016). As a result, eventually there will be international uniformity

of intellectual property rules, providing patent¹⁴ holders with twenty years of protection for products or processes.

A number of TRIPS articles do, however, permit a state the flexibility to implement patent rules that are particularised to its own needs. Article 40, for instance, allows adoption of measures against anti-competitive practices, the definition of which are left to the state. Establishing state's ability to protect health, Article 27 allows exclusion from patentability inventions whose commercial exploitation must be prevented to "protect human, animal or plant life or health" and Article 8 permits members to "adopt measures necessary to protect public health and nutrition". Furthermore, in November 2001, with the much-lauded Doha Declaration, member states of the WTO confirmed the right of any state to deal with health problems by issuing compulsory licenses to override patent protection. To put it briefly, where drugs are not available due to a lack of supply or an unreasonably high price, compulsory licensing allows a state to issue a license to a generic pharmaceutical company for the production of a drug under patent protection; in addition, compulsory licensing can be used to remedy anti-competitive practices or for public non-commercial use.¹⁵

Almost two years after Doha, the WTO resolved the problem of what to do when a state has no pharmaceutical manufacturing capability (the so-called paragraph 6 problem). This problem arose because Article 31(f) says that production under a compulsory license must be predominantly for the domestic market, meaning that where a state with no manufacturing capacity granted a compulsory license to a generic producer in another state, the generic producer might not be able to fill the demand for imports since the majority of the drugs produced must go to the domestic market. The WTO decided, in short, that a state with insufficient or no manufacturing capacity must first notify the WTO and take measures against diversion of the generic medicines; then, in most cases two compulsory licenses will have to be issued, one by the exporting country, one by the importing country. The pharmaceutical company in the exporting country must then make only the amount requested, clearly identifiable by colour or label, and then export the entire amount.

¹⁴ The World Intellectual Property Organisation defines a patent as "an exclusive right granted for an invention, which is a product or a process that provides a new way of doing something, or offers a new technical solution to a problem". The patent then provides protection for the invention, meaning that the "invention cannot be commercially made, used, distributed or sold without the patent owner's consent". <www.wipo.int/about-ip/en/about_patents.html#protection>

¹⁵ Williams, Mariama. 2001. "The TRIPS and Public Health Debate: An Overview". International Gender and Trade Network. August. p3.

The problem with TRIPS

While TRIPS theoretically gives states the ability to prioritise the protection of health, even after Doha, it remains riddled with serious practical problems that may effectively preclude states from safeguarding health. First of all, the main problem with the WTO's paragraph 6 decision, the most recent development on the protection of health under TRIPS, is that it allows countries with generic manufacturing capacity to permit exports, meaning they must pass legislation first to be able to do so. Thus far, only Canada, under considerable pressure from civil society, has passed such legislation.¹⁶ Even where the requisite legislation is enacted, the cost of making each batch of drugs identifiable as well as the seeming requirement that one reapply for a compulsory license for each batch may deter generic manufacturers from producing drugs under compulsory licensing.¹⁷ "Piecemeal, ambiguous and difficult to administer,"¹⁸ by and large, TRIPS may prove too complicated for developing countries and generic manufacturers to use.¹⁹

Most significantly, TRIPS delays the introduction of generic drugs and raises the costs of treating disease.²⁰ In spite of flexibilities in TRIPS articles, once TRIPS is fully implemented, the price of protecting the right to health will certainly rise.²¹ It is estimated that drug prices will increase two-fold or more, making many drugs economically inaccessible.²² Since patented drugs are sold at twenty to one hundred times marginal costs,²³ experience has shown that the introduction

¹⁶ Elliot, Richard. 2004. "Canada's New Patent Bill Provides a Basis for Improvement". *Bridges*. No. 5. May. pp19-20.

¹⁷ Oh, Cecilia. 2003. "The New "Deal" on TRIPS and Drugs: What does it mean for access to medicines?". Third World Network Briefings for Cancun 4. pp3-4.

¹⁸ Williams. *op. cit.* p5.

¹⁹ 2003. "Robbing the Poor to Pay the Rich? How the United States Keeps Medicines from the World's Poorest". Oxfam Briefing Paper. November. p12.

²⁰ Williams. *op. cit.* p2.

²¹ It should be noted that intellectual property protections are not the only contributing factor to the high price of drugs. In fact, many developing countries engage in the destructive practice of imposing high taxes on essential medications. See "Working document on developing countries' duties and taxes on essential medicines used in the treatment of the major communicable diseases". European Commission Directorate-General For Trade. Brussels. 10 May 2003. Ref. 135/03. <europa.eu.int/comm/trade/issues/global/medecine/docs/wtosub_100303.pdf>

²² Oh, Cecilia. 2003. "WHO Assembly Adopts Resolution on IPRS and Public Health". Third World Network. 29 May.

²³ Williams. *op. cit.* p2.

of generics (whether through compulsory licensing or not) is the single most effective way to reduce prices and make medicines widely available.²⁴

Similarly, though much has been made of the UNAIDS initiative whereby pharmaceutical companies pledge to reduce the price of drugs, it will result in only a 6.7 times price reduction, whereas concerted international procurement efforts of vaccines and oral contraceptives for sale to poor countries have reduced prices by 33 times and 240 times respectively.²⁵ Therefore, preventing the introduction of generics for twenty years by protecting pharmaceuticals will inevitably cause a rise in prices.

TRIPS rules also stand to limit the introduction of generics even after the twenty-year time frame has passed, since the WTO has ruled that states may not allow generic companies to stockpile drugs before a patent has expired, a decision which delays introduction of generics to the market. If read broadly, Article 39.3 of TRIPS could further delay access to generics by requiring governments to provide protection for marketing approval data which would mean generic companies would have to expend time and money generating data of their own.²⁶

The ensuing increase in the cost of drugs will have dire effects for health crises like HIV/AIDS with direct implications for women's right to health and reproductive health. For example, the female condom, described by its manufacturers as "the only available product controlled by a woman that protects against sexually transmitted diseases including HIV/AIDS and unintended pregnancy," is under patent protection in a number of countries and may be more expensive than male condoms as a result of lack of competition.²⁷ Similarly, in Uganda, antiretroviral drugs which are under patent protection

²⁴ *Oh. op. cit.*

²⁵ Zakrisson, Tanya L. and Hamel, Paul A. 2001. "Access to Medicines: The global debate over 'free trade'". *University of Toronto Medical Journal*. Vol. 78. No. 2. March. <www.utmj.org/issues/78.2/NVForum.pdf>

²⁶ Koivusalo, Meri. 2003. "The Impact of WTO Agreements on Health and Development Policies". *Globalism and Social Policy Programme Policy Brief*. No. 3. January. 5.

²⁷ See <www.aegis.com/news/pr/2003/PR030350.html>. PR Newswire. 27 March 2003. The Female Health Corporation, however, was developing a cheaper alternative to the current female condom and has worked actively with various NGOs and UN agencies in attempting to reduce transmission of STDs.

are currently in short supply because they are prohibitively expensive for the government; as a result, even those for use as post-exposure prophylaxis (PEP) for rape survivors are not widely available, with direct implications for women's right to health and reproductive health.²⁸ In Uganda as well, when families are unable to pay for treatment for all family members, they almost always choose the men, leaving the women without access to medicine.²⁹ Patent protection under TRIPS will not just affect drug prices but also will have repercussions for women's healthcare in general as increasing drug costs decrease public funding available for primary healthcare or other public programmes (especially in developed countries where 75 per cent of drug costs are publicly or privately insured).³⁰

Implementing TRIPS in a way that is consistent with human rights

Despite all of its problems, TRIPS may be implemented in a way that does conform to a state's obligations to protect health.³¹ By taking full advantage of flexibilities in TRIPS and using them to its advantage in negotiations with pharmaceutical companies and in production of generics, a developing country may successfully protect its citizens' right to health while providing patent protection that encourages research and development. In fact, Brazil has managed to implement its intellectual property laws in a way that is both consistent with TRIPS and its pre-existing human rights obligations. And, Brazil's successful HIV/AIDS strategy should not remain an exception as it is attainable for many Latin American and Caribbean countries and perhaps others.³²

²⁸ 2003. "Just Die Quietly: Domestic Violence and Women's Vulnerability to HIV in Uganda". Human Rights Watch. August. Vol.15. No. 15. <www.hrw.org/reports/2003/uganda0803/6.htm#_ftnref417>

²⁹ 2002. "Generic Competition, Price and Access to Medicines: The Case of Antiretrovirals in Uganda". Oxfam International Briefing Paper. No. 26. 10 July. p2.

³⁰ Labonte, Ronald. 2003. "Dying For Trade: Why Globalisation Can be Bad for Our Health". CSJ Foundation for Research and Education. Toronto. p12.

³¹ See Elliot, Richard. 2001. *TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property*. Canadian HIV/AIDS Legal Network AIDS Law Project South Africa.

³² "The FTAA, Access to HIV/AIDS Treatment". *op. cit.*

Implementation of TRIPS and the right to health: The Brazilian case

By instituting an HIV programme distributing antiretroviral drugs for free, Brazil has halved AIDS mortality since 1997. Even in the short term, this programme has proved cost effective, resulting in savings of USD472 million in hospital and treatment costs for AIDS-related opportunistic infections and, according to Brazil's Ministry of Health, an overall shift in negative attitudes towards people living with HIV/AIDS. Only by driving down the cost of antiretroviral treatment through local production of generics has Brazil been able to administer this programme.

In the fight against HIV/AIDS, Brazil is a success story precisely because it has implemented patent protection in a way that is consistent with the right to health. When incorporating TRIPS' obligations into its national intellectual property laws, Brazil chose to safeguard access to drugs by reserving the right of the government to issue a compulsory license where a patent holder exercises rights in an abusive way or when there is a national emergency, which Brazil defined as "a condition of impending danger to the public" including threats to public health. Without issuing compulsory licenses, Brazil has used the provisions to more successfully negotiate with patent holders, bringing down prices for the pharmaceuticals that are patent-protected in Brazil. For this reason, the High Commissioner for Human Rights has praised Brazil, saying "the Brazilian Government has successfully married implementation of the Agreement with its obligations under human rights law".

- i. Ford, Nathan. 2004. "Patents, Access to Medicines and the Role of Non-governmental Organisations". *Journal of Generic Medicines*. Vol. I. No. 2. pp137-145. January.
- ii. 2002. "The FTAA, Access to HIV/AIDS Treatment, and Human Rights". Human Rights Watch Briefing Paper. 29 October.
- iii. "Trading Away Health: Intellectual property and access to medicines in the Free Trade Area of the Americas (FTAA) Agreement". Medecins Sans Frontieres Campaign for Access to Essential Medicines. p8.
- iv. Report of the High Commissioner on the Impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights on Human Rights. E/CN.4/Sub.2/2001/13. para. 55.
- v. *ibid.*
- vi. *ibid.* para. 58.

The dangers of TRIPS-plus provisions in future trade agreements

The US' aggressive trade policy threatens to prohibit developing countries from protecting the right to health and stemming the spread of infectious diseases. Since the Doha Declaration confirmed that TRIPS allows for health concerns to trump intellectual property rules, the US has inserted "TRIPS-plus" articles, that is, articles that are more extensive and restrictive than the intellectual property rules required by TRIPS, into several regional and bilateral trade agreements. The TRIPS-plus intellectual property rights protections in these trade agreements effectively override the protections to public health contained in TRIPS and the Doha Declaration.³³ And, by severely restricting the availability of generics, these TRIPS-plus rules may produce an increase in the price of medicines of up to 800 per cent.³⁴ Even Brazil's successful implementation of TRIPS is in danger as the US has been attempting to pressure Brazil to adopt TRIPS-plus legislation with threats of a WTO challenge (a strategy which was subsequently dropped because of public opinion) and now through bilateral channels.³⁵

Challenges for Advocates

- Pay careful attention to ongoing trade negotiations, especially those with the US. Publicise the problems of TRIPS-plus articles.
- Maintain contact with human rights advocates in the US and in other countries which are pushing for or which are also being pressured to adopt TRIPS-plus articles. The only successful approach to dealing with the US and its TRIPS trade tactics has been turning international and domestic public opinion against it.
- Publicise the fact that flexibilities in TRIPS are often not implementable given the current system.
- Review national intellectual property laws. If your country has not yet implemented TRIPS in national law, encourage it to follow the Brazilian model.

