MISSING IN ACCESS: A FEMINIST CRITIQUE OF INTERNATIONAL DOCUMENTS THAT PERTAIN TO THE HUMAN RIGHT OF ADOLESCENT GIRLS TO ACCESS TO HEALTH SERVICES AND THEIR IMPACT ON YOUNG WOMEN IN AFGHANISTAN AND IN CANADA

by

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A thesis submitted in conformity with the requirements

for the degree of Master of Science.

in the Graduate Department of Exercise Sciences.

University of Toronto

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Abstract

The health services and programs promoting the well-being of adolescent girls as described in international declarations. covenants and conventions that have been signed by countries around the world are not available to most young women. A feminist cultural studies approach is used to study human rights documents and two case studies that describe access to health services for girls in Afghanistan and girls in Canada. The results expose a historically produced. socially constructed and culturally defined hegemony that denies girls the human right they have to health services. The way forward requires making equity a budget issue. educating civil society and program providers about human rights law. launching a Charter Challenge. conducting gender specific research. changing the measurement of program efficacy and empowering girls to take action themselves through self-esteem building physical activity programs.

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Chapter One

Adolescent Girls and Health Rights: An Overview

> Attention to the girl child – to her nourishment, education, health and safe keeping – will drastically alter the balance of cash in the global village. It's the girl child who can eradicate poverty, save the environment, put a country to work (North-South Institute, 1994).
>
> By addressing key health problems affecting women at all stages of their lives, governments can improve human welfare and national economic efficiency. (World Bank, 1994b).
>
> Societies that discriminate on the basis of gender pay a significant price in greater poverty, slower economic growth, weaker governance and a lower quality of life. Education, health, productivity, credit and governance work better when women are involved (World Bank, 2001).

In a flurry of conferences during the mid-nineties, the girl child was hailed as the hero of change in the developing world. Simply put, if she has adequate food, basic education and access to health services, she will stay at home longer, marry later, have fewer children and those children will be healthier. According to the World Bank these changes are enough to not only improve human welfare but also national economic efficiency (World Bank, 1994b).

Six years later at the *Beijing Plus Five Conference* in June 2000, the representatives from Status of Women Canada reported that around the world, progress

has been made in improving the health, nutrition and education of children. However, girls continue to be disadvantaged compared to boys and the specific needs and interests of girls are often not addressed in the development and implementation of policies and programs. Adolescent girls are particularly at risk and have specific needs in terms of their sexual and reproductive health and the development and implementation of their life skills and self-esteem (Status of Women Canada, 2000).

The most widely used and modern definition of health was developed by the World Health Organization (WHO): Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity (Mann, Gruskin, Grodin, Annas, 1999). Why is it that international documents sanctioned by the United Nations and ratified by countries around the world call for the right to the highest attainable health and yet the health of adolescent girls is at risk? Do the international documents that claim the human right to the highest attainable heath include adolescent girls or don't they? And if they do, what is causing the persistent lack of access to health services?

There are more than one billion adolescents aged 10-19 in the world - 85 per cent of them live in developing countries, half of them girls (Panos, 1999, p. 1). What does it mean for them to be healthy? In terms of the international documents, what does it mean to be a girl? As the review of the literature will show, they are virtually absent from early human rights rhetoric and even the modern human rights documents such as the Declaration of Human Rights (1948) do not mention the adolescent girl. The Convention on the Rights of the Child (1989) lumps the adolescent girl in with infants, toddlers and boys. In fact, the missing adolescent girl wasn't addressed until February 2, 1999, when the Convention on the Elimination of All Forms of Discrimination Against Women

(1979) wrote General Recommendation 24 which stipulates that "women includes girls and adolescents."

For many young people, adolescence (the period of change from childhood to adulthood, a notion that will be established in the theoretical framework) is a healthy transition period during which they learn values and skills that will benefit them as future parents, heads of households, workers, artists and contributing members of all sectors of society. But the health and lives of a large number of teenagers, now and for the coming years, are in danger (Panos, 1999).

At the dawn of the new millennium, and after more than 50 years of debate, the right to health for women and adolescent girls is still elusive, even though it was defined in the constitution of the World Health Organization in 1948 and incorporated into the subsequent Treaties produced by the United Nations. The World Health Organization (WHO) defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Access to health services is also stipulated in the Convention on the Rights of the Child in article 12 (1)(f) that calls for State Parties to develop health care and services and article 12(1) of the Convention on the Elimination of all Forms of Discrimination Against Women that requires State Parties to ensure access to health care services. The question is, how is it that access to health services, defined and signed into international legal documents, remains stubbornly denied to adolescent girls?

The right to health as defined by WHO and used in international legal practice today began with the adoption of the United Nations Charter in 1945 (Cook, 1994a). Article 1 in the Charter says,

> The purposes of the United Nations are to achieve international co-operation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language or religion (Article 1, The United Nations Charter. 1945).

Article 55 states "The United Nations shall promote ... solutions of international economic, social, health and related problems ..."

The Charter was followed by the adoption of the Universal Declaration of Human Rights in 1948. It is significant in the analysis of women's and an adolescent girl's human right to health to note that the preamble in the United Nations Charter deals with people, "the peoples of the United Nations ... " while the articles that make up the Charter deal with state parties. The issue is can individual states fulfil the promise the Charter makes to the people? It is also significant to note that in the Declaration that followed, the discourse uses the male gender and omits the female gender. That raises another question. Were women's rights considered human rights when the documents upon which modern society bases its fundamental rights theory were written? More than seven international and regional covenants and conventions that give explicit recognition to the right to health followed. But today those rights offer little real protection for women and girls. As Rebecca Cook has argued, "The challenge of securing women's [and adolescent girls] health directs attention not simply to physical and mental health services but to the justice of the foundations upon which societies function," (1994a, p.1). Says Dr. A. El Bindari Hammad of the World Health Organization, "The women of the world need more than

treaties. They need urgent action to make the terms of these instruments a reality in their lives and in their access to health" (cited in Cook, 1994a, p. VI).

That challenge was addressed directly at the Beijing Plus Five (BP5) conference in New York City from June 5-9, 2000. Women delegates from 180 countries gathered to debate, protect and enforce the strongest language for women and health in the centuries old debate about fairness, justice and safety for the universal rights of women. At that conference the right to health was expanded to include the right to well being in the absence of violence and coercion (Crossette, 2000). United Nations Secretary General Kofi Annan said, "Women's issues are on the agenda as never before" (Consensus, 2000). The conference opened the door for a sea change for women and girls and health particularly in terms of the ways and means of implementing the right to the highest attainable health and the emerging need to examine the ramification of well being and proactive health policies (Kidd, 1995).

For example, despite the nearly universal ratification of the Convention on the Rights of the Child, children and adolescents remain invisible to policy makers and human rights issues are often discussed in ways which exclude children and adolescents (International Save the Children Alliance, 1999). The Convention on the Rights of the Child is a powerful instrument which can be used to improve the welfare of young people but caution must be exercised to ensure that by defining rights in terms of children, the term does not become synonymous with boy. "Gender neutral terms such as children, teenagers, adolescents and youth can perpetuate greater invisibility of girls and adolescent women in the eyes of policy makers and funders; if we only speak of women's

human rights and children's rights. the rights of girls can be neglected" (ISCA. 1999. pp. 3).

The four principles of non-discrimination in the Convention on the Rights of the Child apply to boys and girls. But when collectively applied to girls. they set out a clear and uncompromising commitment to a girl's right to develop as an individual.

•That girls have equal value as human beings;

•That the best interest of the girl should be primary;

•That due weight should be given to the opinion of girls;

•That every girl has rights (ISCA, 1999).

How can girls be made visible? How can attitudes toward girls be changed? And what needs to be done so that the Children's Convention is implemented in gender-specific ways at national and international levels?

What shapes most adolescents. regardless of their particular circumstances and social class. is the impact on their lives of their societies' gender-based expectations. These are widely shared ideas about characteristics, abilities and behaviours that are considered 'proper' and 'typical' for females and males and which are transmitted by families. schools. religion. laws. the media. advertising, entertainment and other institutions. Young women may learn that females are regarded as more emotional. only considered adults if they are married and even then expected to be submissive to men in decision making (Panos. 1999).

These consequences occur despite the fact that attention to the adolescent girl increased during the last half of the nineties. Some of these congresses and conventions include the First World Congress Against Sexual Exploitation of Children in 1996. the

adoption of the International Labour Organization Convention for the Elimination of the Worst Forms of Child Labour in 1999, The World Summit on Children in 1990. the World Conference on Human Rights in1993. the International Conference on Population and Development in1994 and the World Conference on Women in 1995 where the girl child was identified as a critical area of concern in the Beijing Platform for Action.

A 1997 report by the Canadian Institute of Child Health entitled The Canadian Girl-Child: Determinants of Health and Well-Being of Girls and Young Women has stressed that "gender identity determines how boys and girls experience their environment and the life path they choose" (Status of Women Canada, 2000). The report concludes that gender socialization shapes and limits the lives of girls, especially their education and career choices. For example, girls and young women are making headway in the education system, with young women now more likely to have a university degree than young men. While women make up the majority in most fields of study, almost 7 out of 10 are in education and health-related programs, respectively constituting 69 % and 68 % of the student populations in these fields. In contrast women account for only 29% of students in mathematics and 22% of those in engineering and applied sciences (Status of Women Canada, 2000, p. 2).

To understand the confounding resistance of the right to access to health services for adolescent girls, an interrogation is required of human rights history, the contested definitions of health rights, the international documents that support the right to access to health and the situation adolescent girls find themselves in regarding each of those concerns.

Sorting out the Rights from the Wrongs

Human rights discourses have become part of the lexicon of common language and political decision making in the twenty-first century (Ignatieff, 2000). In fact the literature surrounding women's human rights burgeoned in the 1990s and the literature focusing on a woman's right to health was produced mostly during the last five years of the Twentieth Century. Although codified in international law in 1948 with the Universal Declaration of Human Rights, the notion of human rights is contested in sources as old as the Bible, the Koran and early Buddhist writings more than 2000 years ago. Scholars of antiquity such as Plato, Aristotle, and Cicero called for human rights in terms of "universal brotherhood" and the "common good" (Ishay, 1997). Through the Middle Ages, the Enlightenment Period and the Industrial Age, the debate continued. Women joined the dialogue first in the 1400s (Fraser, 1999) and more forcefully in the 1700s; health care entered the rhetoric in the 1800s (Ishay, 1997). These key shifts in the notion of human rights will be elaborated in chapter two.

In the last half of the Twentieth Century and today, the concept of human rights moved from a philosophy of civil behavior which was paternalistic and elitist, to enforcing the particular rights of the individual. From gay rights and the rights of citizens to a smoke-free environment, to refugee rights and the rights of Aboriginals, the discourse around human rights is deconstructing the effects of today's civil society on the citizen.

The discussion around the human right to health today uses as its starting point, the WHO definition that was signed in 1946 and codified in the United Nations Universal Declaration of Human Rights in 1948, and the eight international and regional covenants

and conventions that refer particularly to health rights. Those international covenants and conventions are: The International Convention for the Elimination of All Forms of Racial Discrimination (the Race Convention, 1965); The International Covenant on Civil and Political Rights (known as the Political Covenant and first generation rights, 1966); The International Covenant on Economic, Social and Cultural Rights (known as the Economic Covenant, second generation rights, 1966); The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, the Women's Convention, 1979); The Convention on the Rights of the Child (the Children's Convention, 1989).

The international documents that can be applied most directly to an adolescent girl's right to access to health services and will be analysed for this research are: The Race Convention, The Economic Covenant, The Women's Convention and The Children's Convention.

Regional conventions which will not be analyzed but also pertain to health rights include: The European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention, 1950); The American Convention on Human Rights (the American Convention, 1969); and The African Charter on Human and Peoples' Rights (the African Charter, 1986). These documents also promote and protect the right to health because "they prohibit discrimination on the grounds of sex and require respect for various rights related to the promotion and protection of health." (Cook, 1994a, p. 2). Together they contain no fewer than 18 articles that can be used to deal specifically with women's health, CEDAW (1979) being the most compelling because it addresses women's rights in particular and is universal in scope. Cook points out, "The Convention is the first international treaty in which member countries, known as State

Parties, assume the legal duty to eliminate all forms of discrimination against women in civil, political, economic, social and cultural areas, including health care and family planning," (1994a, pp. 2 and 3).

A collection of documents pertaining to proactive health and well being will also be analyzed. They include: The European Sport For All Charter (1975); The International Charter of Physical Education and Sport (1978); The Berlin Agenda for Action for Government Ministers (1999).

Other conventions that protect women's health but will not be analyzed in this research paper include; The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1987) and The Convention Relating to the Status of Refugees (1951). The value of these documents is their protection of women as well as men from the harms described in the Conventions. The documents to be analyzed were selected for their direct association with the origin of human rights treaties, the right to health and their application to women and adolescent girls.

But do these documents offer real protection to adolescent girls today? While the health status of adolescent girls will be examined in another chapter, for the purpose of introduction, some startling facts deserve attention. In terms of an adolescent girl's right to access to preventative and medical health services, a number of considerations need to be taken into account. Around the world, young mothers age 15-19 give birth to more than 16 million babies each year, pregnancy complications are the major cause of death in 15-19 year olds world-wide and maternal mortality rates for girls aged 10-14 is five times higher than that of 20-24 year-olds. Nearly one-quarter of the 500,000 women who die each year of causes related to childbirth are teenagers (World Bank, 1994a, p.18).

