

*Birth, old age,
Sickness, and death:
From the beginning,
This is the way
Things have always been.
Any thought
Of release from this life
Will wrap you only more tightly
In its snares.
The sleeping person
Looks for a Buddha,
The troubled person
Turns toward meditation.
But the one who knows
That there's nothing to seek
Knows too that there's nothing to say.
She keeps her mouth closed.*

—Ly Ngoc Kieu, Vietnam, 1041-1113¹

Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any maps of the world. . . . Such are the places where every man, woman, and child seeks equal justice, equal opportunity, and equal dignity, without discrimination.

—Eleanor Roosevelt, U.S.A., 1958²

Women's Health, Poverty, and Rights



EVERY TWO SECONDS, somewhere in the world, eight babies are born, about half of them girls.³ Some 81% will live in poor countries. As we shall see in this and the next chapter, their births are all too often something more to be endured than to be celebrated.

Let us put a human face on the numbers. Think of Hope, the mother of Mary, a baby girl born in western Kenya. Hope was in her mid-thirties and already had five children when I visited the area in 2004 and heard about her from a traditional birth attendant at the local health clinic. Hope was disappointed to produce yet another girl, another mouth to feed, and she was feeling weak and very tired. Her other five children—three girls and two boys—were all under age twelve. To try to pay for the daily costs of her family, her husband searched for work in a nearby town even though he had been feeling very sick, while Hope sold vegetables in a local market. She struggled up after giving birth, thanked the village midwife who had helped her at the birth, and gave the new baby a breast to be shared with a sibling.

Several thousand miles north and east, in a rural village near Lucknow, India, baby Kamla was born in a small house made of clay and palm fronds. Kamla's young mother, Laxmi, age seventeen and already the mother of another little girl, was unhappy. Because she had not borne a son, she had

failed as a wife. Her one-year-old and the new baby were weak because the family she had married into was poor and she had not had sufficient good food to nurture a growing fetus and provide enough milk for her baby. Laxmi had gone to school for a year, not quite enough time for her to learn to read. Her parents arranged her marriage when she was twelve, and she went to the home of her husband when she was fourteen. Her in-laws were mistreating her and resented her for giving birth only to girls. When Laxmi's husband judged that she had not been working hard or keeping the house in order, he sometimes struck her. And here she was with Kamla, another girl, another burden.

My companion on this trip was a woman from BETI (Better Education through Innovation), a women's group working in the Lucknow area. She explained that not all stories of girls' births in India and other poorer countries are sad; many girls are welcomed into the world. But the hard truths are that most women in the world who are giving birth today are poor and illiterate, with little access to health care; that most girls in our world will face discrimination, poverty, unequal access to education and health care, and unequal pay for equal work. And about a third of women giving birth today will face violence at the hands of a partner, a violation of human rights that all too often happens in "small places, close to home, so small and so close that they cannot be seen on the maps of the world."

Women's health cannot be understood or improved without understanding the contextual relationship—the subordination of women, poverty, and violence, resulting in unequal access to education, food, health care, and paid employment.

Women and Poverty

What does poverty mean? The World Bank, in its 2000-2001 report on poverty, offered this description:

Poor people live without fundamental freedoms of action and choice that the better-off take for granted. They often lack adequate food and shelter, education and health, deprivations that keep them from leading the kind of life that everyone values. They also face extreme vulnerability to ill health, economic dislocation, and natural disasters. And they are often exposed to ill treatment by institutions of the state and society and are powerless to influence key decisions affecting their lives.

In an attempt to document the extent of poverty, the report continues: The world has deep poverty amid plenty. Of the world's 6 billion people, 2.8 billion—almost half—live on less than \$1 a day, with 44% living in South Asia. In rich countries, fewer than one child in one hundred does not reach its fifth birthday, while in the poorest countries, as many as one in five children do not. And while in rich countries fewer than 5% of all children under five are malnourished, in poor countries as many as 50% are. . . . The average income in the richest twenty countries is 37 times the average in the poorest twenty—a gap that has doubled in the past forty years. The experience of poverty in different parts of the world is diverse.³ In East Asia the number of people living on less than \$1 a day fell from around 420 million to around 280 million between 1987 and 1998. . . . Yet in Latin America, South Asia, and Sub-Saharan Africa, the numbers of poor people have been rising. And in the countries of Europe and Central Asia in transition to market economies, the number of people living on less than \$1 a day rose more than twenty fold during that period.⁴