³³ Examples include the Central American Free Trade Agreement (CAFTA) and the Free Trade Area of the Americas (FTAA). See "Trading Away Health: Intellectual Property and Access to Medicines in the Free Trade Area of the Americas (FTAA) Agreement". Medecins Sans Frontieres Campaign for Access to Essential Medicines; and "CAFTA and Human Rights". Citizens Trade Campaign. Washington DC. 2004.

³⁴ 2003. "Robbing the Poor to Pay the Rich? How the United States Keeps Medicines from the World's Poorest". Oxfam Briefing Paper. November. p4.

³⁵ Musungu, Sisule, Villanueva, Susan and Blasetti, Roxanna. 2004. "Using TRIPS Flexibilities for Public Health Protection through South-South Regional Frameworks". South Centre. April. p32.

2. *The liberalisation of trade in services*

The key question from a human rights perspective is not whether liberalisation does or does not promote human rights; rather, it is how to determine the right form and pace of liberalisation to ensure the protection of human rights and how to reverse policies that are unsuccessful.

United Nations High Commissioner on Human Rights³⁶

In this section, the focus will be on the effects of the recent phenomenon of liberalisation of trade in services on women's enjoyment of the right to health. Of course, the liberalisation of trade in goods, that is, the opening of markets to foreign goods and providing foreign markets with goods, has also affected the enjoyment of human rights by, for example, making essential foods more (or less) expensive, creating new jobs and destroying small farming. This section will instead examine the liberalisation of trade in services both because the liberalisation of trade in goods has existed for decades in many countries and because the costs and benefits are hotly contested and difficult to measure. Most importantly, as a new and still-developing aspect of trade, the liberalisation of trade in services can still be controlled and monitored so as to ensure liberalisation that is in harmony with the realisation of the right to health. Therefore, we will focus our analysis on the liberalisation of trade in services, particularly under the General Agreement on Trade in Services (GATS).

An introduction to the liberalisation of trade in services

In a nutshell, liberalisation of trade in services means opening up the service sector to foreign companies and allowing them to compete with domestic companies and the state in providing the service. It is important to remember that liberalisation of services is not caused by trade agreements alone. Instead, liberalisation is brought about by any number of forces including IMF and World Bank structural adjustment programmes, desire for competitiveness, declining public revenue, etc. Trade agreements do, however, facilitate and encourage liberalisation. In particular, the GATS implemented with the WTO in 1995 covers a broad range of economic activity that historically has not been considered subject to international trade.³⁷

³⁶ Report of the High Commissioner on Liberalisation of Trade in Services and Human Rights. E/CN.4/Sub.2/2002/9. para. 50.

³⁷ Under GATS, services provided under any of the following four modes of supply are subject to liberalisation: cross-border supply (such as telemedicine), consumption abroad (travel across borders for medical treatment or education), commercial presence (foreign direct investment) and movement of natural persons (allowing service workers to work abroad).

Representing an ideological continuance of IMF and World Bank programs, GATS' liberalisation of services has the potential to most directly affect the enjoyment of the right to health. While liberalisation of services has had benefits in certain sectors such as telecommunication, in other sectors, it has only benefited foreign companies. Indeed, the danger of liberalisation of trade in services is that it may require a state to concentrate on providing financial benefits to corporations rather than ensuring the provision of essential services to its citizens. Therefore, certain services should be privatised only after extensive analysis if at all, for experience has shown that when water, healthcare, sanitation, or education has been liberalised, it has often been at the expense of the enjoyment of social and economic rights. And, since GATS may result in the privatisation of such essential public services as healthcare, water and education, commitments to liberalisation under GATS must be handled with care because the greatest problem with GATS lies not in this trend toward liberalisation which manifests itself in many aspects of economic life, but rather in escalating liberalisation and making it irreversible.

Dangers of liberalising services under GATS

a. No turning back: Irreversible commitments to privatisation

Mostly importantly, services committed under GATS become binding and irreversible in effect. After a commitment is made, the service is locked in for twenty years. Though countries have the option of altering a commitment after three years, to do so is practically impossible as the country must compensate each WTO member who stands to benefit from the original commitment either monetarily or by making new commitments.³⁸ Any alteration of a commitment made without consulting the WTO may cause another member to bring the state before a WTO dispute panel and may result in its being forced to conform to WTO requirements, pay permanent damages or face trade sanctions.³⁹ For example, a country might commit water to liberalisation. Subsequently a foreign company might sign a contract to provide water. If then the country's citizens protested the price increases that would be a result of the contract and the country decided to withdraw the commitment, the state where the water company is based could challenge the withdrawal of that commitment and demand as reimbursement another commitment or damages (which it must be noted are not the amount the company has invested, which might be very little, but the amount that they expected to earn over the contract term).

³⁸ General Agreement on Trade in Services. Part IV. Article XXI.

³⁹ Sexton, Sarah. 2001. "Trading Healthcare Away? GATS, Public Services and Privatisation". The Corner House. July.

b. Ever-growing commitments: Negotiations and more privatisation

Currently, a number of countries have committed health services under GATS.⁴⁰ However, the number will likely continue to grow since Article XIX of GATS mandates “successive rounds of negotiations aimed at achieving a progressively higher level of liberalisation”. Under GATS, for a new sector to be committed, there is a request-offer process in which countries can represent their own interests. This, of course, presents the danger of developed nations bullying developing nations. And, in fact, Northern countries have shown an active interest in Southern countries’ committing their education, environmental, health and social services to liberalisation. Thus, the Special Rapporteur on Health has expressed particular concern that pressure by stronger trading partners may result in “unsustainable commitments to trade liberalisation that, in practice, diminish states’ capacity to realise the right to health”.⁴¹ The danger of new commitments under GATS, however, is hardly limited to developing countries. In fact, multinational corporations plan to target the proportion of gross domestic product that nations spend on public services, which runs to as much as 15% in most of the European Union.⁴²

c. An unclear provision: The threat to public services

Proponents of GATS argue that public services will not be affected because even where a service is committed, GATS exempts “services supplied in the exercise of governmental authority” defined as “any service which is supplied neither on a commercial basis, nor in competition with one or more service suppliers”.⁴³ However, as governments have slowly moved towards privatisation of services that are traditionally governmental either through IMF or World Bank policies or on their own initiative, they may find that, where there is a mixture of public and private funding or where they contract out any part of the public services (such as catering or cleaning in a public hospital), the service might be deemed not a government service but rather a service “in competition with one or more services suppliers”.⁴⁴ As yet the language in this article of GATS has not been defined, but governments and advocates alike should be aware that the unclear and broadly defined language in GATS may make the consequences of committing services even more difficult to ascertain.

⁴⁰ Forty-two countries have already committed their hospital services; 78 health insurance; 52 services supplied in clinics, residences and labs; 28 professional services of nurses, paramedics, etc. “The GATS Threat to Public Health: A Joint Submission to the World Health Assembly”. Equinet, International People’s Health Council, Medact, People’s Health Movement, Save the Children UK, Wemos, and World Development Movement. May 2003.

⁴¹ Report of the Special Rapporteur on the Right to Health. Mission to the World Trade Organisation. Addendum. E/CN.4/2004/49/Add.1. para. 69.

⁴² Scharpf, Fritz W. 1997. “Employment and the Welfare State: A Continental Dilemma”. Max Planck Institute for the Study of Societies. MPIfG Working Paper 97/7. July.

⁴³ General Agreement on Trade in Services. Part I. Article 3(b) and (c).

⁴⁴ Sexton. “Trading Healthcare Away?”. *op. cit.*

Consequences of liberalising healthcare for the enjoyment of the right to health

a. In general

Where a state does commit to liberalising health services as quite a few have, the repercussions for the right to health can be serious. First of all, the expansion of the private healthcare sector tends to undercut the healthcare system as a whole. Essentially, by attracting the most experienced staff and the wealthiest patients away from the public system, private healthcare does away with cross-subsidisation and leads to “cream skimming” (leaving the poor and seriously ill in the public healthcare system).⁴⁵ In Brazil, for example, liberalisation of healthcare has resulted in the wealthiest 25 per cent of the population having access to 120,000 private healthcare system doctors and 370,000 hospital beds while the remaining 75 per cent of the population copes with only 70,000 public sector doctors and 565,000 beds.⁴⁶ In Chile as well, liberalisation has had dire consequences for the public health system, leaving it grossly under-resourced and unable to provide for the health needs of 70 per cent of Chileans.⁴⁷ As a result, health services have become more costly for all Chileans, so that in 1989 more than 81 per cent of health expenditure came from consumers themselves as compared to 19 per cent in 1974 prior to liberalisation.⁴⁸ Indeed, liberalisation often leads the public sector to make up for declining revenues by transferring costs to the consumer in the form of user fees. Such fees can significantly reduce access to healthcare, resulting in the degradation of health, especially for women.

b. For women's health

Overall, women's enjoyment of the right to health is disproportionately affected by liberalisation of health services. To begin with, female workers are less likely to have the same benefits as their male counterparts because they are more often relegated to contract or part-time work without receiving health insurance benefits.⁴⁹ With regard to rural women, studies have shown that once privatisation occurs, rural areas often do not receive any healthcare services at all because “healthcare providers are content to have creamed off the low-risk elite in the

⁴⁵ Report of the Special Rapporteur on the Right to Health, Mission to WTO. *op. cit.* para. 48.

⁴⁶ Zarrilli, S. 2002. “The Case of Brazil”. In Veiera, C. and N. Drager. (eds.) *Trade in Health Services: Global, Regional and Country Perspectives*. Washington, D.C. Pan-American Health Perspectives. pp143-155.

⁴⁷ Sexton. “Trading Healthcare Away?”. *op. cit.*

⁴⁸ *ibid.*

⁴⁹ Sexton, Sarah. 2003. “GATS, Privatisation and Health”. Presentation at “Service without Borders? Privatisation – GATS and the Consequences for Women”. Cologne. 9-11 May. The Corner House UK.

cities, leaving a degraded public system to cope with the rest.”⁵⁰ Rural women bear this loss disproportionately since they often do not have the resources or mobility necessary to access healthcare. This amounts to *de facto* discrimination, a violation of various human rights treaties and a violation of rural women’s right to health under CEDAW.⁵¹

User fees and women’s health

- In Zaria, Nigeria, user fees for obstetric care reduced overall admissions and significantly increased emergency cases and the number of maternal deaths.ⁱ
- In Kenya, a USD0.33 user fee reduced health centre visits by 52%.ⁱⁱ
- In Zimbabwe, within one year, the shift to user fees doubled the number of women who died in childbirth.
- In Uganda, where HIV/AIDS tests are generally economically inaccessible especially for poor women, the AIDS Information Centre which charges USD2.03 for a test found that when they offered free testing the response was overwhelming.ⁱⁱⁱ
- Generally speaking, there is a lack of hard evidence of the impact of user fees on women’s health outcomes and reproductive health services. This does not mean that women are not affected by user fees but rather that they often trade off other needs to pay for health services, for example reducing spending on food, water or education, trade-offs that usually have the greatest impact on female family members.^{iv}

ⁱ Whited, Melissa, Abraham, Minety, Fosse, Farah and Spielloch, Alexandra. 2003. “Gender, Health and Trade”. International Gender and Trade Network. August. p5.

ⁱⁱ *ibid.*

ⁱⁱⁱ 2003. “Just Die Quietly: Domestic violence and women’s vulnerability to HIV in Uganda”. Human Rights Watch. August. Vol. 15. No. 15. <www.hrw.org/reports/2003/uganda0803/6.htm#_ftnref417>

^{iv} Nanda, Priya. 2002. “Gender Dimensions of User Fees: Implications for women’s utilisation of healthcare”. *Reproductive Health Matters*. 10(20): 127-34. 130. See also Watt, Patrick (ActionAid UK) and Rowden, Rick. 2002. “User fees: the right to education and health denied”. *CHER Policy Brief for the UN Special Session on Children*. New York. May.