Adolescent gender socialization shapes and limits the lives of girls, especially their education and career choices. Adolescent girls are vulnerable to stereotypical gender images that idealize being underweight and smoking in Western cultures (although that "ideal" is being increasingly copied in other cultures) and being submissive to men in most cultures. They also face the risk of gender-based violence (Status of Women Canada, 2000). Of the estimated 333 million new cases of curable sexually transmitted diseases (STDs) each year, at least one-third occur in young people under 25 years of age. More than half of all new HIV infections – over 7000 each day – are among young people age 10-24 (WHO/FRH/ADH, 1998, pp. 4 and 5). Deaths related to pregnancy and childbirth are two to five times higher among women under 18 than among those aged 20-29. (WHO, 1998, p. 4). World-wide one third of women hospitalized for abortion-related complications are younger than 20. (Reproductive Health Integration Issues, 1998, p. 1). Every five minutes a young person somewhere in the world commits suicide (WHO, 1998, p. 5). Many of these health-related problems are preventable.

In terms of adolescent girls rights to access to proactive programmes that enhance their well being, more facts need to be considered. Adolescents want to be physically active but face multiple barriers to participating in an active lifestyle (MacNeill, 2000). Young people who are physically active are far less likely to use tobacco, alcohol or other drugs (Heart Health Coalition, 1997). Physical activity stimulates bone growth and bone remodeling. Evidence from the Osteoporosis Association of Canada suggests that exercise is effective in the prevention and treatment of osteoporosis by contributing to the building of bone mass before age 35 and to its maintenance during the rest of the life cycle. (cited in Lenskyj, 1991). Physical inactivity is a major independent risk factor for

cardiovascular disease. Regular physical activity can reduce the risk of coronary heart disease by 50 per cent. (Heart Health Coalition, 1997). Women who participate in physical activity programs report a higher level of self esteem and improved physical health. They also report lower levels of depression, stress, disturbed sleep and loneliness. (Frisby, W. & Fenton, J., 1998). Girls who participate in after school activity that include physical activity are more likely to have a positive sense of self than girls who participate in non-physical activities or do not participate at all (Melpomene Institute, 1996). Although a majority of young women say they feel good about themselves, young men consistently score higher on all measures of self-esteem (CAAWS, 1991). And a study reported in the Canadian Medical Association Journal calls the rising state of obesity due to lack of physical activity among Canadian children, "a staggering rate of change" (Branswell, 2000, p. B1). Participation in physical activity is obviously beneficial to the health and well being of young women. Yet a key gap in the human rights literature and in the health access debate is the lack of attention to physical activity opportunities for girls and the fact that physical education has been sidelined from most school curricula.

How can these potentially powerful, theoretical and practical human rights documents for addressing the issues that loom largest for adolescent girls make the connection between access to health and human rights in the 21st Century? Can the articles within the documents effectively challenge the power structures and hegemony that reinforces adolescent girls' inequality? Can the mechanisms now in place to enforce and supervise the right of the adolescent girl to health services effectively alter the status of the girl child's health? These questions will be pursued in Chapter Five titled, The Best

of Intentions: A Discourse Analysis of the Documents Pertaining to the Right to Access to Health Services.

Fuelling the discussion are the collective results of four international women's forums (1975, 1980, 1985, 1995) and Amnesty International's addition of women and girls to their international mandate in their March 8, 2001 report titled Broken Bodies, Shattered Minds in which they claim violence against women and girls is "fed by a global culture which denies women equal rights with men" (p. 2). These contributions highlight evidence of the critical role human rights discourse will play in the post cold-war era of world politics (Ishay, 1997). A socio-historical analysis of that discourse is needed to examine the progression of human rights rhetoric that begins with one analysis for everyone and graduates to a multi-levelled application that can more effectively realize the original goals of the United Nations Charter.

From a feminist cultural studies perspective, obtaining the right to health is fraught with dilemma. Since rights-based law comes from liberal theory, feminists argue that the interpretations of such laws reflect the experience and interests of male elites in the legal system, the political structures and society in general, and fail to accommodate or acknowledge the realities of women's lives (Mann, Gruskin, Grodin & Annas, 1999).

Moreover, the basis of the right to health needs to be fully explored to understand the intent of the authors of the documents and the obligations of the states that are required to implement them in, for example, access to health services that deliver preventative and medical care and proactive health policies that contribute to well being. Is it the right of a girl in Afghanistan to have access to health services? Is it the right of Canadian schoolgirls to regain access to physical and health education? And if so, can

any of those rights be implemented with current international and regional Treaties? Considering that most of the documents were written by men and the law wasn't feminized until a decade ago, women's experiences have been marginalized and the experiences of adolescent girls have been virtually ignored.

In international law there is a difference between State responsibility and State accountability: The State is legally responsible but politically accountable (Cook, 2000). Women's rights invariably fall in the political sphere. As well, research conducted post 1979 on women's reproductive health, violence against women and abortion are excluded from the documents. Their inclusion today is problematic because of the power of fundamentalist states such as Saudi Arabia, Iran, Pakistan and the Vatican to delay the debate or even annul the hard-won articles that already exist, if the documents are opened for discussion.

A feminist cultural studies approach that examines both gender and inequality, women's experiences of gender oppression, and places emphasis on understanding women as subjects rather than as objects of research (Taylor, 1998) can reveal how the socially constructed role of women and girls affects the interpretation of international documents. Although focusing on gender results in a lack of attention to intersections of class and race, this approach can allow for a better understanding of the reality of women's experiences and challenge the biased assumptions mediating some of the documents and the political positions of those whose task it is to implement the documents. The feminist cultural studies approach will be elaborated on in Chapter Four, The Theoretical Framework and Methodology.

Purpose

The purpose of this research is to critically analyse the articles within the human rights documents listed previously that support an adolescent girl's right to access to health services as a human right in order to determine their efficacy in the realm of adolescent girls' experiences in health care and health outcomes.

This feminist analysis will question whether the human rights documents, the political debates and the struggle to gain equality, have heeded the needs of adolescent girls and whether the documents are effective in providing and promoting access to health services. Two case studies will be used to illustrate the reality of young women's lives through documents pertaining to the girls of Afghanistan and the girls of Canada.

Specific Objectives

- To critically analyse the discourses of the human right to access to health services for adolescent girls in the documents and to question the degree to which they contribute to the highest attainable health for girls;
- To examine the socio-cultural factors and struggle around women's human rights to health and why it has been necessary to separate women's right to health and adolescent girls right to health from other rights.
- To question whether the right to health can be implemented in terms of access to health services and proactive health policies that contribute to well being.

Chapter Outline

Chapter 1: Adolescent Girls and Health Rights: An Overview

Chapter 2: Review of the Literature: The Origins of Human Rights. Modern Human Rights. The Right to Health.

Chapter 3: Review of the Literature: Adolescent Girls, Health and Well Being.

Chapter 4: A Feminist Cultural Studies Approach to Adolescent Girls. Health and Human Rights.

Chapter 5: The Best of Intentions: International Laws for Health Rights are Written With Care. Monitored With Diligence and Failing to Serve.

Chapter 6: Case Study 1: The Adolescent Girls of Afghanistan: Access Denied.

Chapter 7: Case Study 2: The Adolescent Girls of Canada: On the Move Program

Chapter 8: Conclusions and Recommendations

Chapter 9: References Cited

Chapter 10: Appendix

Chapter Two

A Review of the Literature:

The Origins of Human Rights, Modern Human Rights, the Right to Health

The recorded human rights debate begins in the 13th Century BCE. For the purpose of reducing a vast amount of human rights literature to the footprints of the origins, arguments and establishment of a woman's right to health and the search for an adolescent girl's right to access to health services, three sections will be used to separate the distinct stages of the debate and to discover who informed the debate and what their notions of women's and girls' rights were at that time. The first section includes religious humanism and stoicism, from the Bible to the Middle Ages, where the foundations of human rights can be found in the world's major religions; liberalism during the Enlightenment Period when religious traditions became secularized and redefined into political rights (which would later be called first generation rights); the Industrial Age when liberal rights were challenged by socialists (which would later be called second generation rights). The second section reviews social movements such as feminism that draw on both liberal and socialist arguments for human rights raised during the first half of the 20th Century. The third section examines the increasingly proactive involvement of

civil society. the feminist movement and the call for the right to self-determination (Ishay, 1997) in the last half of the 20th Century to the present. It includes the deconstruction of the rights debate by stakeholders who had been marginalized in earlier discussions. This review of the human rights literature will include an introduction to the key human rights documents used in the research.

The Origins of Human Rights: From Religious Humanism During Antiquity, to Liberalism in The Enlightenment Period, and to Socialism in the Industrial Age

"Universal brotherhood" and the "common good" are the themes that connect the earliest writings in human rights discourse. Despite being paternalistic in nature, there is evidence of human rights philosophy and indeed laws for the common good in the earliest religious doctrines. Although the laws, social structures and mores of the time empowered and privileged men over women, the language in the ancient writings makes it clear that universal brotherhood was gendered in language but not in fact and the common good was for women as well as men. However there is no suggestion that children or adolescent girls were part of that dialogue. In the Bible (Acts 17-19), Paul reminds the Athenians that God created all humankind and individuals of all races are equal under his tutelage (Ishay, 1997). The Koran says, "The rights of women apt to be trampled under foot, now clearly affirmed" (Surah 12, 168-242, cited in Ishay, 1997). The Ten Commandments were basically a code of morality and mutual respect. Exodus which was written between 1350 and 1200 B.C.E. calls for the right to equitable remuneration and the right to freedom and redistributive justice (Ishay, 1997). Early Buddhist writings contain similar moral codes for both men and women that call for

seeking the six perfections: generosity, morality, patience, vigor, concentration and wisdom.

More secular scholars such as Plato and Aristotle and Cicero were also constructing human rights doctrine in their manuscripts. Plato's *Republic* contains a defence of human rights for women at a time when women were entirely excluded from political life. "Absolute justice for Plato can be achieved only when individuals fulfil the tasks to which each one is suited in harmony with the common good " (Ishay, 1997, p. xvi). In his notion of the common good he calls for the rights of women. Aristotle also used the common good as the base line for civility in *Politics* and had a profound effect on the development of human rights as did Cicero in his *The Laws* which laid out the foundation of natural law and human rights (Ishay, 1997). In fact, Ishay notes, "Cicero appealed to universal human rights laws that transcend customary and civil laws and endorsed the idea of 'a citizen of the whole universe, as it were of a single city'" (1997, p. xvii).

It is clear that the philosophy, even the law was available in ancient civilizations in Greece and Rome by 300 B.C. but arguments then as now continued to rage. The religious leaders were informed by the Holy Scriptures, the liberals and socialists claimed the concept of human rights was secular. Even the liberals and socialists struggled amongst themselves, the liberals placing emphasis on private property, equality before the law and political liberty and the socialists who saw economic equality as a precondition for freedom and equity (Ishay, 1997). But women's voices were excluded from the human rights agenda.

Paradoxically, it was war itself that often expanded human rights theory (Alston, 1999). The Crusades produced the Magna Charta in 1215 which became a battle cry against oppression and called for free men and the lawful judgement by peers. Clauses of the Magna Charta are contained in the 1628 Petition of Rights in England, the Habeas Corpus Act of 1679 and the national and state constitutions of the United States (Ishay, 1997). The French Revolution, produced The Rights of Man. The First World War resulted in the forming of the League of Nations and called for the rights of citizens and the Second World War produced the United Nations Charter and the Universal Declaration of Human Rights. The wars of the 1990s particularly in the Balkans and Rwanda and civil strife in Afghanistan and the Middle East brought heightened attention to women's rights as human rights.

It needs to be noted that the literature recorded prior to the 20th Century around women's rights has a distinctly northern and western origin. That presumes that southern and eastern women were not involved in the debate. It would be more accurate to stress that the available recorded data is what is used in this review. Having said that, the publication in 1405 of *Le Livre de la Cite des Dames* by Christine de Pizan is the earliest evidence of women joining the human rights debate (Fraser, 1999). The author "encouraged women of all classes to look to their own experience and resist being limited and demeaned by men," (Fraser, 1999, pp. 858). De Pizan argues for the right to education, to live and work independently, to participate in public life and to be responsible for their own fate (Fraser, 1999). This makes a strong argument for the fact that women's human rights were considered long before Olympe de Gouge and Mary

Wollstonecraft presented their *Rights of Women* documents in the 1700s and prior to the Habeas Corpus Act of 1679.

During the Enlightenment period in the sixteen and seventeen hundreds, scholars such as Thomas Hobbes sought to protect the individual's natural right to life and security in *The Leviathan*. He was joined by liberal British philosopher John Locke who maintained in *Of the Dissolution of Government* that "Revolutions don't happen because of every little mismanagement in public affairs but only over a long period of human rights abuses." (Ishay, 1997, p. xxxiii), and Jean-Jacques Rousseau who argued for rights to property, political representation and equality before the law. They were followed by Hugo Grotius, Abbe Charles de Saint Pierre, Thomas Paine, Immanuel Kant and Maximilien Robespierre who took human rights to an international scope. But their references to human rights were rarely inclusive. "In fact the definition of 'human' left out women, the working class, and people of racial communities. But their claim to represent all humans led those excluded to mount their own campaigns for rights." (Kidd & Donnelly, 2000, p. 133).