The World Bank report notes further that experiences of poverty are very different at sub-national levels in countries and for minorities and women. Based on measures of school enrollment and infant mortality rates, women face more severe disadvantages than do men.⁵ Worldwide, women's wages, when women have access to the formal economy, are about two-thirds of men's. The majority of women are in low-wage situations or work informally for part-time wages with little or no benefits. In this age of globalization, which touts the spread of democracy and equality through market forces, the wage gap between men and women persists and is so prevalent that it is now commonly referred to as "the feminization of poverty." Rural women, in particular, have suffered; over the past two decades, the number of rural women worldwide living in absolute poverty rose by nearly 50%.⁶

The Human Poverty Index (HPI), introduced in the 1997 Human Development Report from the United Nations Development Programme (UNDP), attempts to quantify poverty in the world today by accounting for and trying to measure aspects of poverty beyond income, including lack of access to opportunities and resources.⁷ The report suggests that the HPI provides a better, though still incomplete, measure of women's experience of poverty. Though the practice of measuring by entire households makes it difficult to

WOMEN'S COURAGE: BEIJING, CHINA. The Beijing Cultural Development Center for Rural Women, also known as Rural Women Knowing All (RWKA) was formed to address the reality that rural women in China have little access to health services, independent income, and even education. RWKA works across China to improve women's literacy and expand educational opportunities for poor women. It does this through various media projects, including RWKA's magazine—the only magazine for rural women in China—which reaches millions of women using an appropriate level of written language for people with minimal reading skills.

RWKA's television and film projects include a documentary film series which deals with rural women's economic and social rights, environmental protection in China, education, and the construction of the legal system in China. The organization's reach has grown tremendously in recent years and now includes micro-credit programs, migrant women's clubs, literacy education, and reproductive health examinations. RWKA's vision is to inspire Chinese women by introducing them to positive role models and programs for financial and social empowerment.



discern bias and different levels of poverty within the home, “it is clear that poverty strikes women particularly harshly.”⁸

Poverty's greater burden on women has been known for years. It was described in the Platform for Action of the UN Fourth World Conference on Women, 1995: “In the past decade the number of women living in poverty has increased disproportionately to the number of men, particularly in the developing countries. In addition to economic factors, the rigidity of socially ascribed gender roles and women's limited access to power, education, training and productive resources . . . are also responsible.”⁹ It is clear that poverty affects households in general, but because men and women do different work and have different responsibilities for the household, women bear a greater burden as they manage consumption, some production, and scarce resources.

Many conditions of women's lives set them up to have fewer financial resources than their male counterparts, and poverty in turn can influence these conditions. For example, level of school enrollment, one measure of

WOMEN'S COURAGE: PHNOM PENH, CAMBODIA. Urban Poor Women Development (UPWD) initiates projects to help poor women in urban regions of Cambodia improve their economic situations. Many unskilled rural women migrate to Phnom Penh in search of jobs, where they endure poor living conditions in the slums of the city.

Formed in 1997, UPWD offers training to female workers in the city to increase their employability and their rights awareness. Working at the community level, the group gives funds to start small women's businesses, provides workshops on leadership skills, and offers training sessions for non-governmental organizations. UPWD hopes to lift Cambodian women out of poverty and increase their economic and social status.



poverty, reveals that more women than men are denied the education and skills to support themselves. Worldwide, 69% of females over the age of fifteen are literate, compared with 83% of males. In less developed countries the percentages are 66% and 81% respectively.¹⁰ More examples of challenging conditions for women are addressed in more detail in later chapters.

Unsurprisingly, the percentages of women in the paid labor force in virtually all countries are consistently lower than the percentages of men. For example, 37% of women are in the labor force in North Africa compared with 82% of men; 45% in Latin America and the Caribbean, compared with 86% of men.¹¹

If a mother is undernourished, often because she is poor, her baby is likely to be underweight and may even be born with a smaller brain. Maternal mortality, another measure of women's poverty, persists: complications of pregnancy and childbirth, when met with inadequate medical care at the time of delivery, can be deadly. Quality care saves lives, and it doesn't have to be done in a very wealthy country, as Malaysia and Chile have demonstrated. Skilled personnel attended 96% and 100% of births in those countries, respectively, resulting in the deaths of thirty-nine and thirty-three women per 100,000 live births. In Niger, by comparison, where only 18% of births are attended by skilled personnel, 920 women died per 100,000 live births in 2004. In Indonesia, 56% of births were attended by skilled personnel, and 580 women died per 100,000 live births.