⁵⁰ Spielloch, Alexandra. 2001. “GATS and Healthcare – Why do women care?” International Gender and Trade Network. October.

⁵¹ Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Article 14.

Liberalisation and the less economically or physically accessible health services that are its consequence will also burden women with additional work. Already, women's health is disproportionately burdened compared to men because of their limited leisure time; less accessible and available healthcare will only encumber their time and energy more. In fact, when their families do not have access to affordable healthcare and a family member is ill, women and girls usually assume extra work and are sometimes relegated to the home to care for him or her. In Canada, for example, one in five women provides care to a family member in the home an average of 28 hours per week; half of them also work outside the home and all of them experience "tremendous strain".⁵²

Consequences of liberalising determinants of health for women's enjoyment of the right to health

Liberalisation of determinants of health such as water and sanitation also has an enormous impact on women's enjoyment of the right to health. In developing countries, women and girls spend approximately 40 billion hours every year

Failure to ensure available, accessible, acceptable and quality health care

- In Malaysia, many private clinics fail to screen for cervical cancer, doing so only upon request.ⁱ
- In Vietnam, the liberalisation of healthcare and the introduction of user fees have created great inequality of access between rich and poor. Since half of poor families must borrow money to receive any health services, there was a decline of 50% in public health clinic visits in the first seven years after liberalisation.ⁱⁱ
- In Thailand, the 1980s and 1990s saw experienced healthcare providers move en masse from the public to the private sector.ⁱⁱⁱ

ⁱ Hilary, John. 2001. "The Wrong Model: GATS, trade liberalisation and children's right to health". Save the Children. p28.

ⁱⁱ *ibid.* p26.

ⁱⁱⁱ *ibid.* p27.

⁵² Institute of Gender and Health. <<http://www.cihr-irsc.gc.ca/e/institutes/igh/11816.shtml#?>>

hauling water, which exposes them to malaria and water-related diseases that affect their reproductive health.⁵³ In contrast to the liberalisation of goods, which has the potential to improve access and decrease prices, the privatisation of water does not lead to greater access but instead causes enormous price increases. Since water provision is a natural monopoly (in other words, there is only one set of pipes and, therefore, there can only be one water provider), liberalisation of water cannot possibly create competition and lower prices as the liberalisation of other services sometimes does. Even if there is competitive bidding for a water contract, once a private company holds the contract, it faces no competition and can raise prices as it wishes for the contract term. These higher prices result in women collecting water from more remote and unsafe sources, endangering their own and their families' health.⁵⁴ Also, since private companies are not willing to expend the enormous resources necessary to expand coverage and maintain pipelines, privatisation of water decreases access and further impedes full realisation of the right to water and the interrelated right to health.⁵⁵

Challenges for Advocates

- Consider how government officials can be persuaded not to commit services like healthcare and water under GATS.
- Conduct assessments of liberalisation and encourage negotiators to examine or conduct further evaluations of the impact of liberalisation of particular sectors like healthcare.
- Stay updated on discussions of privatisation of public services locally.

3. The movement of skilled workers from the developing to the developed world

As international trade agreements and GATS in particular increase the movement of skilled labour from developing to developed countries, women's enjoyment of the right to health will likely be impaired. Indeed, as more nurses

⁵³ 2003. "Global Population And Water: Access and Sustainability". UN Population Fund.

⁵⁴ See Grossman, Anna and Sidhu, Gretchen (eds.) 2003. "Diverting the Flow: A Resource Guide to Gender, Rights and Water Privatisation". WEDO. November; and Khosla, Prabha and Rebecca Pearl. 2003. "Untapped Connections: Gender, Water and Poverty". WEDO. January.

⁵⁵ International Fact-Finding Mission on Water Sector Reform in Ghana. 2002. Public Citizen/ Water for All. <www.citizen.org/documents/factfindingmissionGhana.pdf>. p53.

Privatisation of water in Ghana

In Ghana, where 78 per cent of the urban poor have no access to piped water and must buy water from tanker trucks, the affordability of water is a serious concern. Yet Ghana's proposal for the privatisation of water calls for a rise in prices through increased cost recovery and automatic tariff adjustments. It also neglects to address the situation of the poor and people outside the piped water system who buy from intermediaries at highly inflated prices. Lastly, the plan fails to expand access, that is, the progressive realisation of the enjoyment of the right to water.

Women in Ghana, especially poor women, suffer most from increased prices and the ensuing decreased access to water. Because provision of water is seen as women's responsibility, as water becomes less affordable or physically accessible they spend more time gathering it and less time performing other work. The resulting increased stress in the home and decreased income sometimes leads to domestic violence.

If water were privatised, the subsequent impairment of women's right to water in Ghana would present an obstacle to their enjoyment of various interrelated rights. For example, because women serve themselves last, they would no longer enjoy their right to health as less and less water is available. The right to food is also implicated since water is the first necessary good women will substitute for food. Reduced sanitation and hygiene would lead to more disease, but it also has less obvious consequences. In Ghana, for example, not only are girls pulled out of school to fetch water but they also sometimes stop going to school because they are unable to bathe, directly impacting their right to education.ⁱ

ⁱ International Fact-Finding Mission on Water Sector Reform in Ghana. Public Citizen/ Water for All. 2002. <www.citizen.org/documents/factfindingmissionGhana.pdf>

and doctors leave developing countries, women may find that healthcare becomes inaccessible or unaffordable. Also, because states face heavy financial burdens from the loss of trained health professionals and the training of other, new health professionals, state funds available for healthcare and other public services will decline. Overall, women's access to healthcare will likely diminish.

In addition to facilitating the movement of health workers from the public to the private sector through privatisation, GATS assists the movement of service workers between countries by permitting the liberalisation of “movement of natural persons”. While the movement of educated workers from developing to developed countries existed prior to GATS and is motivated in no small part by higher wages and better working conditions in developed countries, GATS “encourages industrialised countries to take the best and brightest from poor countries and put up barriers for the low skilled”.⁵⁶ This phenomenon has become known as “brain drain” because it drains away highly skilled, trained workers and leaves behind unskilled workers, depriving the country of its educated members. The so-called brain drain of medical personnel costs developing countries more than USD500 million each year in training expenses alone.⁵⁷ In many developing countries, the loss of doctors and nurses has reached crisis level. In Jamaica, for example, over 50 per cent of nursing positions are vacant because nurses are working in North America,⁵⁸ and 38 per cent of doctors in the US come from India, similarly reducing its medical personnel.⁵⁹

This liberalisation of the “movement of natural persons” in the health services can prove both a benefit and a detriment to women. Movement of natural persons can ease the unemployment rate and increase remittances from expatriates.⁶⁰ Since women tend to be concentrated in the service industry, especially in health services, they may benefit from reduced unemployment and the higher wages available in developed countries. However, to their disadvantage, migrant workers are often hired on a more precarious basis than local workers, with fewer benefits. They also usually bring down wages for local health service workers (who also are female). Furthermore, excessive migration can lead to over-dependence on remittances and, in some countries, can widen inequality because only the higher income group can afford the costs of migration with adverse effects for women remaining in the developing countries.⁶¹ As health services are cut because of fewer personnel and become too remote, women in developing countries will not be able to enjoy the right to health. Indeed, overall, the potential adverse outcomes and the ensuing decline in healthcare will likely outweigh any advantages (such as financial remittances from expatriates) to the citizens of developing nations.⁶²

⁵⁶ Sexton. “Trading Healthcare Away?”. *op. cit.*

⁵⁷ Frommel, D. 2002. “Global Market in Medical Workers”. *Le Monde Diplomatique*. May.

⁵⁸ Sexton. “Trading Healthcare Away?”. *op. cit.*

⁵⁹ Indian Finance Minister Yashwant Sinha at the World Economic Forum. 1998.

⁶⁰ Durano, Maria Fe. 2003. “Labour Mobility: Dependency Theory in an Era of Globalised Services”. *IGTN-Asia*. 8 December. p3.

⁶¹ 2003. “Movement of Natural Persons (MNP), Human Development and Globalisation: Views from Asia”. *IGTN-Asia*. 21 August.

⁶² Report of the Special Rapporteur on the Right to Health, E/CN.4/2003/58. para. 96.

Challenges for Advocates

- Conduct case studies on the costs and benefits of the “movement of natural persons” in trade agreements. Consider how it affects enjoyment of human rights and women’s human rights in particular.
- Hold discussions with health service workers to discover what conditions might encourage them to stay. Include government ministries.
- Advocate for the improvement of the conditions of work in the context of trade discussions.

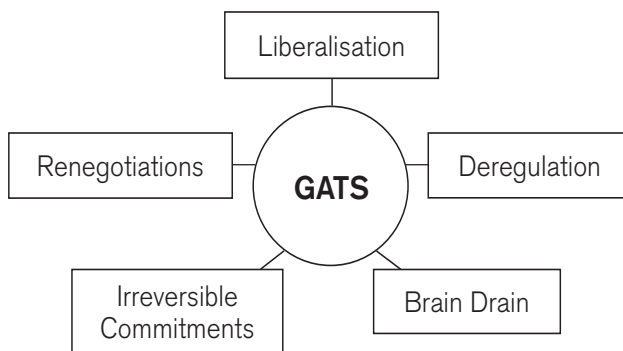
4. Trade challenges to domestic regulations protecting health

Perhaps the aspect of trade agreements that is most immediately threatening to women’s enjoyment of the right to health is the potential for legal challenges to national-level regulations protecting health. Such legal challenges arise because trade agreements give member states to them the ability to contest the regulations of another state as too “trade restrictive” before international trade dispute mechanisms, generally either the WTO or regional trade dispute panels (depending on the agreement sued under). While it might seem that regulations deemed “too trade restrictive” could only concern tariffs and non-tariff barriers to trade such as licensing requirements that effectively discriminate against foreign firms, regulations that have been contested as too trade restrictive include bans on cancer-causing additives to petrol, advertising tobacco products, and depicting healthy babies on baby food (so as to encourage longer breast feeding and healthier babies). These legal challenges have the potential to reduce overall enjoyment of the right to health and severely limit the authority of the state to protect its citizens’ right to health. At the WTO, such legal challenges can be made under one or more of several agreements.

Challenges brought under the General Agreement on Trade in Services

As the trade agreement which presents the most numerous and varied problems for women’s right to health, GATS also allows for challenges to health regulations. While proponents of GATS maintain that states are free to regulate health under Article XIV, which allows states to protect human, animal and plant life or health through measures that might otherwise contravene the agreement, GATS has consistently been interpreted in a way that limits a state’s power to regulate. In fact, only once has a measure protecting health survived a challenge under GATS. In that case, a French ban on asbestos, whose toxicity has been long-

researched and well-established, was upheld in a challenge by Canada, demonstrating that only a health regulation banning a chemical whose threat to human health is well-known can survive a challenge under GATS.⁶³ If no-



thing else, the application of GATS by trade dispute panels has shown that free trade will trump health unless the danger to health is proven beyond any doubt.

Challenges brought under the agreement on Sanitary and Phytosanitary Measures

Governing regulations protecting food safety and human, animal and plant health, the agreement on Sanitary and Phytosanitary Measures (SPS) directly affects a state's ability to protect the health of its citizens. In fact, the SPS is the only WTO agreement that requires that health regulations be based on scientific evidence, a high burden of proof.⁶⁴ When states choose to regulate or ban a product or process for precautionary reasons, the SPS requires scientific proof that harm would result. Because science deals in probabilities rather than certainties, trade rules that require substantial scientific evidence of cause and effect may not be satisfied even where there is compelling evidence to suggest precaution. Therefore, regulations taken as a precaution against potential health threats have generally been deemed violations of trade agreements.⁶⁵

For example, a WTO dispute panel determined that the European Union's ban on hormone-treated beef was a violation of the SPS in spite of substantial research

⁶³ Collishaw, Neil, Callard, Cynthia, Swenarchuk, Michelle and Stanton, Harley. 2001. "Trade Agreements and Tobacco Control: How WTO agreements may stand in the way of reducing tobacco use". Canadian Center for Policy Alternatives. Briefing Paper Series on Trade and Investment. Vol. 2. No. 7. October. p3.