It was at this time that women became directly involved in the rhetoric demanding that these rights be equally applied to females. Olympe de Gouge presented her *Rights of Women and Female Citizens* to Queen Marie Antoinette in France in 1790 (Ishay, 1997). In it she included the first evidence of a social contract, a marriage contract, a widow's pension and equity in a divorce settlement. Two years later Mary Wollstonecraft wrote *The Rights of Women* in England. "Women I allow may have different duties to fulfil; but they are human duties, and the principles that should regulate the discharge of them, I sturdily maintain, must be the same" (Wollstonecraft, 1792/Ishay, 1997, p. 153).

Wollstonecraft also called for attention to women's health arguing that women should be more knowledgeable about health, anatomy and medicine. And she was two centuries ahead of her time in bringing attention to the consequences of violence against women (Fraser, 1999). But although she wrote of change, she wrote as well of her time. For Wollstonecraft, freedom for women didn't mean equality to men. In her demand for the education of women she says, "Make women rational creatures and free citizens and they will quickly become good wives and mothers – that is, if men do not neglect the duties of husbands and fathers" (Wollstonecraft, 1792/Ishay, 1997, p. 157). The term adolescent would not be coined for 150 more years. At this time children were still seen as miniature adults (Aries, 1962).

The concept of human rights flourished along with the concept of socialism during the Industrial Age in the 1800s probably due to the miseries associated with industrialization. Human rights theorists expanded the human rights debate and laid the foundations for rights for the masses rather than rights only for the ruling classes. The right to universal health care, to education, the emancipation of women, along with the prohibition of child labour, the establishment of factory health and safety measures and universal voting rights, including a woman's right to vote were advanced by Pierre-Joseph Proudhon, Karl Marx and Friedrich Engels and John Stewart Mill. In his 1869 essay, *The Subjection of Women*, Mill called for the equality of men and women (Fraser, 1999). Marx, Engels and August Bebel paid particular attention to the dependent status of women and encouraged an alliance between women and workers (Ishay, 1997). The gap in the literature during this period is around the voices of women. The rhetoric around the subjugation of women is written by men.

Following Marx' and Engels' concern for women's rights, Bebel wrote in 1883 in *Women and Socialism* what would be a prophecy for the women's movement for the next 100 years, "Women cannot achieve real equality under capitalism as long as women work for free in the household and for low wages in the workplace" (cited in Ishay, 1997, p. xxvii). Bebel called for economic and intellectual independence and socialized childcare. But the absence of women's voices in the debate suggests the women themselves were the subjects rather than participants in the research, a criticism that would follow even into the 21st Century.

Although public health has its origins in this period and a new Poor Law written in 1834 in England improved on the 17th Century Elizabethan Poor Law, health was mostly defined by infectious diseases. The health of women, who were both marital and reproductive slaves, was not a consideration.

Achieving equality rights would be left to the challenges in the twentieth century when resistance and acts of agency would carry the struggle for women to secure the right to vote (Sage 1990), to be recognized as persons, to deconstruct the rhetoric around the rights debate, and to ensure that women's rights are human rights. With the exception of the call for the right to physical activity for adolescent girls and boys in 1923 at the Conference on Athletics and Physical Education for Women and Girls, and *the European Sport for All Charter* in 1976, adolescent girls would not be part of that debate until the 1990s and not considered in the human rights documents until 1999.

Modern Human Rights: Social, liberal and feminist theory in the first half of the 20th Century

If the years leading up to 1900 set the stage for human rights as a world-wide phenomenon, it was the dawn of the Twentieth Century that saw the recording of those theories in international documents. In 1902, prompted by the women's suffrage movement, government delegates meeting in The Hague, The Netherlands adopted a series of conventions aimed at setting international standards for marriage, divorce and the custody of minor children. It was the start of a century of change for women (United Nations, 1995).

The founding of the Covenant of The League of Nations in 1919, promoted human rights legislation to include humane working conditions, the prohibition of traffic in women and children, the prevention and control of disease and the just treatment of colonial people. These concepts served as a launching pad for the writings of German social democrat Karl Kautsky, Russian revolutionary, Leon Trotsky, American pragmatist, John Dewey, Indian pacifist, Mahatma Gandi and American scholar, David Luban, each of whom expanded the rhetoric on human rights in the first half of the twentieth century.

While Trotsky like Locke and Marx before him, argued for revolution, Kautsky and Dewey advocated a reformist approach and Ghandi called for *Satyagraha* or passive resistance (Ishay, 1997), their writings contributed little to establishing women's rights as human rights. But they did inform today's post cold-war debate about the international community's right to intervene when governments fail to protect the basic human rights of citizens (Ishay, 1997). And their views did inform liberal, social and radical feminists who would pick up the debate in the second half of the 20th Century.

Much of the conceptual groundwork for what would become the United Nations Charter regarding women's rights grew out of the pioneering efforts of the Pan American Union (the precursor to the Organization of American States) and the League of Nations. Women gathered in 1923 in Santiago to establish the route to eliminating legal and constitutional impediments to women's political and civil rights. By 1928 when they met in Havana Cuba, they created the Inter-American Commission of Women. That commission's work led to the adoption of the Montevideo Convention on the Nationality of Married Women which was the first international treaty to proclaim the equality of the sexes in regard to nationality (United Nations, 1995).

The work at the convention resulted in a collection of non-governmental organizations led by females that began a survey of the status of women with the intention of drawing up new international agreements on a wide variety of women's rights. However, shortly after the preliminary agreements were signed in 1937, World War II erupted and the survey was never completed. The work leading up to the survey had however set the stage for women when the United Nations Charter was drawn up in 1945. The detailed history of women struggling for human rights found in the literature is useful in determining the evolving status of women.

The Charter was the first international agreement to proclaim *sex* equality as a fundamental human right. It created an historic legacy of internationally agreed strategies, standards, programmes and goals to advance the status of women worldwide. As for health rights, the founding document calls on the UN to promote solutions for international health problems (article 55b). The Universal Declaration of Human Rights that followed in 1948, states that everyone has the right to a standard of living adequate

for the health and well-being of his family, including food, clothing, housing and medical care and necessary social services (article 25[1]). This means that all member states of the UN have an obligation to create the conditions for health and well being for everyone. (Dutt, Flowers, Mertus, 1999).

While the Charter was being written at the UN, the concept of a Bill of Rights was finding favour among Nation States. For example, a Bill of Rights for Canada was introduced into the House of Commons by Alistair Stewart in 1945 but only as a concept. The idea became The Recognition and Protection of Human Rights and Fundamental Freedoms and presented as Bill C-60 in 1958. It was finally passed by the Senate and received Royal Assent on August 10, 1969 (Tarnopolsky, 1975). The gap in the literature in the area of a Bill of Rights is the exclusion of a discussion about the marginalization of women. It also fails to note the post-war reversal of the role of women who had taken over the factories during the crisis and were then sent home again when the "men" returned.

Human rights rhetoric particularly in the form of Bills of Rights was on the rise all over the world. It was reproduced in documents that began calling for a proactive interpretation of the human right to health. For example, at the same time as Bills of Rights were flourishing, the first declarations of access to sport and physical activity as a human right began to develop. Although those declarations developed largely as a result of the equity movements of the 1960s they wouldn't be raised formally until 1976 in the European Sport for All Charter (Kidd & Donnelly, 2000). And again in 1978 when the International Charter of Physical Education and Sport was adopted by the General Conference of UNESCO in Paris (UNESCO, 1978). The first article states that: The

practice of physical education and sport is a fundamental right for all. As well, "At the 2nd World Conference on Women and Sport in Windhoek, Namibia in 1998, delegates heard how the UN's monitoring of Convention on the Elimination of all Forms of Discrimination Against Women (1979) - article 10-g of which explicitly addresses sport - has pressured many governments to increase their efforts to develop physical activity and sport for girls and women" (Kidd & Donnelly, 2000, p. 139). And on November 5, 1999, The Berlin Agenda, drafted at the World Summit on Physical Education in Berlin, called for action by governments and ministries responsible for education to "Implement policies for physical education as a human right for all children" (Berlin Agenda, 1999, p. 1). And yet the rest of the human rights literature ignores physical activity as a component of optimal health. This research will redress this absence particularly in terms of: the effects of body issues on adolescent girls, the methods employed in physical activities that are detrimental to girls and women and the fact that feminists invariably ignore these concerns in their research (Hall, 1996; Lenskji, 1994; Donnelly, 1996; Hargreaves, 1994; CAHPER, nd; Coakley & White, 1992; Gruneau, 1975; Hay & Donnelly,1996; Humbert, 1995; Vertinsky, 1992 and 1994).

It will also address the need to build on the Charters pertaining to physical activity and amend them to the current needs of civil society. Although the Charters are useful in the argument for health as a human right, these Charters don't carry the clout of law. Accordingly, they remain largely rhetorical and dependent on the will of governments to enforce them.

In the meantime, while the second wave of the women's movement was well and truly launched in the 1960s, it wouldn't be until the last quarter of the 20th century that

women's voices would be heard at major meetings where rights issues were discussed. Women's human rights and the issue of health began to gather steam from the direct and constant input of women.

Fifty years after the Charter, it can be said that few causes promoted by the United Nations have generated more intense and widespread support than the campaign to promote the equal rights of women (United Nations, 1995). However the proclamations of the Charter were not translated into realities for women without first securing the legal foundations of equality and then painstakingly enforcing those legal rights.

In Canada for instance, although men and women were presumably equal under the international law of the United Nations, women did not enjoy equality at home. For example, until 1968 a man had the right to beat his wife because she was considered chattel. A married woman could not open a bank account without her husband's signature. Nor could she go to a hospital for treatment without her husband's signature. Nor could she take her child to the hospital for treatment without her husband's signature. A widow found herself in financial purdah as her husband's assets did not belong to her. There were quotas at universities. Women were not allowed to play team sports at the Olympics until 1964 and then they could only play volleyball as it was considered a non-contact sport. There were unstated presumptions that women who were beaten by their husbands deserved it and women who were raped asked for it (Armstrong, 1995). While the academic literature describes the advances and defeats of women, it was women's magazines and women's groups themselves that challenged the international documents in the light of the actual experiences of women in their day-to-day lives. There was

clearly a lot of work to do on the new found freedoms and rights won in the United Nations Charter.

Much of that work was done by Canadian feminists such as writer Doris Anderson (editor of Chatelaine Magazine 1958-1983) and community activist Laura Sabia (president of the University Women's Club, 1965-1970) and laterally legal scholars such as Marilou McPhedran and Mary Eberts. It was the women's movement in Canada that demanded a Royal Commission on the Status of Women in 1967. The 164 recommendations handed down by Commissioner Florence Bird in 1970 set the stage for a legislated change in women's rights in Canada (Armstrong, 1995).

If the Royal Commission launched the first attack, it was the establishment in 1982 of the Canadian Charter of Rights and Freedoms that scored the first major victory. Sections 15 and 28 guarantee women and girls protection from laws, government regulations and government programs that discriminate against women and girls. The Charter says, "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability" (Canadian Charter of Rights and Freedoms, 1982).

These strong words would mean little to the women and girls of Canada if the provisions were not tested in the courts. That takes money, something that most women whose cases were to be tested in the courts had little of. To redress the lack of access to the courts, the Women's Legal Education and Action Fund (LEAF) was created by a group of women in 1985 so that the required funds would be available to establish the needed precedents in the law (Armstrong, 1995).

In the fifty years that followed the United Nations Charter, the United Nations recorded 126 different documents to establish the status of women as approved by the Charter. One of them was the 1966 International Covenant on Economic, Social and Cultural Rights which became the most explicit thus far in establishing the right to health. In an effort to implement WHO's definition of health, article 12 (1) states, "The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," (cited in Dutt, Flowers & Mertus, 1999, p. 56).

But the most modern and definitive instrument on women's equal rights was the creation in 1979 of The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (Cook, 1994a). Article 12 of CEDAW states that State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Article 5(a) states that State Parties commit themselves to take all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on the stereotyped roles of men and women. Article 16(1)(e) requires that women enjoy rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights. Article 10(h) requires that women have the right to specific educational information to help ensure the health and well being of families, including information and advice on family planning.

With documents such as CEDAW in place, the notion of women's health rights contributed to the struggle for self-determination. But they also forced a new scrutiny of the definition of health rights, a definition that leaves a gap in the literature about the consequences to women when health rights are denied.

The Right to Health

The right to health has been debated by philosophers, scientists and ethicists ever since the WHO definition was signed in 1946 and entered into force in 1948. One of the problems is interpreting the "right to health." It has proved to be a difficult task for those who try to improve the status of women world wide. The oldest recorded definition comes from ancient Greek philosophers whose notion of health was physical in nature. For example Aristotle's definition of health was stated as, "In the case of the body, excellence is health in the form of making use of the body without illness" (cited in Toebes, 1999a, p. 21). When WHO defined the right to health soon after the Second World War, the definition had changed considerably to include physical as well as social well-being. Today mental well being is also included in the WHO definition. But ethicists like Arthur Dyck take the view that implementing human rights is a duty of community members and that human rights and the right to health are about justice and nurturing (Dyck, 1994). The WHO definition has other detractors. Some critics, like Brigit Toebes, feel health does not need a definition at all. Those critics question the use of "state" rather than "process" and the suggestion that health is anything more than the absence of disease (Pederson, O'Neill & Rootman, 1994). They worry that health is being turned into a battleground of rights and resources. Most, however see the WHO definition as a

sweeping and needed change of thinking in terms of the benefits of broadening health to include health services that go beyond traditional medical services.