Discrepancies in infant death rates illustrate women's disadvantaged status in poorer countries, as is discussed in the next chapter. Their disadvantaged status is also expressed in the situation of young women with regard to HIV/AIDS, discussed in a subsequent chapter, where it is noted that the HIV/AIDS epidemic has had a profound impact on the lives of women, especially those whose economic dependence on men and low social status leave them powerless to avoid risky sexual behaviors.

Access to money matters. Poverty is directly correlated with poor health. In a study of socioeconomic status and health, Nancy Adler et al. state: "Throughout history, socioeconomic status (SES) has been linked to health. Individuals higher in the social hierarchy typically enjoy better health than do those below. . . . The effects of severe poverty on health may seem obvious through the impact of poor nutrition, crowded and unsanitary living conditions, and inadequate medical care. . . . There is evidence that the association of SES and health occurs at every level of the SES hierarchy. . . . Not only do those in poverty have poorer health than those in more favored circumstances, but those at the highest level enjoy better health than do those just below."¹²

Health Defined

Now it becomes clear why a narrow definition of health that would refer only to physical fitness and/or an absence of illness would not help much with understanding the situation of women and their health and taking action to improve it. In contrast, the concept and ideal of health defined by the World Health Organization (WHO) as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" makes a lot of sense. Indeed, it is the definition used in this book as not only illnesses (e.g., HIV/AIDS) but also other conditions affecting health (e.g., education and work) are discussed.

Using the WHO definition of health raises the challenge of *measuring health status* across societies and groups that are very different one from another in terms of culture, economy, history, demography, and medical history.¹³ Nevertheless, the United Nations and other multinational agencies have attempted to measure health status; in combination they provide the best statistics and information currently available on the subject. Drawing from

many sources, including as careful work as possible by various multinational, governmental, and nongovernmental agencies, researchers and officials have no doubt that in no society today, including our own, do women enjoy the same opportunities as men. As a 1997 UN Development Programme report notes: "This unequal status leaves considerable disparities between how much women contribute to human development and how little they share its benefits."¹⁴ Three years later, another UN report, *The World's Women 2000: Trends and Statistics*, showed some gains but still found persistent disparities between women and men worldwide in six areas: health, human rights and political decision-making, work, education and communication, population, and families.¹⁵

The extent of poverty and ill health discussed above contrasts with a genuine revolution in human health and well being in the world as a whole. People are living longer—average life expectancy at birth in many developed countries nearly has doubled, from about 45 in 1900 to about 78 in 2003, and poorer countries have also experienced dramatic improvements in terms of declines in mortality—although this positive trend has reversed in some African countries as a result of the HIV/AIDS pandemic.¹⁶ There have been great improvements in health in general and success at controlling such diseases as smallpox and cholera. At the same time, however, the health of people around the world has been threatened by illness-causing substances, including some, like smoking and high-fat diets, that encourage unhealthy behavior. HIV/AIDS and TB have become scourges in more and more countries, threatening whole populations and weakening societal structures.

We live in a paradoxical world: while there have been tremendous health gains in some parts of the world and among some populations, these are counterbalanced by stagnation and decline in others. Health improvements have been unevenly distributed.¹⁷ Gro Brundtland, former head of the World Health Organization, in a 1998 press release, was quoted as follows: "Never have so many had such broad and advanced access to healthcare. But never have so many been denied access to healthcare. The developing world carries 90% of the disease burden, yet poorer countries have access to only 10% of the resources that go to health."¹⁸ Had Brundtland been highlighting women's health, she might have added that women carry the majority of the ill health burden but have access to a minority of resources to lighten it.

Women and Human Rights: A Slow Dawning

The reports mentioned above hint at but do not explicitly indicate the dire consequences that the persistent discrimination against women has for their health status. Jonathan Mann, who spent his life as a champion of human rights and health, made the link clear: “Discrimination against ethnic, religious, and racial minorities, as well as on account of gender, political opinion, or immigration status, compromises or threatens the health and well-being and, all too often, the very lives of millions. . . . Discriminatory practices threaten physical and mental health and result in the denial of access to care, inappropriate therapies, or inferior care.”¹⁹ Being born female is a health hazard, at times a fatal one.