⁶⁴ A regulation must conform to international standards in the FAO/WHO Codex, whose standards are drawn up by a commission dominated by industry representatives or based on scientific risk assessment. Sexton. "Trading Healthcare Away?". *op. cit.*

⁶⁵ *ibid.*

Regulating tobacco

- The benefits of liberalisation of trade in goods (cheaper, better, more accessible products) become disadvantages with regard to tobacco. Studies project that developing countries will experience a four-fold increase in smoking deaths from 1990 to 2020. Yet, countries may find that they are unable to regulate or prevent tobacco use because such measures are deemed too trade restrictive under trade agreements.ⁱ
- Pressure can come in the form of threats of suits. Indeed, after the US threatened to challenge their domestic cigarette regulations in the 1980s, Japan, South Korea and Taiwan dropped the planned regulations. Consequently, smoking has increased in all three nations, especially among women.ⁱⁱ
- Canada similarly withdrew its intent to legislate plain packaging for tobacco after American tobacco companies threatened to sue for expropriation of intellectual property (trademark) under the North American Free Trade Agreement.ⁱⁱⁱ
- In contrast, Thailand refused to bow to US pressure. And, as a result, the US filed a formal legal challenge of Thai regulations banning imported tobacco products and advertising. The dispute panel ruled that the regulation banning imports was a violation of GATT but that concerning advertising was not. Now that GATS has been passed, it is possible that this regulation could also be successfully challenged.^{iv}

ⁱ Collishaw, Neil, Callard, Cynthia, Swenarchuk, Michele and Stanton, Harley. 2001. "Trade Agreements and Tobacco Control: How WTO agreements may stand in the way of reducing tobacco use". Canadian Center for Policy Alternatives. Briefing Paper Series on Trade and Investment. Vol. 2. No. 7. October. p3.

ⁱⁱ 1999. "Trading Away Public Health". Earthjustice Legal Defense Fund. November. p9.

ⁱⁱⁱ Labonte, Ronald. 2003. "Dying For Trade: Why globalisation can be bad for our health". CSJ Foundation for Research and Education. Toronto. p9.

^{iv} GATT decision 1990, Thailand – Restrictions on Importation of and Internal Taxes on Cigarettes. BISD 37S/200 WTO.

showing that it increases cancer in lab animals. By so ruling, the WTO panel seemed to require that any health regulation be based on a majority scientific opinion and also limited the precautionary principle to provisional measures.⁶⁶ This decision cost the EU USD120 million in US trade sanctions in 1999 alone,⁶⁷ illustrating that the consequences of trying to protect human health may be financially unsustainable for all but the richest nations. As a matter of fact, because of the high standard of proof and the possibility of heavy sanctions, the threat alone of SPS challenges may prevent many nations from implementing precautionary health regulations where there is growing but minority scientific evidence as to the ill effects. The outcome of the US's recent SPS challenge to the European Community's moratorium on approving and marketing agricultural biotech product should provide additional guidance as to how WTO panels are treating health regulations under the SPS.⁶⁸

Challenges brought under the agreement on Technical Barriers to Trade

The agreement on Technical Barriers to Trade (TBT) also presents potential difficulties for health regulation. By requiring that regulations not be more trade restrictive than necessary, the Agreement sets up a standard of "necessity" which may be difficult for states to prove. As with the SPS, any health measure that may have a corollary effect of restricting certain types of trade may be challenged as unnecessary. Furthermore, rather than giving a health organisation authority to set standards, the WTO grants an industry-based organisation, the International Organisation for Standardisation (ISO), the authority to draw up standards of what constitutes a necessary regulation.⁶⁹

⁶⁶ Wagner, J. Martin. 2000. "The WTO's Interpretation of the SPS Agreement Has Undermined the Right of Governments to Establish Appropriate Levels of Protection Against Risk". *Law and Policy in International Law*. Vol. 31. pp856-58.

⁶⁷ Sexton. "Trading Away Public Health". *op. cit.* p5.

⁶⁸ The United States brought the challenge in 2003 and made its first submission on 21 April 2004. Oliva, Maria Julia. 2004. "Science and Precaution in the GMO Dispute: A brief analysis of the first US submission". *Bridges*. No. 5. May. pp8-9.

⁶⁹ "The WTO's Agreement on Technical Barriers to Trade (TBT) includes the Code of Good Practice for the Preparation, Adoption and Application of Standards. The TBT Agreement recognises the important contribution that International Standards and conformity assessment systems can make to improving efficiency of production and facilitating international trade. Therefore, where International Standards exist or their completion is imminent, the Code states that standardising bodies should use them as a basis for standards they develop. The Code requires that standardising bodies that have accepted its terms notify this fact to the ISO/IEC Information Centre located at the ISO Central Secretariat". <<http://www.iso.org/en/aboutiso/introduction/index.html#two>>

Challenges for Advocates

- Stay up to date on challenges to your nation's regulations. Also, follow challenges your government makes to other nations' regulations and hold them accountable for making challenges to regulations that protect the right to health.
- Study the impact of legal challenges under trade agreements on the state's obligations to respect, protect and fulfill women's social and economic rights.
- Publicise the legal challenges. Many legal challenges have been dropped when public pressure and media scrutiny are applied to the plaintiff country.

5. Women's working conditions

The most widely publicised effect of free trade on women's right to health has been the adverse working conditions in the export processing zones (EPZs) in developing countries. Geographic areas of a country set aside for the production of items largely intended for export, EPZs are dominated by foreign companies and are infamous for their low labour standards. To attract foreign companies, the government of the country creates incentives that exist only within the EPZs, such as duty-free status, tax holidays and fewer environmental, health or labour regulations.⁷⁰ Though a handful of export processing zones existed already in the 1960s, the numbers have greatly multiplied in the past twenty years. Therefore, while trade agreements may not be solely responsible for the creation of EPZs and the unhealthy working conditions within them, they do foster expansion of and increased investment in EPZs. By allowing countries to enforce (or not enforce) their own labour laws, trade agreements facilitate low workplace health and safety conditions.

As the majority of workers in most EPZs, comprising for example 70% of the workforce in Mexican EPZs and 90 per cent in Guatemalan EPZs, women experience these detrimental work conditions in greater numbers than do men. The disparate gender impact of free trade is most apparent in that the least desirable and worst paid jobs in EPZs are usually reserved for women.

⁷⁰ Wei Ge. 1999. "The Dynamics of Export-Processing Zones". UN Conference on Trade and Development Discussion Paper No. 144. December. UNCTAD/OSG/DP/144. <www.acp-eu-trade.org/documents/128_the_dynamics.pdf>

Furthermore, because of their reproductive function, women are often subject to discrimination based on pregnancy, are abused if pregnant and suffer reproductive and pregnancy-related illnesses as a result of toxins in the workplace. These demonstrate a clear link between conditions fostered by trade agreements and obstacles to women's enjoyment of the right to health and reproductive health.

Women's right to health at work

Sex discrimination and reproductive rights:

- In Latin America, where workers in the EPZs are largely female, foreign companies regularly require pregnancy tests prior to hiring and as a condition of keeping employment.ⁱ
- To avoid paying maternity leave, some employers distribute birth control pills or provide monthly injections. Many require proof every three months that workers are not pregnant.ⁱⁱ
- In Mexico, there is evidence to show women were often forced to resign and that others were assigned to jobs requiring heavy lifting after supervisors learnt that they were pregnant.ⁱⁱⁱ

Women's health and reproductive health:

- In Latin American and African countries, which provide the North American and European markets respectively with cut flowers, the heavy use of pesticides causes menstrual irregularities, birth defects, miscarriages, headaches and upper respiratory diseases.^{iv}
- Between 1987 and 1993, there were 386 anencephalic births (babies born without brains) in Mexican towns near a factory releasing chemicals into the river. In another Mexican town, 54 children with multiple birth defects were born to women who had all worked for Mallory Capacitators, where they were required to handle PCBs^v without protection.^{vi} PCBs also are transmitted through breast milk and can cause neurological deficits.
- At one single Mexican factory, between 1996 and 1997, 14 babies were born with birth defects or serious health problems. In that same period, 15 women had miscarriages, with five miscarriages occurring in just one month. Management simply instructed the factory nurse to give the women who had miscarried aspirin and send them back to work.^{vii}





Sexual harassment and violence:

- In Kenya, many women harvesting coffee and tea are subjected to extreme sexual harassment – even rape – by their supervisors.^{viii}
- In Guatemala City, at the East-West Textiles maquila, women suspected of being pregnant have been beaten in the stomach by company security guards.^{ix}
- In Sri Lankan EPZs, young women often work compulsory overtime, leaving factories at 10 pm or midnight. In a culture where young women do not go out alone after dark, they are subject to sexual harassment and rape.^x

ⁱ Human Rights Watch Report on the Working Women in the Dominican Republic. 2004; “No Guarantees: Sex discrimination in Mexico’s maquiladora sector”. August 1996. Human Rights Watch Report. Vol. 8. No. 6(B); “A Job or Your Rights: Continued sex discrimination in Mexico’s maquiladora sector”. December 1998. Human Rights Watch Report. Vol. 10. No.1(B).

ⁱⁱ Maquiladora Solidarity Network. <www.maquilasolidarity.org>

ⁱⁱⁱ “No Guarantees: Sex discrimination in Mexico’s maquiladora sector”. August 1996. Human Rights Watch Report. Vol. 8. No. 6(B); “A Job or Your Rights: Continued sex discrimination in Mexico’s maquiladora sector”. December 1998. Human Rights Watch Report. Vol. 10. No.1(B).

^{iv} Women Working Worldwide. <www.poptel.org.uk/women-ww/campaigns.html>. The workers are largely female, representing, for example, 70 per cent of flower workers in Columbia and 80 per cent in Ecuador. Athreya, Bama and Cathy Feingold. “How Will the FTAA Impact Women Workers?”. In *Breaking Boundaries II. The Free Trade Agreement of the Americas and Women: Understanding the connection*. US Gender and Trade Network.

^v PCBs are mixtures of synthetic organic chemicals which can be used in many commercial products but have been banned in many parts of the world because of their environmental and carcinogenic effects and impact on the immune and nervous system of workers and their children. <www.epa.gov/oppt/pcb/>

^{vi} Maquiladora Solidarity Network. <www.maquilasolidarity.org>

^{vii} *ibid.*

^{viii} International Labor Rights Fund (ILRF) 2002 Report.

^{ix} Maquiladora Solidarity Network. op.cit.

^x Dabindu Collective. Email: <dabindu@eureka.lk>

Challenges for Advocates

- Study the costs and benefits of Export Processing Zones (EPZs) for women in your country.
- Identify key actors who enforce labour laws or implement more strict labour laws within EPZs. In relation to this, map the possible role of the courts, labour unions, the companies themselves under public pressure.
- Propose alternatives and develop methodologies for monitoring the impact labour conditions in EPZs have on women's health.

III. Upholding states' obligations to realise women's right to health

Although a fundamental human right, with the same international legal status as freedom of religion or the right to a fair trial, the right to health is not as widely recognised as these and other civil and political rights. Many different actors, such as states, international organisations and civil society groups, can help to raise the profile of the right to health as a fundamental human right.

Special Rapporteur on the Right to Health, Paul Hunt⁷¹

As we have seen, trade and women's right to health are not unrelated. In fact, international trade agreements and policies have national and local impacts on women's ability to realise and enjoy social and economic rights. For this reason, various bodies of the UN have begun to recognise the need to strengthen the linkages between trade agreements and human rights, focusing most especially on the right to health. The UN General Assembly has invited the WTO, the World Health Organisation and other organisations concerned with trade and health to help developing countries analyse the consequences of trade agreements "for health equity and the ability to help meet the health needs of people living in poverty".⁷²

⁷¹ Report of the Special Rapporteur on the Right to Health. E/CN.4/2003/58. para. 38.