But questions persist in the definition of health. Is it the right to health: the right to health care or the right to health protection? Or, is it a combination of the three? (Toebes, 1999a). The literature on the definition of health rights is weak in that it is presented more as an argument for and against and rarely as a consequence in the lives of women. The rhetoric around the argument made by Toebes (1999) for example becomes pointed and accusatory. The definition backtracks on what health is and what rights are, rather than focusing on who's rights are being violated and how that violation can best be addressed.

The right to health as it is recorded in international treaties and declarations appears to formulate health as a human right. Generally the right to health is perceived as the right to certain health services and the right to be safeguarded from certain threats to health for which the State can be held responsible (Toebes, 1999a). If the State denies its responsibility for the right to health, infringements of people's well being and dignity are at stake. "Accordingly, attention must be given to the full range of human rights that go beyond the provision of medical, nursing and related health services, and that contribute in different ways and at different levels to the achievement and maintenance of health as defined by WHO." (Cook, 1994, p. 4).

General Comment 14 in CESCR, written in August, 2000, interprets the right to health as defined in article 12.1 as an inclusive right extending not only to timely and appropriate health care 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 including on sexual and reproductive health. This modern concept of health "includes yet goes beyond health care to embrace the broader societal dimensions and context of individual and population well being." (Mann et al., 1999, p. 8).

It expands on the Lalonde Report (1974) in Canada which declared that the health care system was not the most important factor in determining health. By introducing the health field concept – human biology, environment, lifestyle, and health care organization – the federal government established Canada as a conceptual leader in advancing thinking about health (Pederson et al, 1994). This report riveted attention to the relationship between physical activity and coronary heart disease, osteoporosis, diabetes, reduced risk of cancer and an enhanced feeling of well being (Federal, Provincial and Territorial Advisory Committee, 1999).

The Ottawa Charter of 1986 picked up on the Lalonde Report and built on the WHO definition and in fact left its mark around the world as a new concept in health. It relies on five strategies: building healthy public policy, creating supportive environments for health, strengthening community action, developing personal skills, and reorienting health services (Pederson et al., 1994). The Charter was coupled with a framework that included reducing inequity, developing mutual support and enhancing coping skills.

Missing in the research is an analysis of health policies as they relate to politicians. Similar to the early entries of human rights literature, the policies are paternalistic and elitist in that they serve the position of a government in power, the Trudeau years for example as opposed to the Mike Harris Ontario government. As much

as the definition of health has evolved over the years the current definitions need to be questioned from the aspect of an adolescent girl's right to access to health services.

The right to health also needs to be questioned from the point of view of who has the right to be involved as research subjects or participants, who has the right to participate in the research process and clinical trials that inform the preparation of medical professionals and the discovery of new treatments and drugs. Women and girls have, until recently, been excluded from that research. From breast cancer drugs to common Aspirin, women have not been part of the trials. Women also accuse researchers of medicalizing women's bodies by prescribing, for example, estrogen for menopause and calcium for osteoporosis (Dewar, 1998). The literature points to the need to include women and girls in the research but it leaves out many of the specific examples of medicalizing women for profit.

And the rights debate needs to include the thorny issue of maternity health care. Although article 12 of CEDAW says "State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (The United Nations and the Advancement of Women, 1995, p. 237), in fact 500,000 women die every year from pregnancy based complications, the equivalent of four jumbo jets crashing every single day of the week (Cook and Dickens, 2000). As Cook points out, "The challenge of achieving safe motherhood, like the challenge of overcoming racism, is that the reforms that are necessary threaten conventional practices and value systems." (Cook, 1998, p. 358). This is the area where the debate has raged as some say the right to be healthy cannot be guaranteed and others claim that health is a

state of being, not something that can be given. Implementation of the right to health and the reporting procedures in use therefore become a problem particularly in developing countries and certainly in countries around the world where justiciability, the right to bring a case to court, is at issue (Byrnes & Connors, 1996). However it should be noted that the inability to bring a case to court does not excuse a country's violation of the right to health. The conundrum appears for example, with applying the law to a country such as Mali which has the second highest maternal mortality rate in the world after Afghanistan or for that matter to western countries that have higher rates of cancer among women than in developing countries (Cook, 1994b). In more than 2000 years of human rights literature, the research in the last six years is examining the accusations made by de Pizan in 1405.

At stake in establishing the right to access to health services is not only the implementation of existing covenants and conventions but also examining the traditional view of morality that is reflected in existing laws. "The moral belief was that if women could enjoy sexual relations, with recourse to methods to prevent pregnancy, and sexually transmitted diseases, sexual morality and family security would be in jeopardy. This traditional morality is reflected in laws that attempt to control women's behaviour by limiting, conditioning or denying women's access to reproductive health" (Cook, 1992).

The problem with enforcing the right to health is not with lack of codification - the right to health is in fact justiciable – but rather the absence of a consistent implementation practice (Toebes, 1999a). All of which points to the need to re-examine the broad underpinning of health as a human right and the need to focus on how the right can be enforced.

For as much as academics and public policy makers may establish the right to health, women and girls can never benefit from it as long as the status of women remains second class.

> Women's de facto second class status in society creates both direct and indirect threats to their health. Since women are far more likely than men to be poor; they often receive less nourishment and are more vulnerable to disease. Many women who suffer poor health lack information, skills, purchasing power and access to health services. Socially constructed gender roles and the relations that arise out of these often lead to family and societal pressures that may push women to take care of others first and neglect themselves. In addition, violence against women, substandard working conditions and a poor living environment also wear down women's health (Dutt, Flowers & Mertus, 1999, p. 50).

Additionally, since most laws have been written by men, applied by male courts and have only very recently been re-analysed in the context of the lives of women, the rights of women continue to be marginalized. Domestic family life has traditionally been viewed as the centre of the private world and not the law's business. Yet women live mostly in that world and the sufferings of women are contained mostly in the private world (Charlesworth, 1994). "The privacy of domestic life makes women's concerns invisible and ensures preservation of the status quo which means we need to challenge the gendered dichotomy of public and private worlds," (Charlesworth, 1994, pp.69). The literature reveals a gap in the examination of the lives of girls within these texts. That gap

was not addressed until 1999 and is still evident in for example the State of the World Forum and the World March of Women which finally highlighted women's concerns but left girls off the agenda.

Challenging the public/private dichotomy on an international stage has brought stakeholders together and increased the exposure of the harms women suffer which can in turn affect the treatment of girls. The World March of Women held in October, 2000 in cities around the world and culminating in Washington and New York on October 17 and 18 shone a blazing spotlight on poverty and violence against women (World March of Women, 2000). International bodies such as The State of the World Forum have highlighted women's issues as the key to making the Twenty-first Century work, (State of the World Forum, 2000), and government organizations such as The Canadian International Development Agency (CIDA) have made women's issues, in particular women's health issues a priority. These actions resulted in part from 25 years of international conferences that examined the ways and means of reducing harm to women and implementing the human right to health.

At a consultation of lawyers held at the University of Toronto Faculty of Law in August, 1992, women advocates from Africa, Asia, Australia, and Europe tried to bring legal theory and practice to bear on the relationship between international human rights and women's rights in order to develop legal strategies to promote and protect women's international human rights. Key in these deliberations is the fact that while women in most societies start from a disadvantaged position, rights discourse offers a significant vocabulary to formulate political and social grievances which is recognized by the powerful (Cook, 1994c). For example, in the tiny African village of Malicouda in the

West African country of Senegal. the village women took a public declaration to ban the 1000-year-old custom of female genital mutilation. For more than 100 years. diplomats. the UN and Western feminists tried to stop the practice but failed. It was when the women learned that they had "the right to health" that they said, "Never again. Not my daughter" (Armstrong. 1998b). By making a public declaration as a group. they were able to break the taboo and eradicate the practice. The Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights denounce inhuman or degrading treatment and are nonderogable rights and a principle of jus congens. Although they are available to women's groups that are positioning ancient customs as harms women suffer in violation of their rights, the women of Malicounda knew of no such particulars. But the concept of rights. the very idea that they had the right to health was enough to empower these women to fight for change.

The consultation process also sought ways to make treaty-based bodies and charter-based bodies and both regional and domestic protection more effective for the human rights of women. The prerequisites they suggested for reform include improved education and training in human rights law and process. provision of legal services for women's empowerment. development of capacities to research facts and publicize findings. and promotion of the feminist presence on human rights committees. courts and commissions (Cook. 1994c). In 1999 General Recommendation 24 in the Women's Convention affirmed that access to health care is a basic right and in 2000 General Comment 14 in the CESCR affirmed that health facilities, goods and services have to be accessible to everyone without discrimination. These additions to the human rights treaties made the breakthrough rights lobbyists had been waiting for.

Are these efforts enough to enforce an adolescent girl's right to access to health services? Certain rules of international law exert more compliance than others do. And some of the strides women have made in taking their place as activists, legal experts and treaty monitoring candidates have been more effective than others, (Cook, 1999). The collective results of four world conferences on women highlight the changes women's groups have made in generating an understanding about the nature of subordination that women face, how they are marginalized by different developments whether locally or globally and how international law might be made more responsive to women's needs (Coomaraswamy, 1994). But have these efforts made the right to access to health services available to adolescent girls?

It is known that the knowledge gained from these international conferences has allowed the debate about women's human rights to broaden its scope and re-examine the interpretation of rights. For example, during the past 15 years, the international community has begun to interpret the refugee definition to encompass the experience of groups not specifically mentioned in the United Nations Convention Relating to the Status of Refugees definition (Ramirez, 1999). Canada has been the world leader on this issue. In March 1993, the Immigration and Refugee Board (IRB) issued its groundbreaking Guidelines on Women Refugee Claimants Fearing Gender Related Persecution. The guidelines provide substantive legal and procedural guidance in analyzing forms of persecution which are particular to women: rape, genital mutilation, bride burning, domestic violence, forced abortion and compulsory sterilization (T94-07910). While there is growing awareness internationally that women often fear persecution for reasons different than men, Canada is the only country to have adopted

formal guidelines for re-interpreting the meaning of persecution to reflect the experience of women refugees. The same principles which underline the Guidelines are evident in the draft Guidelines for Women Asylum Seekers, presented by the Women Refugees Project at Harvard University to the Immigration and Naturalization Service in the United States (Ramirez, 1999). The process was also able to put to rest many of the myths about women refugees and describe the more accurate lifestyles and usual health practices women experience in both good and bad times in their homelands (Giles, Moussa & Van Esterik, 1996).

On June 1, 1994, Citizenship and Immigration Canada issued a Declaration on Refugee Protection for Women, which explicitly recognizes that women's rights are human rights. Canada also contributed to the 1993 United Nations High Commission on Refugee Rights (UNHCR) Conclusions on Refugee Protection and Sexual Violence. And Canada sponsored the consultation calling for the UNHCR to appoint a special rapporteur on violence against women. Shortly afterwards, Radhika Coomaraswamy, Director of the International Centre for Ethnic Studies in Sri Lanka, was appointed to the post.

Aboriginal women's rights received the same kind of scrutiny. Because the Indian Act of 1886 governs all activities of native people from birth to death and because that same Indian Act overrides the Canadian Human Rights Commission, Aboriginal people are denied human rights otherwise provided in the Canadian Constitution. And since the rights of Aboriginal women within their own community are greatly at risk, they suffer double jeopardy in terms of: access to health care, the negotiation of health transfer agreements as well as a one in three rate of domestic abuse as compared to one in ten for non-Aboriginal women (Eberts, 1995). Eberts work in this area has contributed

knowledge that has been missing from the literature about health rights and aboriginal people.

The complicated system in Aboriginal government further denies women their rights. But international instruments such as the Universal Declaration of Human Rights. article #25 enshrines the right to a standard of living adequate for the health and well being of the person and his [or her] family, including food, clothing, housing and medical care. Article #26 stipulates that everyone has the right to education, and that parents have the right to choose the kind of education that shall be given to their children. And the International Covenant on Economic, Social and Cultural Rights (1966) ensures the highest attainable standard of physical and mental health. These arguments have been used to substantiate the abuses of Aboriginal women's human rights. (Eberts, 1995).

The right to health for indigenous people as well as women world wide were among the issues raised at the International Conference on Population and Development (ICPD) in Cairo in 1994. One hundred and eighty-four United Nations Member States met to consider the broad issues of and interrelationships between population, sustained economic growth and sustainable development and advances in health, education, economic status and empowerment of women. The consensus reached at this meeting was expressed as a 20-year programme of action (Girard, 1999). The commitments to action included the statement that women's right to the enjoyment of the highest attainable standard of health must be secured throughout the whole life cycle in equality with men. Good health is essential in leading a productive and fulfilling life, and the right of all women to control all aspects of their health is basic to their empowerment (Family Care International, 1999). In 1999, over 170 government delegations and 200 non-

government organizations met again to discuss progress and obstacles, and to decide on steps for further implementation of this International Programme of Action. Referred to as the ICPD Plus Five, this review showed that the ICPD Programme of Action has resulted in significant changes in the health policies and programmes in a number of countries. The literature surrounding the ICPD Plus Five exposes a much more proactive course of action for young women and a rhetoric that is increasingly frank and forthright about the human right of girls.