Mann is, to be sure, talking more broadly about human rights, a concept that first became a worldwide preoccupation after the Second World War, when representatives of the newly formed United Nations tried to identify and agree upon what governments should not do to people and what they should assure to all. Out of these discussions came the Universal Declaration of Human Rights, promulgated on December 10, 1948.²⁰ But as significant as this achievement was, the Universal Declaration was a product of its time. The concept of “universal” human rights was, after all, developed by a particular set of people, people who were in positions of power at that time. For the most part, they were male, with the notable and inspiring exception of Eleanor Roosevelt. In subsequent decades, as individual people and groups—previously marginalized and certainly not party to the earlier discussions—began demanding their “rights,” the UN had to rethink its definitions, broadening them to include the needs of people whose special vulnerabilities were not taken into consideration in the past—women, children, indigenous people, the disabled, and so on.

Despite progress, the process was slow. These days, the idea that “women’s rights are human rights” seems obvious, but it was not until 1993, when the UN held a conference on human rights in Vienna, that the member states began to talk about abuses such as rape and domestic violence as “human rights” violations. It took even longer and prodding by women’s and human rights organizations for the UN Security Council to recognize the particular violations of women’s human rights in situations of war and armed conflict, including systematic rape as a policy of war and sexual slavery for the “comfort” of soldiers. As Human Rights Watch noted, “Combatants

and their sympathizers in conflicts, such as those in Sierra Leone, Kosovo, the Democratic Republic of Congo, Afghanistan, and Rwanda, have raped women as a weapon of war with near complete impunity.”²¹

The problem, though, was much deeper and broader than had been recognized. As Human Rights Watch put it:

Millions of women throughout the world live in conditions of abject deprivation of, and attacks against, their fundamental human rights for no other reason than that they are women. . . . Men in Pakistan, South Africa, Peru, Russia, and Uzbekistan beat women in the home at astounding rates, while these governments alternatively refuse to intervene to protect women and punish their batterers or do so haphazardly and in ways that make women feel culpable for the violence. As a direct result of inequalities found in their countries of origin, women from Ukraine, Moldova, Nigeria, the Dominican Republic, Burma, and Thailand are bought and sold, trafficked to work in forced prostitution, with insufficient government attention to protect their rights and punish the traffickers. In Guatemala, South Africa, and Mexico, women’s ability to enter and remain in the work force is obstructed by private employers who use women’s reproductive status to exclude them from work and by discriminatory employment laws or discriminatory enforcement of the law. In the U.S., students discriminate against and attack girls in school who are lesbian, bisexual, or transgendered, or do not conform to male standards of female behavior. Women in Morocco, Jordan, Kuwait, and Saudi Arabia face government-sponsored discrimination that renders them unequal before the law—including discriminatory family codes that take away women’s legal authority and place it in the hands of male family members—and restricts women’s participation in public life. . . . Abuses against women are relentless, systematic, and widely tolerated, if not explicitly condoned. Violence and discrimination against women are global social epidemics, notwithstanding the very real progress of the international women’s human rights movement in identifying, raising awareness about, and challenging impunity for women’s human rights [and health] violations.²²

In response to ever-louder criticisms and complaints, the UN promulgated two conventions of particular importance to women and girls: the Convention on the Elimination of All Forms of Discrimination Against Women (known

as CEDAW or the women's convention, adopted in 1979 by the UN General Assembly)²³ and the Convention on the Rights of the Child (adopted in November 1989 and entered into force in September 1990).²⁴ Both of these conventions laid out guidelines to protect the rights of women and children, but like many such documents, they lack enforcement mechanisms that are indispensable to creating meaningful change.

The Universal Declaration and other UN documents spelling out human rights are not as far removed from the everyday health concerns of women as they may seem. After all, as Mann wrote, "Human rights and public health are two complementary approaches, and languages, to address and advance human well-being."²⁵ Invoking international agreements like these lends strength to women's groups and others who try to encourage governments to improve conditions that affect women's health. In 1992, for example, at a Global Fund for Women meeting of a women's circle working to eliminate trafficking in women, some American participants asked activists from South and Southeast Asia what they (the Americans) could do to help the most. Expecting the activists to say that they needed more money for their work, the eager donors were awakened by the answer: "The most important thing that you and other Americans can do to help is to get the U.S. Government to ratify the women's convention [CEDAW] and the Convention on the Rights of the Child, both of which address the issue of trafficking in women and girls." The activists explained that without U.S. ratification of such conventions, it was difficult, if not impossible, for them to lobby their governments for legal change in such countries as Nepal, the Philippines, and Thailand.