⁷² Report of the Ad Hoc Committee of the Whole of the Twenty-Fourth Special Session of the General Assembly. A/S-24/8/Rev.1. commitment 6. paras. 102 and 104.

Also, the Sub-Commission on Human Rights called upon Mary Robinson the then High Commissioner to report on linkages between trade agreements and human rights several times since 2000.⁷³ And, in her first report, while acknowledging the effect of the agreement on TRIPS on various rights including food, development, and those of indigenous peoples, the High Commissioner chose to focus on health.⁷⁴ Moreover, her Report on Liberalisation of Trade in Services and Human Rights gave a great deal of attention to the consequences of GATS for the right to health.⁷⁵

Similarly, the Special Rapporteur on the Right to Health, Paul Hunt, has focused much of his attention on the effects of trade agreements on the right to health. Most recently, in order to highlight the importance of a human rights approach to trade agreements and trade liberalisation, he conducted a mission to the WTO and reported on the right to health in trade agreements (with a section on gender and trade).⁷⁶ These are simply a few examples of the international community's acknowledgement of ties between trade and rights.

Given the impact of trade agreements on women's human rights, it is essential that the right to health and state's legal obligations under international human rights treaties be taken into consideration in trade negotiations. It should be emphasised that we are advocating the use of a human rights framework informed by CEDAW as an alternative or supplement to the WTO framework of analysis, which does not look at gender issues or consider human rights obligations. The human rights framework is useful because, though states have shown themselves willing to protect sovereignty or their citizens' civil and political rights in negotiating trade agreements, they usually fail to consider the right to health and a host of other social and economic rights.

By using the international human rights treaties that establish the right to health, advocates can ensure that their governments are aware of their obligations to protect the right to health in all of their policy-making, including

⁷³ See, e.g. Sub-Commission on Human Rights Resolution 2001/4 and Resolution 2000/1.

⁷⁴ Report of the High Commissioner on the World Trade Organisation Agreement on Trade-Related Aspects of Intellectual Property Rights. E/CN.4/Sub.2/2001/13. It should be noted that this report was written prior to the Doha Declaration on TRIPS.

⁷⁵ Report of the High Commissioner on the Liberalisation of Trade in Services and Human Rights. E/CN.4/Sub.2/2002/9.

⁷⁶ Report of the Special Rapporteur, Paul Hunt. Addendum. Mission to the World Trade Organisation. E/CN.4/2004/49/Add.1.

the negotiation of international trade agreements. Advocates can also use a human rights framework to hold governments accountable for the protection of women's right to health. The documents that set out these obligations and provide the legal basis for the right to health are international human rights treaties signed and ratified by our governments, in particular the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW Convention) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Since 146 of the 147 members of the WTO have ratified at least one human rights treaty, 112 have ratified the ICESCR⁷⁷ and 137 are parties to CEDAW,⁷⁸ there is a clear "legal basis for adopting human rights approaches to trade liberalisation"⁷⁹.

A human rights basis for women's right to health and reproductive health

The right to health is much more than a principle or ideal; it is a legal right recognised by international human rights treaties. Just as constitutions create legally enforceable civil rights that national governments must respect, so too international human rights treaties establish legally enforceable human rights that states must protect. Once an international human rights treaty has been signed and ratified by a state, that state must abide by its obligations under the treaty and ensure all rights guaranteed under the treaty. For this reason, international human rights treaties can prove powerful legal and advocacy tools to hold governments accountable for the realisation of human rights. Various international human rights treaties, in particular the ICESCR and the CEDAW Convention, recognise the right to health as well as other rights with direct implications for the enjoyment of the right to health, such as the rights to water, sanitation, food, etc. In conjunction with these legally binding treaties, international documents and conferences, though not legally binding, are also useful to remind a government that it has committed itself to the right to health.

⁷⁷ One member of the WTO, Chinese Taipei has not been recognised as a State or admitted to the United Nations and therefore cannot ratify human rights treaties as a State. These numbers are as of June 2004.

⁷⁸ 136 WTO Members have ratified CEDAW. However, technically 137 WTO members are bound by it since one of the WTO members is the European Community (the States of which have ratified CEDAW). These numbers are as of June 2004.

⁷⁹ Report of the High Commissioner on the Liberalisation of Trade in Services and Human Rights. E/CN.4/Sub.2/2002/9. para. 5.

Women's right to health

Several widely ratified international human rights treaties and documents establish women's right to health. A clear declaration of the right to health, Article 12 of the ICESCR⁸⁰ endorses "the right of everyone to the highest attainable standard of physical and mental health," a right which is possessed by women on an equal basis with men.⁸¹ The Committee on Economic, Social and Cultural Rights (CESCR Committee) has further articulated the most comprehensive definition of this right:

The right to health is not to be understood as a right to be healthy. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, 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.⁸²

Most significantly for women, Article 12 of the CEDAW Convention further substantiates women's right to health and their equality in access to healthcare services, an equality that is extended to the protection of health and safety at work and in rural areas as well with Article 14.⁸³ Furthermore, CEDAW General Comment No. 24 requires states to consider biological factors (such as reproductive function and greater susceptibility to HIV/AIDS), socio-economic factors (such as unequal power relationships) and psychosocial factors (such as anorexia and post-partum depression) that may impair women's enjoyment

⁸⁰ As a widely ratified international human rights treaty, the ICESCR could arguably be understood as customary international law. The principles of customary law say that widely-ratified treaties, declarations and other instruments become evidence of a general state practice which states perform out of a sense of legal obligation which in turn imposes obligations on states that have not ratified the treaties. Therefore, because the ICESCR is so widely accepted internationally, it can be argued that it is binding on all countries whether they have ratified it or not. Kinney, Eleanor D. 2001. "The International Human Right to Health: What does this mean for our nation and world?" *Indiana Law Review*. Vol. 34. No. 4.

⁸¹ Article 2(2) of the ICESCR guarantees that all rights in the Covenant be exercised "without discrimination of any kind as to...sex".

⁸² ICESCR. General Comment No. 14. para. 8.

⁸³ CEDAW. Articles 11(1)(f) and 14(2)(b).

of the right to health.⁸⁴ Similarly, to ensure women reach the “highest attainable standard of health”, states must provide treatment especially tailored to women’s health needs since certain diseases affect women differently or progress more quickly for them due to biological or sociological factors.⁸⁵

Even those states that have not ratified the ICESCR or the CEDAW Convention can be held accountable for protecting women’s right to health if they have ratified one of a number of other treaties. For example, Article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 and Articles 11.1 (f) and 24 of the Convention on the Rights of the Child of 1989 also recognise the right to health and create obligations for States Parties to those treaties to protect it.⁸⁶ And all of these treaties are legally binding upon states that have ratified them. Though non-binding, the 1946 Constitution of the World Health Organisation⁸⁷ similarly confirms the human right to health while Article 25 of the Universal Declaration of Human Rights further clarifies that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services”.

As we have seen, some trade agreements, such as TRIPS and GATS, do have articles allowing states to protect public health and permitting implementation of the agreement in a way that is consistent with the right to health. However, as we have also seen, these articles often are inadequate to truly protect the right to health. Furthermore, in no way do WTO agreements acknowledge the primacy of human rights or states’ pre-existing human rights obligations. In fact,

⁸⁴ CEDAW. General Recommendation No. 24. para. 12.

⁸⁵ *ibid.* para. 10.

⁸⁶ For other binding and non-binding state obligations, see: International Covenant on Civil and Political Rights Article 6(4) and 18(4); Declaration on the Elimination of Discrimination Against Women Article 9(e); Declaration on Population and Development para. 7; Beijing Declaration and Program of Action Paras. 89, 94 and 96; American Convention on Human Rights Article 4(5); San Salvador Protocol Article 10; Inter-American Convention on the Protection, Punishment and Eradication of Violence Against Women Article 4(b); American Declaration on the Rights and Duties of Man Article Xi; Declaration on Social Progress and Development Article 11(b); Maternity Protection Convention Article 3; and African Charter on Human and People’s Rights Article 16.

⁸⁷ Constitution of the World Health Organisation as adopted by the International Health Conference. New York. 19-22 June. 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organisation, no. 2, p. 100) and entered into force on 7 April 1948.

instead of considering the prior international human rights treaty obligations of the state in question, trade dispute panels tend to look at regulations which are being challenged as too “trade restrictive” independently of human rights, labour or environmental concerns.

Indeed, at the WTO, the issues of food safety, intellectual property protection and liberalisation of public services are typically decided in isolation. Negotiators focus on increasing trade instead of weighing the effect of trade policies on the realisation of social and economic rights such as the right to health. As a matter of fact, governments often commit to trade agreements without so much as consulting the ministries of health, environment or women. And most governments do not perform trade impact assessments that evaluate impact by gender; consequently, any disparate effect on women’s ability to enjoy their social and economic rights goes unobserved.

Women’s right to reproductive health

In order that women experience the overall enjoyment of the right to health, women’s right to reproductive health must be respected, protected and fulfilled. Worldwide, sexual and reproductive diseases account for 32 per cent of diseases among women of reproductive age (15-44).⁸⁸ In developing countries where one in four persons is a woman of childbearing age, this burden is even larger.⁸⁹ While the right to reproductive health does not mean freedom from reproductive disease, it does mean ensuring women have access to acceptable and affordable reproductive care that permits them to avoid or treat reproductive illness. For example, the right to reproductive health does not guarantee a woman a pregnancy free of complications; it does however guarantee that should she have complications during pregnancy, she will have access to health services. Significantly, by reducing public expenditure on social security and healthcare, good reproductive healthcare has long-term effects on women’s education, productivity and poverty reduction with positive consequences for overall good health and a multitude of interrelated human rights.⁹⁰

⁸⁸ Singh, Susheela, Darroch, Jacqueline E., Vlassoff, Michael and Nadeau, Jennifer. 2003. “Adding It Up: The benefits of investing in sexual and reproductive healthcare”. The Alan Guttmacher Institute and UNFPA. p9.

⁸⁹ *ibid.* p17.

⁹⁰ See Singh, et.al. *op.cit.* p11.

Due to the clear connection between health and reproductive rights, the international community has recognised the need to protect and foster the reproductive rights which are so important for women's right to health. The Commission on Human Rights has acknowledged this fundamental link, saying that "sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".⁹¹ States parties to CEDAW have affirmed the right to family planning and maternal health⁹² as well and have accepted the legally binding obligation to protect these rights and safeguard women's reproductive rights and pregnancy in the workplace.⁹³ With the Cairo International Conference on Population and Development Programme of Action, states committed themselves to furthering the right to reproductive health and came to the most comprehensive definition of reproductive health thus far:

*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive healthcare is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.*⁹⁴

⁹¹ Commission on Human Rights Resolution 2003/28. para. 6.

⁹² CEDAW. Article 12.

⁹³ CEDAW. Articles 11(1)(f) and (2).

⁹⁴ Programme of Action of the International Conference on Population and Development. para. 7.

Other international documents such as the Beijing Platform for Action and the Millennium Development Goals have also stressed the importance of reproductive health rights in development, and its linkages to health and well being. While these documents are not legally binding upon states, they serve to remind states of commitments they made publicly and their responsibility to live up to those commitments.

However, like women's right to health, women's right to reproductive health is not part of the WTO negotiation process. Trade agreements are not evaluated in terms of their impact on women's ability to access and enjoy their right to reproductive health. While, as we have seen, several trade agreements allow states to protect health, there is no explicit acknowledgment of state's obligations under international human rights treaties and documents to protect women's right to health and reproductive health. Instead, issues which directly affect women's enjoyment of reproductive health, such as intellectual property protection which raises the cost of pharmaceuticals, are decided without consideration of women's reproductive rights.