One of the conclusions of the ICPD Plus Five was that there is a reciprocal relation between rights. Respect for human rights is a prerequisite for the enjoyment of the highest attainable standard of health and conversely that the right to control every aspect of one's health and sexuality forms an important basis for the enjoyment of other rights (Family Care International, 1999). Are the current articles in international documents enough to reduce harm for adolescent girls and enforce the right to access to health services? And in the current fiscally responsible climate of making the consumer a victim of her own health problems (Ingham, 1985), is there the political will to honor the documents State Parties have signed?

It has taken more than 2000 years to advance the understanding of human rights. Adolescent girls only entered the debate during the last decade and their needs in terms of access to health services were not recorded until 1999. The implementation of their human right to access to health services requires additional research.

The principle behind the provisions for the right to health for women and girls are found in the UN Charter, the Declaration, the Covenants and Conventions as well as the regional Conventions and Charters. How do each of them inform the debate about the

right of the adolescent girl to access to health services? Do key elements of the human rights documents mediate actual access to health services? And how can they be implemented in case studies such as (a) Access to health services for adolescent girls in Afghanistan and (b) Proactive health policies for well being in physical activity and health education for girls in Canada.

These two case studies allow the researcher to explore the issues that will interrogate the efficacy of the treaties, the will of State Parties to implement the treaties and the effectiveness of women's groups to make change. By examining adolescent girls' actual life experiences as recorded in two different areas of the world, in the On the Move program in Canada and the health clinics in Afghanistan, these case studies will document the gaps in the treaties, the language biases, question the resistance in the implementation process, the flaws in the policy making decisions and the emerging power of civil society, namely women's groups to force change.

The feminist cultural studies approach, the theoretical framework for this research, will be used to analyze how cultural practices and beliefs influence access to health services for young women.

Chapter Three

Review of the Literature: Adolescent Girls, Health and Well Being

Access to health services is the indispensable partner for human rights in building counter-hegemonic practice (Freedman, 1999).

This chapter will examine the facts of an adolescent girl's life in terms of her status as a consumer of medical health services and proactive health programs. It will also question the position of young women in international documents that are bound to protect them.

The term adolescence has only been used widely for the last 50 years. In itself, the term is a sweeping generalization for a passage that is one of the most crucial periods in an individual's life. The danger of casting all young women into a single category is that it suggests a one-size-fits-all policy for individuals who are vastly different one to the other in terms of the bio-physical, socio-cultural and behavioral consequences of their lives. For example, adolescent women may be students or workers, married or single, mothers and daughters, disabled and abled. They are from well-to-do families and poor families, from urban and rural areas, from the developing world and the developed world. Some are refugees, some live on the street, some live in the suburbs. Some are spoiled, some abused. Some are advantaged, some disadvantaged. Some have a great deal of sexual experience, others have none. It is a group that is diverse but also very similar. Together these young women share a status that keeps them marginalized, disadvantaged and disenfranchized because they are female. The powerful male hegemony that rules

their lives from birth to death shapes their behaviors, their socio-cultural opportunities and their bio-physical health. Their status demands conformity "to the feminine stereotype and the intensification of gender difference" (Duncan, M.C. 2000). The consequences of that conformity affect their self esteem, academic performance, athletic involvement and body image in what Pipher (1994) describes as " a social and developmental Bermuda Triangle" in which girls "lose their assertive energetic and tomboyish personalities and become more deferential, self-critical and depressed" (Pipher, 1994, p. 19).

Adolescence is a culturally produced term that is constantly shifting and providing multiple representations at any one time. The social construction of adolescence is formed not only by individual experiences but also by the shape of groups and societies in which they live. For some, adolescence is a time to struggle to stay out of harm's way. For others it is a time of experimentation that includes taking on new responsibilities, discovering ways to improve appearance (exercise, sports, make-up, clothing) and trying new behaviors such as drinking and smoking. For all of them it is a time of physical, emotional and social change (Panos, 1999).

During this period between age 10 and 19, many key social, economic, biological and demographic events occur that set the stage for adult life (Bongaarts & Cohen, 1998, p. 99). But the evidence suggests that for the girl child those events are dictated primarily by gender. Bio-physical consequences include the fact that girls are more vulnerable to chronic disease, and their poor health interferes with learning. In developing countries, the vast majority of adolescent girls suffer from iron deficiency, and an estimated 45 million adult women are stunted as a result of malnourishment during childhood (World Vision, 1998, p. 1). In developed countries, three out of every five children and youth aged 5-17, are not physically

active enough for optimal growth and development (Canadian Fitness and Lifestyle Research Institute (1998, p. 1). And in Canada, alarming statistics show that more than 80 per cent of girls diet before age 18; the rate of smoking is substantially higher among young women than young men and over half of the female victims of sexual offences are less than 18 years of age (Status of Women Canada, 2000, p. 2).

Socio-cultural consequences mean that women and their daughters constitute some 70 per cent of the world's absolute poor (Buvinic, Gwin & Bates, 1996, p. 7). In many social and cultural contexts, it is accepted that a girl's interests are subordinated to her family's well being. From a very early age she is expected to care for younger siblings, to cook, to clean, to fetch fodder and fuel. Education may be considered unnecessary as it is assumed the girl will continue to carry out these duties in her husband's household (ISCA, 1999). Although the majority of girls in Canada believe in gender equality, they continue to be affected by systemic inequalities prevalent in society. Most girls don't recognize either the potential barriers they face, or the new opportunities that are available to them compared to other generations (Status of Women Canada, 2000).

Behavioral consequences in the general public include attitudes that value girls not for what they achieve but for how they look and how skilled they are at courtship rituals (Duncan, 2000). All of these consequences affect the physical, social and mental health of adolescent girls. The quality of their future depends largely on the extent to which they have access to the health services – preventative, medical and proactive services that will profoundly affect their futures (World Bank, 1994b).

The confounding fact is that although services that would overcome these consequences have been guaranteed to adolescent girls by international documents such as the

Universal Declaration of Rights, 1948, the Convention on the Rights of the Child, 1989, and the Convention on the Elimination of All Forms of Discrimination Against Women, 1979 the fact is, young women are not able to access them to a degree that is acceptable in reducing the risks adolescent girls face throughout the world today. Margaret McCain, co-author of the Early Years Study calls this a social virus. "There is increasing evidence that many of the risks for health problems later in life (high blood pressure, Type II diabetes, some mental health problems are set by the conditions of early life" (McCain & Mustard, 1999, p. 6). She sees the exponential consequences of ignoring girls – and she refers primarily to single homeless teenagers - as a price society can no longer afford. Calculations by the World Bank show that "spending for improving health care for women aged 15-44 offers the biggest return of health care spending for any other demographic group of adults, men or women" (World Bank, 1994, p. 24).

The Convention on the Rights of the Child is an important instrument in the struggle to improve the status of girls worldwide. It is the Convention that was signed sooner and ratified faster than any other UN treaty. Although the American government didn't sign the Convention until 2000, the only other country to refuse to sign was Somalia. One hundred and eighty-one countries have ratified the Convention since it was adopted by the UN General Assembly in November 1989. This means that more than ninety per cent of the children in the world live in countries with a government that has pledged to implement the principles and norms of the convention. But despite the reporting processes and systematic monitoring, the health status of the adolescent girl stubbornly remains the same.

Sociological and medical evidence of the girl child's status of health in terms of their access to medical and preventative health as well as programs that enhance their well being in

both the developing world and the developed world highlight the preventable health dilemmas facing half of the world's teenagers. Surveys found that girls in many countries are often less cared for, less well fed, more undernourished and often illiterate (World Bank, 1994b, pp. 16-19). The poor health and nutritional status of girls reduces their learning capability (World Bank, 1994). Adolescent girls account for 10 per cent of the world's births (Panos, 1999, p. 1). Worldwide one third of women hospitalized for abortion-related complications are younger than 20. Up to 4.4 million abortions are sought by teenagers every year, the majority of them unsafe (Reproductive Health Integration Issues, 1998). Among groups in more than 30 countries of Africa, Asia, the Middle East and the industrialized world, approximately two million girls and young women each year risk undergoing female genital mutilation (WHO, 1996).

While the debate continues about how to best address health risks for teenagers, most agree that making appropriate health information and services easily accessible to adolescents will reduce the risks they face today. Most of these risks are preventable but many parents, opinion leaders and policy makers are afraid to act (Panos, 1999). They do not want to inform young people about sex and its consequences because they believe this will lead to teenage promiscuity and immorality (Cook and Dickens, 2000). This puts accessibility into a context that is often ignored. It is not enough to make health services free. Patriarchal values and family power systems may prevent young women from accessing the services they need. Future research needs to address cultural relativity as it relates to the health outcomes for young women.

The need to protect adolescents' sexual health has been recognized by governments in international treaties and agreements such as the Convention on the Rights of the Child and

the Program of Action from the International Conference on Population and Development held in Cairo in 1994. Programs increasingly acknowledge that teenagers' health concerns cannot be separated from either cultural attitudes and practices that influence their vulnerability or socio-economic situations that affect their access to reproductive health information and services. For example, while appearance of physical changes during puberty can cause emotional turmoil among young people, many adolescents don't understand the changes they undergo because they receive no or faulty information. Dr. Gro Harlem Brundtland, Director General of WHO, states,

> Young people need adult assistance to deal with the thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are not encouraging irresponsible lifestyles. Evidence from around the world has clearly shown that providing information and building skills on human sexuality and human relationships helps avoid health problems, and creates more mature and responsible attitudes (p. 3, 1999).

Health education programs that inform young women about their developing bodies and body image which is reviewed later, have empowered girls to make their own choices and to better understand their emotional development. However, many mainstream policy approaches that are considered to be gender sensitive are geared to view adolescent girls only in their roles as mothers or potential mothers. Thus health programs concentrate on reproduction and negative outcomes of sexuality (unwanted pregnancies, HIV/AIDS and other sexually transmitted diseases). Accordingly education initiatives are based on the rationale that there is a correlation between female literacy rates and fertility (ISCA nd).

But the right to health and health services calls for more than reproductive health services. It also calls for other rights that contribute to health such as the right to have access to participation in physical activity that benefits well being. Both the Convention on the Elimination of All Forms of Discrimination Against Women (article 10-g), and the Convention of the Rights of the Child (articles 28, 29 and 31), specifically mention access to and participation in sport and physical activity (Kidd & Donnelly, 2000). The lack of attention to these other "rights" to health services could be the Gordian knot that has heretofore prevented a workable link between the health needs of adolescent girls and the health services that can act on those needs.

Untying that knot means searching for new approaches for fulfilling the needs of young women. Increasingly health service providers are identifying physical activity as a program that not only contributes to well being but also empowers girls because it boosts confidence and self-esteem. While several non-government organizations such as World Vision have identified the value of this intervention, the Population Council, an organization devoted to family planning, has also stated that sports may be the way to reconfigure the status of adolescent girls (Brady, 1998). Creating opportunities for girls to develop self-esteem, master new skills, and formulate a sense of body integrity may be critical to improving girls' health and self-image. "Physical education and sports programs may play a role in achieving such opportunities; they are an untapped, yet potentially important locus for public health intervention" (Brady, 1998, p. 79).

The flip side to these confounding statistics is found in well-documented evidence of the multiple positive effects that access to physical activity has on an adolescent girl's health. Numerous studies done by the Heart Health Coalition, (1997), Lenskyj (1991), Frisby and

Fenton, (1998) and the Melpomene Institute (1996) have shown that physical activity increases both self-esteem and quality of life. In fact on February 13, 2001 researchers at Cancer Care Ontario announced their finding of a strong link between regular physical activity and a reduction in colon and breast cancer. In terms of its effect on confidence and self esteem, additional research shows that physical activity has a beneficial effect on mood, cognitive functioning and psychological well being and that exercise is also related to a decrease in levels of anxiety, depression and psychological stress (Reid & Dyck, 1999). Moreover, it has been found that participation in physical activity is essential to maintaining a good body image because it helps discourage eating disorders and smoking, and contributes to the ongoing cardiovascular fitness and healthy bone development of girls and women (Fenton, Kopelow and Lawrence, 2000).

Other findings support the suggestion that denying young women the right to participate in sport has a detrimental affect on her health and body image. For example, by age 18 more than 50 per cent of women perceive themselves as too fat, despite having normal body weight (Henderson and King 1998). Females at an early age under-value and underestimate their capacity and potential competency in physical activity. Therefore their skill levels fall behind their male peers and so they are turned off physical activity (Dahlgren, 1988). Beginning at the age of 12, girls' involvement in physical activity declines steadily until only 11 per cent are still active by age 16-17 (Hay and Donnelly, 1996). And only 10 per cent of female students in British Columbia enroll in physical education when it becomes elective (Gibbons, Wharf Higgens, Gaul. & Van Gyn, 1999). If a girl does not participate in sport by the age of 10, there is only a 10 per cent chance she will be physically active when she is 25 (Melpomene Institute, 1993). And although a majority of young women say they

feel good about themselves, young men consistently score higher on all measures of self-esteem (CAAWS, 1991).