The UN may seem distant to many of us, and its ways are often bureaucratic, but women's groups around the world have used the UN system to lobby for change in their own countries. These activists were saying that around the world, caring women and men must join together to demand full human rights for all women. (As of 2007, the U.S. Government has not ratified CEDAW or the Convention on the Rights of the Child. For information, see section on "Some Useful Resources," pp. 277–283.)

For decades, women's health issues have been approached as purely "development" issues (i.e., improving economic and social development). This focus is an instrumental one (i.e., improving women's health in order to increase productivity or providing family planning in order to reduce population levels). Why now complicate things by shifting to a human rights

framework? The answer highlights a critical difference: The human rights approach moves the intention away from a broad instrumental approach to an individual, human approach—to improving women's health and/or providing family planning simply for the sake of justice.

The stories of Kamla and Mary, the little girls born in India and Kenya, would not have been relevant if we were to take a strictly developmentalist approach to their situations without addressing their rights as human beings. Recall that both were born into poor families, that one of the mothers had suffered violence, and that just because they were born female, both were destined to have problems gaining access to education and other services. Arguing a development rather than a human rights approach would result in the idea that the poor will always be with us, that governments should try to educate girls in order to increase national productivity, and that domestic violence is a private rather than a public matter and need be considered primarily to calculate a society's health costs.

A human rights perspective demands that we recognize that providing education for girls, for example, is not only a good development decision but also a question of justice, of individual rights. It leads us to see that tolerating sexual abuse is not just a bad economic choice, in terms of health costs, but also a violation of a woman's right to bodily integrity. A human rights view reveals that maternal mortality is not only a tragedy because it deprives children of a caregiver but an abrogation of the right of a woman to basic health care.

The rights to "life, liberty, and security of person" and to freedom from "slavery or servitude" and "cruel, inhuman, or degrading treatment or punishment" in articles 3, 4, and 5 of the Universal Declaration were to be guaranteed to every person. Who could take issue with that? The problem is the context: these words referred to civil and political prisoners, not to people who were subjected to "slavery," "torture," or "cruel, inhuman, or degrading treatment" in their homes or places of work. It was the human rights advocates who highlighted the importance of equality and freedom from bodily harm for individual people whose circumstances were not recognized in early international conventions on human rights. It was women's advocacy groups who proclaimed at the 1993 UN Conference on Human Rights in Vienna: "Women's rights are human rights." This is an idea that Eleanor Roosevelt would surely have fully understood, but it is an idea that did not make its way into public consciousness until the 1990s.

Why Focus on Women?

The discrepancies in opportunity and access for women already highlighted here may be reason enough to focus a discussion on women. But there are other reasons to learn more about the experiences of women and their health. Women, whether healthy or not, are at the heart of family and society. A woman's health affects every area of her life and therefore of her family and community. Today, for a variety of reasons, women often end up as the sole supporters of their children. While percentages vary around the world, in many countries more than 30% of households are headed by single females.²⁶ Women are not just productive members of a family; often they are its safety net. If the truth of women's lives, in all their complexity, is hidden from us, change is unlikely.

The subordination of women as well as the persistence of poverty, the proliferation of violence, and continuing gaps in access to food, health care, education, and living wages are in their breadth and depth like a war on women. These inequalities—these violations of the human rights of women—stem from a basic dislocation in society that distorts the lives of both men and women. This dislocation has to do with the way we conceive of ourselves in relation to others. Focusing on and learning more about the situation of women may help us transform our “either/or” way of thinking and change the way that we view and treat each other in this world.

At the moment, we are caught in a paradigm of behavior that is unhealthy. It is an either/or paradigm that leads us to categorize people and then assign values to the various categories—black versus white, male versus female, strong versus weak, educated versus uneducated, rich versus poor. Instead of appreciating and welcoming such differences, we use these dichotomies to separate ourselves and even pit ourselves against one another. Although there is nothing inherently unequal or even negative about assigning categories—perhaps a natural human tendency—it is the destructive value judgments that follow that need to be eliminated. This paradigm of seeing people who are different from ourselves as the “other” and possibly of lesser value has resulted in the marginalization and subordination of certain groups over the years (groups such as people of color, indigenous people, differently abled people, and women). The result has been the development of hierarchical social structures, structures that have subordinated more than half of the world's population—women and groups of marginalized

men as well. We need to understand and work to change the paradigm of “either/or” to “both/and.”