Determinants of health

Determinants of health can be understood as a wide range of rights that are necessary for enjoyment of the rights to health and life. The CESCR Committee has defined the right to health as "an inclusive right extending not only to timely and appropriate healthcare but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information".⁹⁵ The CEDAW Committee has highlighted, in particular, the right to food as a determinant to health, saying "the full realisation of women's right to health can be achieved only when States parties fulfill their obligation to respect, protect and promote women's fundamental right to nutritional well-being".⁹⁶

⁹⁵ CESCR. General Comment No. 14. para. 11.

⁹⁶ CEDAW. General Recommendation No. 24. para.7.



These determinants of health can have a great impact upon women's ability to enjoy the right to health. For example, where water has been privatised and becomes too expensive, lack of access to clean water affects women's health directly and indirectly. A woman directly suffers when she contracts cholera, diarrhea, etc. from drinking or bathing in unclean water. A woman experiences indirect harm to her health when she must travel long distances, collect unsafe water, and reduce her food and water intake in order to save money and provide her family with more water. Inadequate nutrition, dirty water, extra work and hours of carrying heavy burdens have significant negative consequences for her health. Similarly, insufficient sanitation, inadequate food and poverty all adversely affect women's right to health.

Regrettably, while the WTO may look at issues like food and poverty reduction, the focus at the WTO is on increasing and expanding trade, not on improving health or the determinants necessary for the enjoyment of the right to health. Focusing on trade and financial benefits leads to situations, as with the privatisation of water, where enjoyment of a fundamental human right yields to corporate gain. Also, though some aspects of WTO agreements can improve people's enjoyment of these determinants of health, the WTO tends to assume that there will be winners and losers in trade. Therefore, inevitably, some people's enjoyment of rights to water, sanitation, adequate food, etc. is sacrificed.

Interrelated rights

Women's enjoyment of the right to health positively affects their other human rights; conversely, the deprivation of the right to health hinders their enjoyment of other rights. For example, a woman who cannot enjoy the right to access health services may not be able to have safe sex because she has no access to condoms. She may not be able to decide when or whether she has children. As a result of the lack of accessible health services, she may be unable to treat an STD or may have an unplanned pregnancy. If she gets very sick, she may lose the ability to work and support herself.

Because of the interrelatedness of rights,⁹⁷ the CESCR Committee has recognised that the right to "health is a fundamental human right indispensable for the exercise of other human rights".⁹⁸ The CEDAW Committee has urged states to recognise the interconnection between the right to health and other articles of CEDAW including access to education, protection of health and safety at work, etc. The right to health is essential, for instance, to the right to life and also encompasses women's right to privacy.⁹⁹ The Human Rights Committee, which monitors the implementation of the International Covenant on Civil and Political Rights (ICCPR), has even commented that "women's privacy may... be interfered with by private actors, such as employers who request a pregnancy test before hiring a woman"¹⁰⁰ – a violation of the right to privacy which has implications for reproductive and health rights as well. Since civil society and women are rarely consulted in drafting trade agreements, the fundamental right to self-determination may also be implicated. Life, privacy and self-determination are merely a few of the many political, social and economic rights related to the right to health.

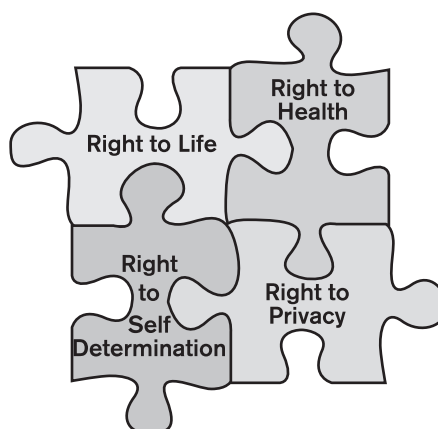
⁹⁷ "All human rights are universal, indivisible and interdependent and interrelated". United Nations General Assembly, Vienna Declaration and Programme of Action, I, 12 July 1993. A/CONF.157/23 t para. 5.

⁹⁸ CESCR. General Comment No. 14. para. 1.

⁹⁹ ICCPR. Articles 3 and 17.

¹⁰⁰ Human Rights Committee. General Comment No. 28. para. 20.

Negotiations at the WTO generally do not take into account the principle of interrelatedness of human rights. Since the WTO is said to deal only with trade, human rights become separate and other and are, therefore, not a concern of the WTO. Even where there is acknowledgement that rules concerning food security may implicate the right to food, there is no connecting of the right to food to rights to health, employment, housing, etc.



Non-discrimination, substantive equality and the right to health

Non-discrimination

The principle of non-discrimination, that is, that human rights be respected, protected and fulfilled equally, is at the very foundation of international human rights law.¹⁰¹ In fact, the International Law Commission recently held that the principle of non-discrimination, at least on the basis of race, is a peremptory norm of international law.¹⁰² Legally binding international human rights treaties make clear that non-discrimination is at the heart of states' obligations.

The ICCPR, for example, demands both that each state respect and ensure civil and political rights "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status"¹⁰³ and that the law prohibit any discrimination and guarantee equal and effective protection against discrimination.¹⁰⁴ The Covenant further clarifies that the states must ensure the equal right of men and women to the enjoyment of rights,¹⁰⁵ and in its General Comment on Articles 2 and 26 of the ICCPR, the Human Rights Committee adopts a definition of discrimination which

¹⁰¹ Report of the Special Rapporteur on the Right to Health, E/CN.4/2003/58. para. 60.

¹⁰² A/56/10 p208.

¹⁰³ ICCPR. Article 2(1).

¹⁰⁴ ICCPR. Article 26.

¹⁰⁵ ICCPR. Article 3.

includes actions that have the purpose or effect of discriminating and requires that states notify it of any discrimination in fact.¹⁰⁶

With regard to social and economic rights, Article 3 of the ICESCR similarly obliges State parties to “undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights”; while Article 2(2) requires that States parties “undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”. Clearly, women and men are entitled to the same level of enjoyment of all human rights, including the right to health.

Substantive equality

As the most powerful international instrument for women’s rights, the CEDAW Convention demands that equality between men and women be substantive rather than merely formal. Under this treaty, discrimination against women means “any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women...of human rights”.¹⁰⁷ That is, even if laws do not purposely discriminate against women, if they have the effect of discriminating against women, they are not sufficient to meet a state’s obligations under CEDAW. As the Montréal Principles on Women’s Economic, Social and Cultural Rights – developed by women with expertise in human rights – say, policies must be “designed in ways that take women’s socially constructed disadvantage into account, that secure for women the equal benefit, in real terms, of laws and measures, and that provide equality for women in their material conditions”.¹⁰⁸

In sum, the principle of substantive equality means that a State party cannot fulfill its obligations under human rights treaties by merely passing laws granting formal equality. Rather, a state must act to make equality between men and women a reality. Thus, where women are unwilling to see a male doctor, a state has not fulfilled its obligation by passing a law granting equal access to healthcare facilities with exclusively male doctors. Though formal equality in access to the right to health has been achieved, discrimination

¹⁰⁶ Human Rights Committee. General Comment No. 18.

¹⁰⁷ CEDAW. Article 1.

¹⁰⁸ Montréal Principles on Women’s Economic, Social and Cultural Rights. 7-10 December 2002. para. 9.

still persists; equality is not substantive. Therefore, under a number of human rights treaties, unintended discrimination can constitute a breach of the right to health and the state's obligations.¹⁰⁹

Non-discrimination and substantive equality at the WTO

According to the principles of non-discrimination and substantive equality incorporated in international human rights law and the CEDAW Convention in particular, even when trade agreements at the WTO are neutral on their face and have no discriminatory purpose, they can be considered discriminatory if their effect is to discriminate against women. In such a case, by permitting discriminatory effects to occur, a member state of the WTO and party to a human rights treaty is in violation of its human rights obligations.

By contrast, the WTO rules contain no such principle of substantive equality with regard to individuals. While WTO agreements do insist upon non-discrimination, there is a fundamental difference between the principle of non-discrimination in trade agreements and that in human rights treaties. WTO agreements require non-discrimination between national and foreign companies and states, as with the most-favoured-nation status; human rights treaties, on the other hand, require non-discrimination with regard to individuals. As the then UN High Commissioner on Human Rights observed, the “principle of non-discrimination under human rights law will consider the impact of trade rules, not only on the need to minimise trade distortions but also on individuals, in particular vulnerable individuals and groups, and set rules accordingly”.¹¹⁰

In the words of the Special Rapporteur on the Right to Health, “while some trade and development theorists accept that there will be some ‘losers’ in the process of trade liberalisation and development... a human rights approach focuses on protecting the rights of all, particularly the potential ‘losers,’ and seeks to design policy accordingly”.¹¹¹ Women's rights advocates must, therefore, ensure that women are protected by human rights law principles of non-discrimination and substantive equality rather than allow them to “lose” under trade rules.

¹⁰⁹ Report of the Special Rapporteur on the Right to Health. Mission to WTO. *op. cit.* para. 25.

¹¹⁰ Report of the High Commissioner on Liberalisation of Trade in Services and Human Rights. *op. cit.* para. 8.

¹¹¹ Report of the Special Rapporteur on the Right to Health. Mission to WTO. *op. cit.* para. 49.

Obligations of states to realise the right to health

Having ratified an international human rights treaty, states have the legal obligation to guarantee that all individuals, male and female, can access and enjoy the rights included in a treaty. With regard to the right to health, States parties to any number of international human rights treaties have assumed the obligation to ensure conditions exist in which the right to health can be enjoyed by all. As parties to human rights treaties, member states of the WTO are not excused from their binding human rights obligations when entering into WTO agreements. Rather, having accepted the legal obligation to respect, protect and fulfill the right to health, states should “ensure that their actions as members of international organisations take due account of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and that the application of international agreements is supportive of public health policies which promote broad access to safe, effective and affordable preventive, curative and palliative pharmaceuticals and medical technologies”.¹¹²

Treaty monitoring bodies have provided States parties to both ICESCR and the CEDAW Convention with instructions as to their obligations to ensure the right to health. The most comprehensive application of the principle of state obligation with regard to the right to health is General Comment No. 14 to Article 12 of the ICESCR which sets out the obligations of States parties. ICESCR General Comment No. 14 also explains the two approaches to the analysis of a state's fulfillment of the obligation of the right to health (availability, accessibility, acceptability and of good quality; and the duty to respect, protect and fulfill) while General Comment No. 24 to Article 12 of CEDAW further clarifies states' legal duty to respect, protect and fulfill women's right to health.

Availability, accessibility, acceptability and of good quality

Realisation of the right to health requires that health facilities, goods and services be available, accessible, acceptable and of good quality. For healthcare to be available, a state must have adequate provision of healthcare, including determinants of health such as safe drinking water and adequate sanitation. Medical personnel should receive competitive wages and adequate medicines should be available. Accessibility in turn requires that healthcare be provided without discrimination, be physically accessible (that is, within safe physical reach of vulnerable groups such as women) and be economically accessible (that is,

¹¹² Commission on Human Rights Resolution 2002/32. para. 6(b).

affordable for all). Information concerning health issues should also be readily accessible. For healthcare to be acceptable, it “ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”¹¹³ Coercive practices such as forced sterilisation or mandatory pregnancy testing as a condition of work are unacceptable and violate a woman’s dignity and right to informed consent.¹¹⁴ Lastly, health services as well as determinants of health like water and sanitation provision must be of good quality.

Determining whether healthcare within a state meets these requirements proves helpful when engaging in policy analysis. The second approach, on the other hand, will provide effective legal analysis of a state’s obligations to bring healthcare to the level of this first approach.

Obligations of the state to respect, protect, fulfill

The right to health is not violated every time a person falls ill. Rather, ill health constitutes a human rights violation when it arises in whole or in part from the failure of a state to respect, protect or fulfill the right to health.¹¹⁵ For example, where the health condition of a poor woman worsens because the state has allowed for the privatisation of healthcare without any safeguards to protect the poor and she can no longer access healthcare as a result, the state has failed to respect, protect and fulfill her right to health. In such a case, any State party to CEDAW or the ICESCR will be in violation of its obligations under these treaties.