Not surprisingly, The Foundation for Active Healthy Kids in Canada says, "The physical inactivity of Canadian children has become a serious health and social development issue" (2001, p. 1). Their point is made by others who feel that denying adolescent girls the feelings of mastery and pride and the opportunities for growth that physical activity can offer is a blow not only against their cardiovascular fitness but against their long term potential including their academic, social and emotional capacities, in ways we are only just beginning to understand (Zimmerman and Reaville, 1998). Moreover, physical activity has been identified as one of the ways to right one of the wrongs for women: that is she can be taught to develop a healthy relationship with her body, a relationship that has been lacking in most cultures (Chalmers, 1992). But accessing physical activity needs to be prefaced with an understanding of the ways and means of making activity beneficial for girls says Margaret Talbot. Her work in particular points to the need to examine the difference between equity and access. Her findings indicate that:

1. girls are less actively involved in coeducational than single sex settings;
2. boys actively harass and limit girls' behavior often ridiculing their efforts;
3. girls perform less well in coeducational than single sex settings;
4. girls' and boys' behavior and role play are more polarized and more opposed in co-educational than in single sex settings;
5. boys dominate leadership roles and girls take on subservient ones in coeducational settings – they revert to stereotypes;

6. in coeducational schools, subject choice is more sex stereotyped (boys take science, girls take arts) than in single sex schools (Talbot, 1989).

Equity, as Chapter Eight will show, needs to play a much larger role in accessing physical activity and gaining the self confidence young women need. Building self-esteem and a healthy relationship with her body may empower young women to make healthy choices that are beneficial not only to her well being and her future but also to the future of the children she will have. One of the problems with making the corollary between physical activity and both preventative and medical health care in terms of human rights as they are presently constructed is that "the right to leisure has never been formally recognized because leisure and sport are not seen as vital needs" (Harvey, 1988, p. 318). Yet the provision of sport and leisure opportunities has often been attached to other rights such as the right to work and the right to health.

The association between health and human rights is a powerful, modern approach to defining and advancing human well-being (Mann et al., 1999). While the international documents pertaining to the right to access to health services will be addressed in Chapter Five, the Children's Convention can be cited here as an example of the difference between the wording of the documents and the interpretation of them in the lives of the adolescent girls they are suppose to protect.

The Children's Convention calls upon State Parties to guarantee children up to 18 years access to free primary education and facilities for treating illnesses. More than 95 per cent of children live in countries where governments have ratified the Convention (UNICEF, 1999) but more than 130 million children aged 6-11 almost two-thirds of them female do not attend primary school. It is known that the more educated a woman is, the more likely she will

postpone marriage and childbearing (Tunick and Guttmacher, 1999). It is also known that in the poorest countries for every year a mother is educated, there is a five to 10 per cent decrease in child deaths (Population Council and Rockefeller Foundation, 2000). Three examples underscore the point. First, a long term study in the Matlab district of Bangladesh found that while the death of a father increased child mortality by six deaths per 1,000 children under five, regardless of the child's sex, a mother's death increased child mortality by 50 per 1,000 for boys and 144 per 1,000 for girls. Clearly the social gains from reducing premature death among women of childbearing years are very high (World Bank, 1994, p. 23). Second, a study in Pakistan suggests that the outcomes from female education can be considerable. An additional year of school for 1,000 women at a total cost of $30,000, is estimated to increase wages by 20 per cent and prevent 60 child deaths, 500 births, and three maternal deaths (World Bank, 1993). Third, the Safe Motherhood Initiative was launched in 1987 in an international effort to address the problem of maternal mortality. Co-sponsored by the World Bank, WHO, The United Nations Fund for Population Activities, and agencies from more than 45 countries, the initiative had as its objective the reduction of the number of maternal deaths worldwide which were 500,000 per year when the initiative was launched, by one-half by the year 2000. In fact by the year 2000, the number had increased to about 560,000 deaths (Cook and Dickens, 2000). Clearly the status of women's health requires more than money, more than programs that too often fail.

Today, General Comment 14 on the International Covenant on Economic, Social and Cultural Rights, signed during the 22nd UN session in Geneva from April 25 to May 12, 2000 adds clout to General Recommendation No. 24 on the Convention on the Elimination of All

Forms of Discrimination Against Women, signed at the 20th session of the UN on February 2, 1999. Together they highlight the access to health issues that have been denied to girls.

Young women may have been hailed as the new panacea for dealing with the ills of the economy (North-South Institute, 1994). The literature is filled with statistics about the needs of girls and the benefits of serving those needs. But it also shows that responding to the needs means finding a way to overcome a systemic problem that requires a lot more than statistical surveys.

In the next chapter, a feminist cultural studies approach will reveal the hegemonic barriers in the lives of girls. It will address the historically produced, socially constructed and culturally defined practices and beliefs that stand in the way of making change for girls.

Chapter Four

A Feminist Cultural Studies Approach to Adolescent Girls. health and Human Rights

> A gender approach in health while not excluding biological factors. considers the critical roles that social and cultural factors and power relations between men and women play in promoting and protecting or impeding health (WHO. 1998. p. 6).

The theoretical framework for the research I am conducting on the human right to access to health services for adolescent girls is a feminist cultural studies approach. Using this framework. I will investigate the human rights discourses in the documents pertaining to the World Heath Organization. international human rights law. international human rights organizations and the gendered concepts of the adolescent girl in terms of her access to health services in case study documents. Using the Zoom Model. to be discussed at the end of this chapter. I will examine those health services at macro. meso and micro levels. The range of services will include medical health services for both wellness and sickness and proactive health services such an adolescent girl's right to physical activity programs.

As the review of the literature has pointed out. the paucity of research in the area of the right to health services for adolescent girls creates gaps that need to be addressed. For example. the Convention on the Rights of the Child. lumps adolescent girls in with infants. toddlers and boys: the concerns of adolescent girls are mentioned rather than

directly addressed in much of the health and legal literature; in many countries the line between adolescent girls and women is blurred. While several sports sociologists (Theberge, N. 1987, Talbot, M., 1989, Vertinsky, P., 1994) have addressed the needs of adolescent girls in terms of their health, those needs have rarely been investigated in terms of rights discourse. Conversely, the health and legal literature (such as WHO, 1998, Cook, R., 1994b, Schuler, M., 1995, Toebes, B., 1999) virtually ignores the proactive health aspects of physical activity that are also guaranteed in international documents such the Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989). The research done by The World Health Organization, the World Bank, the North-South Institute, and the Panos Institute concentrates almost exclusively on women's reproductive rights to health. A similar absence of adolescent girls in feminist theories exists, as does the very notion of adolescence and therefore leaves gaps in the literature. While the age of adolescence, particularly in the developing world, is a debatable issue that will be dealt with later, there is clearly an overlap with the issues women and adolescent girls face in terms of their access to health services. Accordingly, the framework for this study will apply a feminist analysis established for women to the needs of adolescent girls and highlight the gaps in the analysis that need to be addressed for adolescent girls.

A feminist cultural studies framework assumes that cultural practices and beliefs are historically produced, socially constructed and culturally defined. For example, the right to health services is defined in the international documents that pertain to the right to the highest attainable health. But how does the wording in the documents affect girls?

And how are the documents interpreted? Do the discourses about access to health vary from one country to another, from men to women, from women to girls?

Ann Hall describes cultural studies as a field in which different disciplines intersect in the analysis of culture. "Although it draws upon sociology, political science, philosophy, semiotics, history, literature, communication studies and, more recently, feminism, it is antidisciplinary in the sense that cultural processes do not correspond to the contours of academic knowledge" (Hall, 1996, p. 34). Cultural studies therefore, may address popular culture such as television, movies, novels and music as well as employment, sports, parenting and schooling (Hall, 1996). It is all of that and something more than its sum because it looks at the whole way of life and all the relationships people have with the varied aspects of their lives.

Cultural studies emerged in the 1950s due to the appearance of a mass culture made possible through the rationalization, capitalization and technologization of the mass media (Blundell, Shepherd & Taylor, 1993). Although it evolved out of critiques of oversimplified and flawed models of traditional sociological perspectives (Theberge & Birrell, 1994), feminists intervened in the 1970s because the cultural studies approach itself needed redressing in the oversimplified models of gender roles and relations. Feminists such as Angela McRobbie (1986), Trisha McCabe (1981) and Gill Frith (1981) found they could use cultural studies to investigate the role of culture in the reproduction of gender inequality and to ask how an analysis of gender can contribute to an understanding of culture (Franklin, Lury & Stacey, 1991).

Currently feminist theory has such influence in cultural studies that theorists suggest no cultural study is without the influence of feminism (Blundell et al., 1993).

Although successful in bringing an analysis of class and race to the cultural studies approach, there needs to be more study of the intersections between class, race and gender. As well, another adjustment is needed today to include religion. The rise in fundamentalism heightens the importance of including religion as one of the points at which "the value laden structures of society interact with the psychic life of individuals as represented in cultural texts" (Hoggart, 1969, p. 19). Just as the examination of ableism and ageism exposed discrimination, so religion-isms need to be analysed.

Although cultural studies resists definition, it is committed to the study of the entire range of a society's arts, beliefs, institutions, and communicative practices and it has a long history of commitment to disempowered populations. (Grossberg, Nelson, & Treichler, 1992). Stuart Hall cautions against forcing a definition of cultural studies that confines it to being one thing (1990). And Richard Johnson, a former director of the Centre for Contemporary Cultural Studies at the University of Birmingham in England, argues against codifying it because the code itself could eliminate an examination of useful reactions (Johnson, 1983). He describes cultural studies as "a process, a kind of alchemy for producing really useful knowledge" (Johnson, 1983, p. 24). Ann Hall adds "another important aspect of cultural studies is the belief that its practice does matter, that there can be a bridge between theory and material culture, and that contemporary scholars can affect social change" (1996, p. 34).

Cultural studies allows the researcher to critique the culture people live in and examine the affects it has on their lives. Questions surrounding adolescent girls' access to health services in Canada or in Afghanistan need to be asked to examine the efficacy of the international documents. In doing so the researcher can produce and present an

interpretation of how culture works and what it means (Theberge and Birrell. 1994). Although limited to document analysis. the documents contain qualitative data that gives voice to the girls themselves in terms of what health. illness and physical activity means to them.

Like cultural studies generally. the feminist cultural studies approach rejects the positivist approach to scientific research. While one can observe the disadvantages women struggle with culturally at home, at work, in the community. one cannot observe the motives or meanings applied to the disadvantages using positivist approaches (Johnson. 1995). Feminist cultural studies recognizes that the positivist model of science is merely one model of reality. that science is shaped by human beings and filtered through human consciousness and that traditional positivist science reflects and reinforces dominant culture and values (DuBois, 1983).

Feminist cultural studies is instead a network of approaches that link theory. politics and praxis. It places focus on gender. is women centred. it places a spotlight on the everyday concerns. experiences and beliefs of women. it has a concern for inequity and has a policy or action component to be politically relevant. It is multi-methodological. including participatory methods. and is reflexive. This framework can be used to question cultural practices in terms of an adolescent girl's access to sport or young women's access to health practices for birthing their babies. A feminist cultural studies approach assumes these practices are always historically produced. socially constructed and culturally defined usually to serve the interests and needs of the powerful.

Historically Produced Ideological Representations:

The classic tradition that examines social forms through which human beings live (Johnson, 1983) is considered in terms of the diffuse and complex role of gender relations in the lives of girls and women. In this perspective, one can search for historically produced, socially constructed and culturally defined practices that affect the lives of girls and women. For example, "The fact that women have historically been identified with the domestic or private instead of public sphere, with feelings instead of reason, with consumption instead of production, and with nature instead of culture, are all primary instances of the ideological misrepresentations which feminists seek to expose or deconstruct" (Brantlinger, 1990, p. 132). There are historically specific ways in which some practices are inserted into the apparatuses of everyday life. The popular then describes concrete, historically loaded 'sensibilities' (Bourdieu, 1984). It is a matter of the affective and determined ways in which bodies and practices are taken up, invested in and articulated. For example, female genital mutilation in parts of Africa and Asia are seen as a privileged arrival at womanhood, honor killing in the Middle East and parts of Asia are seen as preserving a family's honor. Both practices sacrifice women for culturally defined beliefs that are usually adopted by the women themselves.

<u>Socially Constructed Inequality:</u>

Ideology, cultural values and power relations all place women and girls in a socially constructed position of inequity (Hall, 1996). Although as Hall points out, "Western culture [indeed most cultures] tends to associate women with bodies/nature/emotion/private and men with the more valued mind/culture/reason/public, thus trapping women in their bodies as "natural" (1996, p. 51). Social constructionists

argue that it is not biology per se but the ways in which the social system organizes and gives meaning to biology that is oppressive to women (Hall, 1996).

If women are unjustly unequal to men because of the social meaning of their bodies and gender is a determinant of life chances, it is women who differentially suffer from the distinction of sex (MacKinnon, 1989). MacKinnon argues that compared to men, women lack control over their social destinies, their contributions and accomplishments are restricted and undervalued, their dignity thwarted, their physical security violated.