The “either/or” paradigm is perfectly illustrated by the significant statements: “It’s a girl!” or “It’s a boy!” Society’s different and value-laden reactions to these two statements will determine the course and health of a person’s life.

The subordination of women is deeply ingrained in the lives of both men and women. Sometimes it is explained in terms of biological differences.²⁷ Over time, culture, religion, and most social systems, including educational, legal, and medical systems, which in both traditional and modern forms tend to be hierarchical in structure, have assigned less status and power to women and other marginalized groups.²⁸ The subordination of women and girls takes many forms. At the moment of birth, celebrations may differ according to the sex of the baby. In childhood, girls’ and boys’ access to food, health care, and education often differs. Later in life, women’s subordination is illustrated in the objectification of women’s bodies, the gendered division of labor, and persistent abuse of women and girls.

As the realities of women’s lives demonstrate, the state of women’s health is critically connected to the subordination of women. Throughout this book, many examples of this subordination will be cited and described. However, it is important to remember, as Gerda Lerner argues in *The Creation of Patriarchy*, that:

While women have been victimized by . . . many other aspects of their long subordination to men, it is a fundamental error to try to conceptualize women primarily as victims. To do so at once obscures what must be assumed as a given of women’s historical situation: Women are essential and central to creating society; they are and always have been actors and agents in history. Women have “made history,” yet they have been kept from knowing their history and from interpreting history, either their own or that of men. . . . The tension between women’s actual historical experience and their exclusion from interpreting that experience I have called “the dialectic of women’s history”. . . [which] has been a dynamic force, causing women to struggle against their condition. . . . This coming-into-consciousness of women becomes the dialectical force moving them into action to change their condition and to enter a new relationship to male-dominated society.²⁹

WOMEN'S COURAGE: ACCRA, GHANA. The African Women's Development Fund (AWDF) raises money and gives grants to projects initiated by African women for African women. Founded in 2000, the Fund is one of about twenty women's funds around the world that have formed in the last ten years to provide support to women's human rights organizations in their countries or regions. AWDF gives grants ranging in size from about \$10,000 to \$25,000 to strengthen and link smaller women's groups throughout Africa. The Fund also provides technical assistance in organizational management and assistance in communications and networking.

The Fund helps women's groups defend and improve women's rights in areas such as reproductive health, political participation, access to healthcare, and employment. Between 2000 and 2007, AWDF provided grants to groups in more than thirty-two African nations.



The examples of women's groups inserted throughout the text in this book represent this "coming-into-consciousness" of women, that force that is moving them into action to change their condition.

A final and important reason to understand the complex health situation of poorer women is to better appreciate our global interconnectedness. William Bud, a physician, writing about typhoid in 1931, noted: "This disease not seldom attacks the rich, but it thrives among the poor. But by reason of our common humanity we are all, whether rich or poor, more nearly related here than we are apt to think. The members of the great human family are, in fact, bound together by a thousand secret ties, of whose existence the world in general little dreams. And he that was never connected with his poorer neighbor, by deeds of charity or love, may one day find, when it is too late, that he is connected with him by a bond which may bring them both, at once, to a common grave."³⁰ Adding SARS, avian flu, or HIV/AIDS along with one or two politically correct changes in pronouns makes this quote timely today.

Women in poorer countries are much more vulnerable to the kinds of infectious diseases alluded to in the previous paragraph than are people in richer countries. Still, women around the world deeply feel their shared struggles around such health issues as domestic violence, reproductive rights, and equal access to paid employment.

But the clarion call in Dr. Bud's statement, to me, is the phrase "*by reason of our common humanity* [my emphasis] we are all, whether rich or poor, more nearly related here than we are apt to think." Though women and men may share vulnerabilities and struggles relating to issues of health and human rights, our true bond of interconnectedness is in our common humanity. We can choose to live by universal standards of justice, and we can choose to create change to make that justice possible for all.

To improve women's health we must treat specific health problems, but the conditions of women's lives must also change so that we women can gain more power over our lives and our health. At the base of such social change is extending women's capacity to be in charge of our own lives, to exercise our human rights.

We focus on women, therefore, because women's experiences are different and under-studied, because societies need women to be healthy and fully engaged, because it is only fair that women have full equality in their societies. And we focus on women because understanding their unique challenges is a prerequisite to justice.