Indeed, both the CEDAW Convention and the ICESCR oblige states to respect, protect and fulfill the right of everyone to the highest attainable standard of physical and mental health. First, respecting the right to health entails abstention from directly or indirectly interfering with the enjoyment of the right to health. “Imposing discriminatory practices relating to women’s health and status” is therefore a violation of this duty.¹¹⁶ States similarly fail to respect women’s right to health by passing “laws that criminalise medical procedures only needed by women [and] punish women who undergo those procedures.”¹¹⁷ Secondly,

¹¹³ CEDAW. General Comment No. 24.

¹¹⁴ *ibid.*

¹¹⁵ Report of the Special Rapporteur on the Right to Health 2004. *op. cit.* para. 13.

¹¹⁶ CESCR. General Comment No. 14. para. 34.

¹¹⁷ CEDAW. General Comment 24. para. 14.

protecting the right to health refers to the duty of states to adopt legislation to create equal access to healthcare and to ensure that privatisation does not threaten the availability, accessibility and quality of health. This obligation is breached where, for example, a state fails to regulate corporations to prevent violations of the right to health, to protect workers or to discourage marketing and production of tobacco and other harmful substances.¹¹⁸ Finally, the obligation to fulfill compels states to recognise the right to health in national political and legal systems and ensure availability of healthcare including “equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions”.¹¹⁹ Failure to fulfill includes not taking gender into account in the state’s approach to health or misallocating public funds so that vulnerable or marginalised groups are unable to enjoy the right to health.¹²⁰

Most fundamentally, a state is not only obliged to respect, protect and fulfill through government agencies but also must “take action to prevent and impose sanctions for violations of rights by private persons and organisations,”¹²¹ including transnational corporations.¹²² For example, where services are privatised, states must adopt a regulatory system that effectively monitors service providers and ensures that services are being provided in a way that guarantees women’s equal access and enjoyment of services.¹²³

State obligations at the WTO

Member states of the WTO are concerned with their accountability for terms contained in trade agreements rather than their pre-existing human rights obligations. Therefore, even though states have the legal obligation to respect, protect and fulfill women’s right to health upon ratification of the ICESCR or the CEDAW Convention, they sometimes assume obligations through trade agreements that impair their ability to respect, protect and fulfill human rights.

¹¹⁸ CESCR. General Comment No. 14. para. 51.

¹¹⁹ CESCR. General Comment No. 14. para. 36.

¹²⁰ CESCR. General Comment No. 14. para. 52.

¹²¹ CEDAW. General Comment No. 24. para. 15.

¹²² Report of the High Commissioner on Liberalisation of Trade in Services and Human Rights. *op. cit.* para. 10, citing the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights.

¹²³ Montréal Principles on Women’s Economic, Social and Cultural Rights. 7-10 December 2002. para. 22.

Indeed, trade agreements at the WTO neither acknowledge members states' obligations under human rights treaties nor do they create obligations to abide by human rights treaties. They only establish the obligation to conform to the articles of the trade agreement. And, unlike obligations to protect, respect and fulfill human rights, obligations under WTO trade agreements are enforced by WTO trade dispute panels which have the authority to impose sanctions upon any state that violates the trade agreement. Because of this powerful enforcement mechanism, states may consider obligations under trade agreements more important than those under human rights agreements though both are binding legal obligations.

Progressive realisation of a state's obligations

Of course, having a legal obligation to respect, protect and fulfill the human right to health and to ensure accessible, acceptable, available and quality healthcare does not mean states must realise these obligations overnight. A developing country with few resources and little policy-making experience is not expected to be able to guarantee perfect implementation of international human rights treaty obligations. This is known as the principle of progressive realisation of human rights. The ICESCR, for example, makes clear that progress must be made incrementally and that each State party has the legal obligation "to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means".¹²⁴ Some obligations, however, are assumed immediately, such as the guarantee that the right to health will be exercised without discrimination of any kind (Article 2.2) and the obligation to take steps (Article 2.1) towards the full realisation of the right to health.¹²⁵

Furthermore, progressive realisation does not mean that the state can move as slowly as possible towards the full realisation of the right to health, "otherwise progressive realisation can empty human rights of substance and turn them into mere rhetoric".¹²⁶ Rather, progressive realisation means that States parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of the

¹²⁴ ICESCR. Article 2(1).

¹²⁵ CESCR. General Comment No. 14. para. 30

¹²⁶ Report of the Special Rapporteur on the Right to Health. E/CN.4/2004/49. para. 52.

right to health.¹²⁷ As the CESCR has clarified, “a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party”.¹²⁸ Additionally, “even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes”.¹²⁹ Any consequences of trade agreements that interfere with this minimum level of enjoyment of rights or impede the progressive realisation of human rights are violations of various international human rights treaties, in particular the ICESCR and the CEDAW Convention.

IV. How human rights and gender advocates can influence international trade agreements

Thus far, when negotiating trade agreements at the WTO, states often have not lived up to their legal obligation to respect, protect and fulfill women’s right to health, though they are required to do so by international human rights treaties such as the CEDAW Convention and the ICESCR. When signing trade agreements, governments have not always considered and evaluated obligations to which they have committed themselves through international human rights treaties or world conferences. In addition, with no civil society members or gender representatives at the table (often with no women at all at the table), negotiations of international trade agreements have remained largely free of gender analysis and policies that ensure women’s rights are respected. Also, before signing trade agreements, states usually do not evaluate how these might disproportionately affect women or other vulnerable groups. As a result, trade agreements have typically been implemented without assessing the impact of trade agreements on women’s enjoyment of human rights. Consequently, women often suffer harm to their enjoyment of social and economic rights; they become the “losers” of international trade. And, unless women’s human rights advocates act, they will remain so.

Women’s groups, with a few vocal exceptions, have been late to enter discussions of trade agreements. The acronyms of international trade, WTO, GATS, TRIPS, seem to have little to do with women’s daily lives and less to

¹²⁷ CESCR. General Comment No. 14. para. 31.

¹²⁸ CESCR. General Comment No. 3. para. 10.

¹²⁹ CESCR. General Comment No. 14. para. 18, reminding States of General Comment No. 3. para. 12.

do with women's human rights. Yet the repercussions of international trade agreements are felt by women nationally and locally. And, as we have seen, trade agreements have been implemented in a way that threatens women's right to health.

Therefore, as gender and human rights advocates have become increasingly aware of the failure of the WTO to take into account the human rights implications of trade agreements and policies, they have brought the issue to the attention of the UN and regional human rights bodies and have rallied against the WTO itself. While these strategies have been significant in raising the awareness of the human rights community, to influence trade policy advocates must also target their national governments as members of the WTO and parties to human rights treaties. Under national pressure, governments are more likely to accept their accountability for binding human rights obligations and bring a human rights perspective to trade negotiations. Only then can trade agreements be implemented in a way that fosters both trade and the ability of states to respect, protect and fulfill women's right to health.

Why it is not enough to criticise the WTO

Since the WTO came into effect, anti-globalisation activity has exploded. Many members of civil society have chosen not to engage with the WTO. Having seen the consequences of trade policies for women's enjoyment of social and economic rights, other advocates have preferred to bring trade agreements into human rights discussions and documents at the UN and regional human rights bodies. Very few, if any, have systematically and consistently incorporated human rights into efforts to influence their national governments' stances at WTO trade negotiations. While civil society has arguably scored some victories stalling WTO negotiations, international trade agreements have multiplied and negotiations have proceeded without civil society participation. And so, regardless of civil society criticism, international trade agreements will likely continue to proliferate and WTO members will likely continue to neglect their human rights obligations in trade negotiations.

Even if the WTO was disbanded, the intensification of international trade would continue in the form of bilateral and regional trade agreements – if not on a larger scale. Therefore, it is most essential that civil society influence national governments as members of the WTO and of regional trade groups to formulate international trade policies which have both trade and respect for human rights as their goal.

Making the case that human rights obligations enjoy supremacy over trade agreements

- The UN Charter takes precedence over all international agreements and the International Court of Justice has ruled that state action “which constitutes a denial of fundamental human rights is a flagrant violation of the purposes and principles of the Charter”ⁱ
- Significantly for States parties to the ICESCR, violations of that treaty include “the failure of a State to take into account its international legal obligations in the field of economic, social and cultural rights when entering into bilateral or multilateral agreements with other States, international organizations or multinational corporations”ⁱⁱ
- The WTO Secretariat has stated publicly that the WTO Secretariat and member states are bound by international law and that member states must respect their obligations under human rights treaties and take them into consideration when interpreting WTO provisions.ⁱⁱⁱ

ⁱ Elliot, Richard. *TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property*. Canadian HIV/AIDS Legal Network AIDS Law Project South Africa. 2001.

ⁱⁱ Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (adopted January 22-26, 1997), at paras.15(j) and 19.

ⁱⁱⁱ Gabrielle Marceau, Representative of the World Trade Organisation. Comment to the Subcommission on Promotion and Protection of Human Rights. 53rd Session. 8 August 2001. For more information, see Elliot, Richard. *TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property*. Canadian HIV/AIDS Legal Network AIDS Law Project South Africa. 2001.

By providing for human rights obligations in trade agreements, member states of the WTO can ensure trade agreements that allow sufficient flexibility to encourage enjoyment of human rights and to change policies should they have detrimental or discriminatory effects. Given that international trade will continue regardless of civil society’s criticism of the WTO, it is instrumental that women’s groups and other members of civil society work to encourage and conduct studies of the negative effects of trade on human rights so that these effects can be recognised and mitigated in future agreements.

How local actions affect negotiations on international agreements at the WTO

Most of our suggestions for women's advocates involve national-level activity instead of direct engagement with the WTO. The reasons are several. First and most importantly, the WTO is composed of states that have legal obligations under human rights treaties to respect, protect and fulfill women's human rights. These obligations are non-negotiable and cannot be discarded in the course of trade obligations. Therefore, by publicising states' failure to live up to human rights obligations and the potential for trade agreements that do protect human rights, advocates are more likely to influence these states (and the politicians representing them) because they are more susceptible to targeted pressure than is the more remote and amorphous WTO.

Secondly, it may be more practicable to mobilise opposition to trade policies within a state. That is, because state representatives are accountable to their citizens, once again there is more opportunity to insist that they meet their obligations to the public. The appropriate government representatives and ministries are also more identifiable and easier to target for advocacy than are officials at the highly secretive WTO. Moreover, people are more likely to mobilise in opposition to policies they feel affect them locally and personally. By making people aware of the repercussions of trade agreements on a local or personal level, women's NGOs can rally community action.

Mary Robinson, former High Commissioner for Human Rights, on national-level advocacy for human rights

"I believe that the nation-state level is very important. The whole human rights structure is based on the accountability of governments. It remains the task of governments to implement the fundamental human rights standards which should influence all aspects of globalisation, including even trade talks, and to be answerable for this in a democratic way. The structure is international, but the accountability is national and I would like to see that accountability being more penetrating at regional and local levels...We're saying that this process of accountability should not only be upwards, to UN committees with few or no sanctions, it should also be downwards to civil society and a public opinion that is educated to demand those rights"ⁱ

ⁱ "Making 'Global' and 'Ethical' Rhyme: An interview with Mary Robinson". 12 September 2003. <www.opendemocracy.net/articles/ViewPopUpArticle.jsp?id=6&articleId=1627>.

Finally, national action is instrumental to preserving women's right to health precisely because our governments have failed to include ministries of health and women in discussion of trade policies. In fact, many states sign trade agreements and commit health services to liberalisation under GATS without so much as notifying the Ministry of Health. By acting nationally, civil society can encourage the involvement of the Ministries of Health and Women, which may counter-balance the Ministry of Trade to ensure that each state maintains its flexibility to ensure access to medicines and health services for all.