Feminists place women's experiences and perspectives at the center of inquiry because the other sciences, both bio-physical and social sciences have not adequately incorporated women's experiences and the production of knowledge (Costa & Guthrie, 1994). Feminists such as Gamman and Marshment (1988) and Strinati (1995) are critical of the way the academic study of social and cultural phenomenon has failed to take seriously or consider more fully the position of women and gender oppression.

The consequences of giving priority to the lives and viewpoints of women and girls are vast as research has shown they will marry later, have fewer children and those children will be healthier if even minimum care is paid to their education and health needs (World Bank, 1994). The question is what are the consequences for adolescent girls when their social construction leads to exclusion from programs that will promote and protect their health? In terms of access to health services, for example, it has been thought that men had greater rates of malaria than women. However a study in Thailand reported by WHO showed that rates of exposure, infection and illness are the same among women (1998). But women had unequal access to the clinics where the diagnosis

was made. The same was found for tuberculosis. Unless these issues of inequality are taken into account, the research will be flawed. As Sandra Harding has argued, "Once we undertake to use women's experiences to generate research problems, hypotheses and evidence, to design research for women, and to place the researchers in the same critical plane as the research subject, traditional epistemological assumptions can no longer be made" (1987, p. 181).

Culture including media settings and the popular culture of sport can be seen as sites where "meanings are contested and where dominant ideologies can be disturbed" (Gamman and Marshment, 1988, p. 2). What things mean in terms of a girl's right to access to health services whether it be the right to take part in a physical activity program or the right to access to a health clinic needs to be questioned.

Since this study seeks to address the unequal access to health care for adolescent girls, the discourses of the international documents that call for the right to health need to be examined. For example, the patriarchal discourse of gender-insensitive language may contradict human rights. According to the Council of Europe, the sexism that marks language usage – which gives the masculine precedence over the feminine - is an obstacle to the process of establishing equality between women and men, and of recognizing, in law and in practice, a female's human rights. It also stands in contradiction to the commitments made by governments at the national and international level toward establishing equality between women and men (Callamard, 1999). Examining language quickly exposes gender sensitivity: the use of "man-to-man defence" in sports, for example, or "chairman" of the health services board or "one-man-one-vote" electoral lingo all serve to dis-empower women and girls. The language of the international

documents requires examination to determine the validity of access to health services for adolescent girls.

Culturally Defined Power Relations:

Perhaps the most influential conceptual framework for culture especially in cultural studies has been Raymond William's distinction between culture as "a whole way of life of a social group or whole society... and its more restricted sense as "works and practices of intellectual and especially artistic activity" (Williams, 1981, p. 13). He sees culture as a signifying system through which a social order is communicated, reproduced, experienced and explored. This thinking has helped cultural studies researchers to understand that the variant meanings of culture are the expression of a range of signifying practices across different media and discourses (Brooker, 1999). Do the adolescent girls of Afghanistan wear a burqa because they feel it is culturally correct or do they wear it out of fear? The question needs to be answered with research that has not yet been carried out. Do expressions such as "girls don't like sports" match up with the wants and needs of girls or is it a cultural myth that is propagated by hegemony? Research has determined this is a cultural myth but the myth hasn't been demystified or adequately exposed in sporting culture.

Women are culturally identified with the domestic or private instead of public sphere, with feelings instead of reason, with consumption instead of production, and with nature instead of culture. Although Patrick Brantlinger sees the women's movement as a force that has changed some of these assumptions, he refers to the work of feminists such as Kate Millett, Gerda Lerner and Catharine Stimpson to make the point the notions of private and feelings and consumption are all "primary instances of the ideological

misrepresentations which feminists seek to expose or deconstruct" (Brantlinger. 1990. p. 132) in cultural studies. Veronica Beechey argues

> Whether or not patriarchy is given theoretical priority over class. its construction in feminist theory produces a map of social reality that is at least multidimensional: the 'motor of history' can no longer be understood as merely the 'economic mode of production' as classical Marxism; it must also be understood as the 'family mode of production' or 'reproduction,' including most obviously sexual reproduction (cited in Brantlinger, 1990, p. 132).

While patriarchy plays a powerful role in culture, class signifies the most basic category of oppression according to Marxist theory, which treats all forms of oppression as functions of the division of labour and class conflict. But this view has been challenged by feminists. For example in The Creation of Patriarchy, Gerda Lerner (cited in Brantlinger. 1990) contends that the class divisions of a capitalist society originated in patriarchy and the enslavement of women. instead of the other way around. Patriarchy is understood as the central focus of feminist theory and practice. "Patriarchy was considered the natural order of society. and women were perceived to be acting unnaturally if they presumed to engage in the affairs of men. such as politics. trade and warfare" (Cook. 1994b. p. 131). This oppressive impact on women is key in the feminist analysis of power. It is apparent that power results from the fact that certain groups have no representation in recognized political structures and therefore their position tends to be unaltered. their oppression continuous. their culture defined (Brantlinger. 1990). The question is how can these culturally defined and false conceptual divisions between self and society. private and public be broken down?

Power relations, the systematic hierarchical structures of wealth, privilege, jurisdiction, and dignity are at the root of culturally defined behavior. Such structures are organized along lines of gender, race, ethnicity, class, age, sexual preference and physical and mental challenges. "Relations of dominance are maintained through many interlocking and reinforcing forces ranging from violence and coercion at one extreme to subtle forms of socialization, ideological indoctrination and apparent consent at the other." (Theberge and Birrell, 1994, p.326).

The concern for relationships of power and hegemony, the concern for representation or the negotiation of meaning and the concern for equity are key to deciphering cultural practices that deny women and girls access to their right to health services in this study. Whether access to health clinics in Afghanistan or access to hockey rinks at reasonable playing times in Canada, international documents call for the right of girls to health care and to proactive health programs. And yet so-called cultural determinants stand in the way of girls realizing their rights.

Power can be dominating, hegemonic (consensual), or coercive. Hegemonic power can make meaning stick. Feminist research is guided by feminist theory because other theoretical traditions ignore or downplay the interaction of gender and power. For example some girls in Afghanistan consent that Allah doesn't want them to be active. There are different levels of power such as the big P powers of law, human rights, economics and political power. Or the small P power of coercion in the form of the relationship of domination and subordination between the teacher and the student, the mother and the daughter, the doctor and patient.

The most effective exercise of power is when people are persuaded that a situation is right and proper. An example of hegemonic influence is when girls think they belong on the sidelines, and young women think health services are a sin in the eyes of Allah, the power of patriarchy is operating at a structural level and creating barriers to girls (Parr, 1998).

The social relations of power and how they are negotiated is the site of resistance for women and girls. Female genital mutilation for example was seen as a legitimate practice where everyone consented to the leadership that allowed it to continue. When women in Senegal empowered themselves through the knowledge that other women didn't suffer the same health problems they have, they started trying to renegotiate the status quo (Armstrong, 1998b). Within one year, they had eradicated the practice and the government of Senegal had made the practice illegal.

The social mechanisms and basis of dominance is as much a part of hegemony as the fact of dominance itself (Johnson, 1995). "As a concept it [hegemony] draws attention to how dominance and subordination are defined as part of the normal structure of society and woven into the institutional framework of major aspects of social life, from the family to education to organized religion" (Johnson, 1995, p. 128).

Cultural studies is useful in determining the gendered inequality women and girls face in their day to day lives. Although the theories of Marx, Althusser and Gramsci are the basis of much of the cultural studies approach, feminists have difficulty with their use or misuse of difference and the near absence of feminist theories of patriarchy, as well as the failure to account for sexuality, reproduction and violence within the theorizing. However, cultural studies examines hegemony and the relationships of power as well as

representation and the negotiation of meaning. One of the best examples of the negotiation of meaning comes from Robert Scott's groundbreaking ethnography, Making of Blind Men (1969). His study exposed the relationship between Americans who are blind and the institutions and workers who presumably serve them. Two facts of paramount sociological importance emerged from his fieldwork. The first is that many attitudes, behavior patterns, and qualities of character that have long been assumed to be given to blind people by their condition are, in fact, the result of ordinary processes of socialization. The second is that organized intervention programs for the blind play a major role in determining the nature of this socialization. Blindness, then, is a social role that people who have serious difficulty seeing or who cannot see at all must learn how to play. The characteristics of blind people – docile, dependent, melancholy and/or helpless - are learned behaviors that the current theories justify. If a similar study were conducted on adolescent girls, it would likely expose identical learned behaviors.

The human, cultural and social sciences are concerned with the production and consumption of meaning and thus with the modes and media of representation in which this is articulated (Brooker, 1999). How we understand representation is bound up with the objects of study – texts, events, social processes – the discourse, ideology, institutions, economy and the methods of investigation which map out these changing fields. For example Peter Donnelly argues the perspective is grounded in the assumption that cultural practices, including sport, are arenas in which values, meanings and ideologies are contested (Donnelly, 1988).

Using a feminist cultural studies approach to study access to health services for adolescent girls will fill in some of the gaps in the literature around the right to health.

But that is not to say it is without problematic implications. For example, objects, events and processes exist in an unmediated reality, authentic meaning may come to mean re-presentation, rather than representation and one form of representation may be presented as more true to an original than other forms (Brooker, 1999). For example, it has been argued by fundamentalist religious leaders that the girls in Afghanistan are being protected rather than denied their human rights. Similarly the myths around women and sport has been relied on to excuse the sidelining of girls in sport in Canada. Stewart Hall suggests, "things don't mean. We construct meaning using representational systems, concepts and signs (1997b, pp. 25). The abstract rights of women and girls for instance, are given a concrete form when applied against their access or denial of health services. It's the social process of making sense within all available signifying systems, print, video, film, tape, even the health records of girls at a clinic, that allows us to see that a subject's representation is organized and regulated across different media and within different discourses (O'Sullivan et al., 1994).

Feminist cultural studies examines gender and inequality, women's and girls' experiences of gender oppression, and places emphasis on understanding women and girls as subjects of research (Taylor, 1998). It also assumes the possibility for social change and political practice that will benefit the adolescent girls this research is concerned with. The framework allows questioning of the socially constructed role of women in society and the interpretation of international documents that call for the right to the highest attainable health. It also questions how feminist praxis has transformed the interpretation of human rights documents. By analyzing each human rights article that calls for the right to health services in the context of a girls' life experience, the concept

of equality can be examined against the recorded reality of what happens to an adolescent girl when the human rights documents need to be implemented. The concept of equality in terms of access to health and proactive health policies for well being that are provided in the international documents will be examined by discourse analysis of the documents and how the articles in these documents mediate two reported health services.

The two case studies I will examine include (1) the access to health services in the On the Move Program for adolescent girls in Canada and (2) the denial of health services to the adolescent girls of Afghanistan by the ruling Taliban.

Relying on praxis which means putting theory and belief into action (Hall, 1996) the framework can deconstruct the realities in the experiences of girls lives. It can also expose praxis as "the recognition of the continuing and shared feminist commitment to a political position in which 'knowledge' is not simply defined as 'what knowledge' but also as 'knowledge for' and in this case is for women" (Hall, 1996, p. 78). Karl Marx' argument is that praxis lies at the core of human existence, and what we think is important is a reality only insofar as it shapes and gives purpose to action (Johnson, 1995). These case studies will be used to make girls' experiences visible and allow a challenge of gender inequality within the international documents that call for the right to the highest attainable health. The cases will also permit "a recognition of the gendering of social movement processes and theory" (Taylor, 1998, p. 357).

For example, a social movement was necessary when midwifery was made illegal in North America. The movement was driven by the valid and thoughtful questioning of birthing women in the 1980s who had realized the medical profession and hospitals had no evidence to support many of the restricting practices that were standard hospital

childbirth procedures (Bennett and Archibald, 2000). "In trying to answer those questions, I discovered that many of the answers weren't very good. The standard answer was 'Because that's the way it's always been done' and I'm more comfortable doing things the way I was taught. I soon realized there was little or no evidence to support many traditional obstetrical practices" (Bennett and Archibald, 2000, p. 61). Their work in examining childbirth practices, based on what is best for women and their babies during birthing rather than what is best for hospital staffs and doctors, has "reclaimed childbirth as a much more natural phenomena and as a result babies are born very differently today" (Bennett & Archibald, 2000, p. 62). A similar study by Dagmar Celeste in Ohio, when she experienced bizarre symptoms after the birth of her sixth child showed that postpartum depression is a legitimate psychiatric disorder (Taylor, 1998). Putting theory to "praxis" is obviously a test that benefits women and girls.

Determining the Age of Adolescence

For purposes of this study the age of adolescent girls will be determined as 10 to 19 years which is the age assigned to adolescence by WHO. While the concept of childhood is a 17th century phenomena (Aries, 1962) and prior to that children were seen only as miniature adults, in some countries where child labour is the norm, the same can be said today. There are dozens of qualifiers of adolescent ages in Canada alone. The Canadian Medical Association cites teens as 12 to 17 years. Canadian Business Magazine called the newly minted consumers, "Tweens" (between childhood and the beginning of the teen years) and categorizes their ages as 9 to 14 years, (Steinberg, 1998). Statistics Canada cites teens as 14 to 17 years. The legal age of adulthood in Canada is 18 years, making under 18 years a youth category. And psychologists cite adolescent girls as 11 to

17 years (Jaffe & Lutter. 1995). There are definitions of adolescence that range from legal to biophysical but most conclude that adolescence begins with menstruation and ends with the assumption of independence, which is a variable within particular cultures.