What women's groups can do

Unless women's voices are raised during trade negotiations and unless disaggregated data on the impact of trade agreements is studied, women's rights will come into conflict more and more frequently with trade agreements and, as a result, women's rights worldwide will suffer. It is, therefore, the responsibility of women's NGOs to advocate for the inclusion of gender equality and the protection of women's human rights within trade agreements. This, however, does not necessarily mean taking on entirely new responsibilities and direction. Rather, women's NGOs should make a concerted effort to consider the implications of trade for work in which they are already engaged.

For example, women's groups working on education should be aware of the danger of privatisation of education and the implications of trade agreements for women's access to education. Groups focusing on women's political rights should similarly advocate for the inclusion of female advocates of gender equality and women's rights in international trade negotiations lest they find that women no longer can enjoy their right to participate in determining whether their water is privatised or how their schools are managed. By mapping the connections between a state's obligations under human rights treaties and the effect of trade agreements on various sectors, women's human rights advocates can bring government attention to human rights obligations and the fact that that trade policies might prevent the enjoyment of human rights unless properly implemented.

To protect women's human rights, women's NGOs can adopt a number of strategies to engage with their governments and the public at large:

- Encourage inclusion of gender representatives of civil society at all levels where trade agreements are negotiated both internationally and nationally. This will promote consideration and further study of gender issues before and after trade agreements are signed.
- Learn about trade agreements and policies. Stay abreast of developments in trade, using the resources compiled in Appendix C.

- Conduct case studies of the effect of trade agreements on women's right to health.¹³⁰ This is particularly important because so few case studies have been done that link trade agreements to consequences for women's right to health (and other economic and social rights). While it is possible to argue that women are disproportionately affected by trade agreements because they have less access to resources, reduced mobility and higher work burden, it is more convincing to offer evidence of particular cases. Also, where healthcare is being privatised, it is important that advocates determine what trade-offs women are making in order to provide healthcare for their families.
- As a corollary activity to compiling your own case studies, encourage government ministries and local government to disaggregate data by gender when compiling data on public services such as water, health and education. This data can then be used to supplement or form the statistical basis for case studies.
- Use case studies to educate the community. Issue press releases and target local women's groups that may not have considered the local effects of international trade or a rights-based approach to trade analysis.
- Include information compiled in case studies in CEDAW Shadow Reports. Even if you have yet to gather information, give the CEDAW Committee questions on the issues of international trade and rights guaranteed by the CEDAW Convention.
- Ensure that local decision makers, community activists and media are aware of the alternatives to and dangers of privatisation/liberalisation as well as the potential negative effects trade may have locally.
- Work with influential groups within government and civil society, such as unions or doctors' organisations, so that they too can mobilise their members to lobby for consideration of gender, health and labour issues.
- Coordinate activities internationally, promoting exchange of information between women's NGOs across countries. If, for example, India and

¹³⁰ For comprehensive instructions on how to do a complete trade impact review considering the consequences of a trade agreement for women's well-being and rights overall, see Women's Edge Coalition Trade Impact Review, Report by Sarah Grammage, Helene Jorgensen, and Eugenia McGill with Marceline White, Washington DC, April 2002. <www.womensedge.org/pages/referencematerials/reference_material.jsp?id=160>. For a good example of the effect of an economic plan (privatisation of water) on the right to water, see International Fact-Finding Mission on Water Sector Reform in Ghana. Public Citizen/Water for All. 2002. <www.citizen.org/documents/factfindingmissionGhana.pdf>

the US are negotiating a trade agreement with provisions that may prevent women from enjoying the right to health, cooperation between women's groups in the US and India is more likely to bring gender issues into the public eye and onto the negotiating table than if the groups work independently of one another.

- Work with other NGOs to organise discussion to generate awareness and share information.
- Determine who are the key players in the government, that is, who makes decisions on human rights, economic policy, trade agreements, etc. Identify any lack of coherence between the policies of these different officials. Foster communication to create coherence between the key policymakers.
- Engage in targeted lobbying of individual members of government in national parliaments, political parties and sector ministries (especially in women's machineries). When conducting such lobbying, remind your governments that human rights agreements have primacy over other international obligations.¹³¹
- Include Human Rights Commissions in holding dialogues with all government ministries and NGOs. These Commissions are the best place to encourage coherence between government ministries in regard to respect and promotion of human rights treaties.
- Call for a moratorium on GATS to give states time to assess the impact on women and vulnerable groups. Remind your governments that they should be careful about further liberalisation especially in the absence of an assessment of liberalisation's effects. Particularly in developing countries, there is often inadequate data to properly assess effects of liberalisation; this hinders efforts to develop safeguard mechanisms.

Therefore, it is essential that advocates make it clear to government ministries, the press and the public that if the state believes it can benefit from liberalisation, it can liberalise autonomously without committing the service under GATS. This gives the state the opportunity to reverse liberalisation if the benefits are not as hoped.¹³²

¹³¹ For a detailed discussion of the primacy of human rights treaties over trade obligations, see Elliot, Richard. *TRIPS and Rights: International Human Rights Law, Access to Medicines and the Interpretation of the WTO Agreement on Trade-Related Aspects of Intellectual Property*. Canadian HIV/AIDS Legal Network AIDS Law Project South Africa. 2001. pp28-62.

¹³² Yen, Goh Chien. 2003. Report on the UNCTAD Commission on Trade Meeting in Geneva. February. Third World Network.

Questions for advocates to ask

*Questions on negotiations of trade agreements*¹³³

- ✓ Is your government negotiating a bilateral or regional trade agreement?
- ✓ What has the position of your government been in trade negotiations? With which states does it align itself?
- ✓ Are representatives of women's groups being included in these negotiations on any level?
- ✓ Which ministries are being included in negotiations? Which ministry dominates the discussion? What is the role of the health ministry? In the process of trade negotiations, do the negotiators receive information from the women's ministry?
- ✓ Are the ministries included in trade agreements giving input to the CEDAW reports? Are trade negotiators knowledgeable of CEDAW and do they have access to the government reports to the CEDAW committee?
- ✓ Are there any aspects of the draft trade agreement which raise particular issues of concern for women and women's rights?

Questions on the legal and social framework

- ✓ What UN human rights treaties has your government ratified?
- ✓ With regard to women's working conditions, what national-level legislation is available to protect workers' rights?
- ✓ What gender-based constraints or limitations might prevent women in your country from having the same access to healthcare as men?

Questions on public awareness of the impact of trade agreements

- ✓ Has there been public debate or fora on the impact of trade agreements? Has there been media publicity? Parliamentary debate on the subject?
- ✓ Has there been academic research done on the subject of the impact of trade agreements?
- ✓ Are NGOs negotiating with their governments at the national level and are they including of information relating to trade and the right to health in their reports to treaty bodies?

¹³³ For a list of additional questions and considerations, see Williams, Mariama. 2003. *Gender Mainstreaming in the Multilateral Trading System: A Handbook for Policy Makers and Other Stakeholders*. London: Commonwealth Secretariat.

- ✓ If women's NGOs are working on the issue of trade and human rights, what support are they receiving from other civil society groups such as trade unions, doctors' groups, etc.?

Questions on the impact of trade agreements and possible solutions

- ✓ Have changes in the local economy caused any redistribution in access to resources, employment opportunities or healthcare? Can those changes be connected to a change in economic policy on a national or international scale?
- ✓ How are economic changes in your community (plant closings, outsourcing, mechanisation of cottage industries, etc.) affecting women?
- ✓ Is there talk of privatising water or healthcare?
- ✓ Are there any measures that might remedy the inequalities caused by trade agreements?

Questions on the implementation of TRIPS

- ✓ Do women in your community have access to HIV/AIDS drugs, birth control pills and other drugs?
- ✓ What is your government's position on TRIPS and access to essential drugs?
- ✓ Has your country modified its national-level legislation yet to conform to TRIPS?
- ✓ Is your country engaged in bilateral or regional negotiations of agreements that may include TRIPS-plus provisions? If so, to what extent is the media aware of these provisions? Ministry of Health? Ministry of Women?

Appendix A

Glossary of Terms

Determinants of health: Any and all outside factors that affect and determine a person's physical and psychological health and well-being. These can be economic factors such as water, sanitation, food supply, etc. These can also be political and civil factors such as education, access to employment, etc.

Generic drugs: Those drugs that are not protected by intellectual property laws and are virtually identically to and have the same effect as brand name drugs whose patents have expired. They are generally much less expensive than the brand name drugs.

Intellectual property: Intellectual property rights are a way of providing legal protection for inventions or ideas as if they were physical property. To attain intellectual property rights, a person must register the invention, artistic work or name with the national government. Such registered intellectual property falls into three basic categories: trademark (registered mark to identify a certain product or service), patent (for inventions), and copyright (for literary, musical and artistic works)

Liberalisation: Process of removing and reducing controls or barriers to trade, including both tariffs and non-tariff barriers such as licensing requirements.

Moratorium: An agreed-upon temporary suspension of some activity. For example, a moratorium on the import of a specific and possibly dangerous product allows the state time to evaluate the effects of the product. The stoppage of importation is only temporary, unlike a ban of the product.

Patented drugs: In contrast to generic drugs, these drugs are registered with the government and are given protection by intellectual property laws. A patent generally gives the holder the right to exclude others from making, using, selling, or offering to sell the invention in the country, or importing the invention into the country. Until the patent expires, no one can produce a drug that is essentially the same, i.e. a generic.

Peremptory norm: A decisive standard. It admits no contradiction and must be obeyed.

Privatisation: Process of changing from a government-controlled or public-owned system to a privately run, for-profit system.

Tariff: A list or system of duties or a duty imposed by a government on imported or exported goods.

Appendix B

Some Relevant Treaties and Trade Agreements

HUMAN RIGHTS TREATIES AND THEIR TREATY BODIES

- The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – The CEDAW Committee
- The International Covenant on Economic, Social, and Cultural Rights (ICESCR) – The Committee on Economic, Social and Cultural Rights
- The International Covenant on Civil and Political Rights (ICCPR) – The Human Rights Committee

WORLD TRADE ORGANISATION AGREEMENTS

- Agreement on Sanitary and Phytosanitary Measures (SPS)
- Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS)
- Agreement on Technical Barriers to Trade (TBT)
- General Agreement on Trade in Services (GATS)
- General Agreement on Tariffs and Trade (GATT)

Appendix C

Helpful Sources of Information

- ActionAid** (www.actionaid.org)
- Alliance for Responsible Trade (ART)** (www.art-us.org)
- Bridges Weekly Trade News Digest** (www.ictsd.org/weekly/index.htm)
- Business and Human Rights Resource Center** (www.business-humanrights.org)
- Center for Health and Gender Equity** (www.genderhealth.org)
- Center for Policy Analysis on Trade and Health** (www.cpath.org)
- Center of Concern Women’s Project** (www.coc.org)
- Central America Women’s Network (CAWN)** (www.cawn.org)
- Development Alternatives with Women for a New Era (DAWN)** (www.dawn.org.fj)
- European Women’s Lobby** (www.womenlobby.org)
- Friends of the Earth** (www.foe.org)
- International Women and Trade Network** (www.genderandtrade.net)
- Institute of Gender and Health** (www.cihr-irsc.gc.ca/e/institutes/igh/8673.shtml)
- Intellectual Property Rights Online** (www.iprsonline.org)
- Latin American and Caribbean Committee for the Defense of Women’s Rights**
(www.cladem.com)
- Latin American and Caribbean Women’s Health Network (LACWHN)**
(www.reddesalud.web.cl)
- Medecins Sans Frontieres Campaign for Access to Essential Medicines**
(www.accessmed-msf.org/index.asp)
- Network Women in Development Europe (WIDE)** (www.eurosur.org/wide)
- Public Citizen’s Global Trade Watch** (www.citizen.org/pctrade/tradehome.html)
- Third World Network** (www.twinside.org.sg/)
- 3D – trade – human rights – equitable economy** (www.3dthree.org)
- Women’s Edge Coalition** (www.womensedge.org)
- Women’s Environmental and Development Organisation** (www.wedo.org)
- World Trade Organisation** (www.wto.org)