Since girls are menstruating at earlier ages and since girls in developing countries are often married during early teenage years, some as early as 13. the interpretation of their right to access to health services can and often does overlap with the provisions documented for women's rights. But who determines policy documents for adolescent girls in health clinics and in physical activity centres? What are the assumptions in a teen hockey program or a maternity care clinic about adolescent girls?

Cultural Practices in Social Activity

An examination of the right to access to health services. needs to begin with culture as a significant sphere for the reproduction of social power inequalities and the consequences of those practices on the lives of adolescent girls. Cultural practices have been identified as a determining. and not just determined part of social activity ever since the late 1960s when the notion of culture was reworked in terms of Marxist. feminist and multi-cultural approaches (O'Sullivan. Hartley. Saunders. Montgomery. Fiske. 1994).

During the 1970s. gender. a term for the social. cultural and historical construction of sexual difference came from feminist theory and criticism. The use of gender naturalizes the standard traits of sexual difference established in society: men are assumed to be physically stronger and therefore associated with the world of labour, sport and physical combat and are active in the public domain; women are physically weak and therefore passive; their sphere is the home; their bodies determine their roles as

mothers and objects of male desire (Brooker, 1999). This dualism reinforces male authority over women.

Analysing culture brings meaning to social divisions in which class, gender and race and other inequalities are naturalized. Culture is also used as a means of resisting subordination. The camaraderie around girls' hockey is an example of women refusing to stay on the sidelines of a sport they ultimately made into an Olympic event for women in 1998. But for the most part, hegemonic relations, practices and ideas constitute the bulk of dominant culture. The Gramscian concept of hegemony describes the ability of the dominant class to exercise social and cultural control and maintain power over the economic, political and cultural direction of the people (O'Sullivan et al., 1994). This notion accounts for the way a ruling class maintains itself in power, or secures and sustains its hegemony. It does this not only through the direct expression of its economic authority but by actively exercising its intellectual, moral and ideological influence in the realm of civil society. It persuades the majority of the population of its economic and cultural legitimacy as a ruling class (Brooker, 1999). Max Weber's definition of power is the ability to control others, events or resources – to make happen what one wants to happen in spite of obstacles, resistance or opposition (Brooker, 1999). Power as authority then, is the occupancy of a particular social status, authority being a form of power that is socially defined as legitimate which means it tends to be supported by those who are subject to it (Johnson, 1995). While Weber uses power in terms of the individual, Marx uses it in relation to social classes and social systems. Key sociological questions about power focus on how it is distributed within social systems.

Since power plays an important part in social inequality and conflict, feminists base power on the capacity to do things, to achieve goals, especially in collaboration with others. They stress the potential of cooperation, consensus and equality and power-to rather than power-over.

Ann Hall argues that focusing on power "is to treat gender as a relational category rather than as a characteristic of individuals" (1996, p. 25). For example, in the sports organizations she studied "there was a clear valuation of men over women, the public over the private realm, production over reproduction and heterosexuality over other sexualities just as there is in other rationalized bureaucracies" (Hall, 1996, p. 85).

The feminist cultural studies approach employed in this research seeks to account for the power structures in cultural differences and practices that afford or deny the right of adolescent girls to health services. By assuming that cultural practices and beliefs are historically produced, socially constructed and culturally defined, it becomes clear that "everyday meanings, representations and activities are organized and made sense of in such a way as to render the interests of the dominant bloc into an apparently natural, inevitable, eternal and hence inarguable general interest, with a claim on everybody" (O'Sullivan et al., p. 134).

Examining culture exposes the concept of power as authority and representation of adolescent girls in terms of their access to health services. A feminist cultural studies approach looks at why hegemonic power acts out one way in a country such as Afghanistan and another in Canada? It asks how expressions such as "poverty is a feminist issue" and "women's rights are human rights" and "the personal is political" became part of mainstream language during a social movement? It asks what effect the

women's movement has had on the lifestyles of girls and women in terms of their access to health services? Social and cultural reproductions of the male hegemony, of the values, ideas and activities that maintain the status quo perpetuate the inequalities for girls and the ideologies that inequality is based on. Applying a feminist interpretation to the cultural studies approach is a process of examining these meanings (what does it mean to an adolescent girl to be healthy?), representations (how are adolescent girls represented in the human rights documents?) and existing patriarchal practices and power relationships.

Feminists don't comply to a single theory on these issues. They have historically accommodated multiple perspectives (Costa and Guthrie, 1994). Three traditional approaches of feminist theory have been used to critique health services: liberal feminism, radical feminism and Marxist-feminism. Liberal feminists (Ehrenreich, B. and English, D., 1973, Frankfort, E., 1973) who see the social subordination of women reflected in the sexual structure of the health care system, do not seriously challenge the hierarchical structures of the health care system. They want access to the same choices as men stating their exclusion from the centres of power has no rational or biologic basis (Fee, 1983). Radical feminists' goals (Firestone, S., 1972, Hornstein, F. 1974) are not to achieve equality with men under the existing social and economic structures, but to entirely transform existing social institutions. They see the health care system as yet another system that conforms to the patriarchal pattern established in the family. Marxist-feminists (Kelman, S., 1971, Robson, J., 1973) on the other hand see the essential task as bringing together feminist consciousness with the historical oppression of women. They see the health system as one that is committed to the imperative of production for profit, rather than the fulfilment of people's needs (Fee, 1983). Whatever its stripe (whether

liberal, radical or Marxist) feminism provides a place from which women can speak, make political demands and challenge patriarchal structures (Hall, 1996). She says that applying any particular brand of feminism to the gender discourse is to make it more political and points to the need for the relationship between theory and practice.

While this feminist cultural studies approach poses many questions, asking the woman question (or in this case the adolescent girl question) is critical in this cultural study. It contests assumptions about gender neutrality. Katherine Bartlett, who coined the phrase "woman question" argues, "In exposing the hidden effect of laws that do not explicitly discriminate on the basis of sex, the woman question helps to demonstrate how social structures embody norms that implicitly render women different and thereby subordinate" (Bartlett, 1990, p. 843).

This is at the core of the issue of access to health services for adolescent girls all over the world. Statistical data cannot convey the full extent and experience of inequality within the health care system. Qualitative feminist research uncovers new levels of understanding inequality that hasn't been uncovered using positivist statistical representations. During the last two decades, feminist interventions have begun to alter the grossly unequal status of girls in both the developing and the developed worlds. But there remains a great deal of progress to be made. An encouraging point of reference is found in *Gender and Health: Technical Paper*, which was prepared for the World Health Organization (WHO) in 1998. It offers a useful, theoretical framework for the examination of a young woman's access to health services, primarily because it begins with a shift from an exclusive focus on women to a focus on gender. In itself that shift exposes the socially constructed differences and power relations between women and

men, as a determinant of health. At the Fourth World Conference on Women in Beijing in 1995 this was the point of view urgently expressed by participants and promoted for the Platform for Action so that a gender perspective would be mainstreamed into all policies and programmes of the United Nations System. By adopting gender perspectives into these policies and programmes, WHO made a broad reaching attempt to inform the actors in the business of public health including the researchers, policy makers and programme planners about the value of gender analysis. (WHO, 1998).

Epistemologically, asking the woman question is the key to knowing. Whether a physical activity program in British Columbia or a health clinic in Afghanistan, the presence or absence of adolescent girls in all aspects from policy making to programme delivery is an index that can identify unequal power relations between the sexes. Identifying unequal access can be matched up with exposure to risks factors that endanger health (WHO, 1998). Access acts like a pebble in a pond sending out ripples of power, control, education and resource management, which ultimately benefit those who have access over those who do not. A gender analysis can explain if, why and how adolescent girls are disadvantaged and why they consequently pay for their disadvantage with their health.

Although statistics about the unequal status of women have been available for years (Buvinic, Gwin & Bates, 1996), the status of the experiences and meanings of adolescent girls need to be factored into those statistics. Statistical data cannot convey the full extent and experience of inequality within the health care system. Qualitative feminist research is required to counter positivist statistical representations and to reach a new level of understanding inequality.

Despite their diversity, all societies are divided along gender lines (Moore, 1988). Feminist researchers particularly in the south, point to the difference between public and private worlds (Coomaraswamy, 1994). The public world is a world of work where men have power. The private world on the other hand is the world of the family, a woman's place. These gender divisions shape the lives of women and men in fundamental ways. "As individuals with particular identities and as actors in an infinite variety of social contexts, they are shaped and reshaped by their femaleness or their maleness and constrained by their membership in a particular social group" (WHO, 1998, p. 9). This social construction, used in most societies, justifies major inequalities for women.

In examining the evidence around the unequal status of women, the researcher needs to listen for the silences and interpret them to construct the meaning in the lives of girls and women. Silences have multiple meanings that include withholding or resistance or reflecting a cultural mode of self-presentation. "It may reflect what is taken for granted or what goes without saying, or it may represent that which cannot be said, the unthinkable." (Poland, 1998, p. 294).

Some of the silences in the debate about the right of adolescent girls to access to health are in the field of physical activity. As the literature review points out, women were not even considered Olympic athletes in team sports until 1964 and could not join contact team sports until 1998. While sports feminism was a relative late-comer to the women's movement, beginning in the 1970s but not gaining ground until the 1980s (Hargreaves, 1994), it is playing a vital role in research around women's access to health today (Bonne, 2000). Much of that research focuses on the female body. "As a social movement, second-wave feminism has been responsible for raising consciousness about

the exploitation and control of women's bodies" (Hall, 1996, p. 50). Patricia Vertinsky makes the point, "sexuality, female physicality, and the long-standing hegemonic control that men have claimed over women's bodies are central to the history of women's sport (1994, p. 23).

Sport sociologists such as Nancy Theberge argue that the real culture significance of sport lies in its power to represent and embody beliefs about gender physicality and sexual difference. Her arguments suggest a direct link between lack of access to health services and the sidelining of women and girls. She maintains the sociological study of women in sport is developed against a backdrop of the history of women's exclusion and a set of beliefs about women's frailty and inferiority that renders women unsuitable for physical activity (Theberge, 1989).

But the gap in the right to health literature around a proactive course for well being is immense. Says Ann Hall,

> Female bodies have always been central to feminism but sporting bodies have not. As a social movement, second wave feminism has been responsible for raising consciousness about the exploitation and control of women's bodies. Feminists have fought hard to out sexual harassment and abuse, domestic violence and rape, pornography and advertising, medical interventions and reproductive technology on public and political agendas. A major feminist demand is that women have the right to control their bodies and to make choices in their interests, not those of men and the state. However feminists have rarely paid attention to female sporting bodies, nor have they always seen the relevance of physicality, or empowerment through physical activity, to feminist politics (1996, p. 50).

If the human rights theorists aren't raising the issue about an adolescent girl's right to access to proactive health services, how can the documents that claim such services as a human right be applied?

A Change in Inquiry

Patricia Vertinsky sees the academic and gendered studies in sport history as much more valuable than simply correcting history's missing records of women and girls in sport. "It seeks to forge new understandings of the historical relationship between sport and social construction of gender by examining gender as a dynamic, relational process through which unequal power relations between women and men have been continually constructed and contested" (Vertinsky, 1994 p. 23).

Helen Lenskyj charges that policy makers ignore feminist research into physical activity at their peril. Referring to the gap between research and praxis she says, "This female deficit model upholds traditional male values and attitudes of sport as the ideal. Female perspectives are judged by the male standard and found lacking, and women are then blamed for having the "wrong" attitude" (Lenskyj, 1994, p 7).

In asking the woman/girl question in research, the issue about attitude needs to be included and analyzed in a socio-cultural manner. Apart from economic, social and cultural obstacles for women and girls, the emotional and cognitive capacities of women themselves limit their access to health care. Feminist research needs to highlight issues such as low self esteem and girls being taught that suffering is their lot in life to understand why women and girls wait in line for health care and push everyone else in the family first. It also needs to highlight the fact that research, until very recently has not included women. Women are often ignored or not included in appropriate numbers

among the subjects in health studies. The researchers and the subjects themselves tend to be male. As well, the design of the studies fails to provide a complete picture of women's health.

However research conducted by women's advocacy groups between 1993 and 1998 was marked by a significant growth in the number of well executed studies on the intimate concerns of women that have little or no experience of putting either themselves or their ideas in the public arena (Weiss, Whelan & Das Gupta, 1996).

Research that takes account of gender has to consider the differences between women's and men's roles and responsibilities, their knowledge base, their position in society, their access to and use of resources and the social codes governing female and male behaviour. Strategies to improve women's health need to be grounded in a rigorous analysis of the whole range of their productive and reproductive activities and of the way these change across the life span. Femaleness can no longer be equated with motherhood and the scope of health research needs to shift accordingly (WHO, 1998, p.46).

Women like men, are not a homogenous or monolithic group. Girls as a group aren't entirely monolithic either. Each of their experiences of work, political and economic participation and enjoyment of their rights differ according to race, class, ethnicity, religion, economic status, sexual orientation (Callamard, 1999). These issues need to be factored into research that is effective in changing the unequal access a girl has to health services.

For example, Margaret Talbot's work on equity and access shows that it's not clear what you need for equality – equal time, equal opportunity, equal space or shared humanity (Talbot, 1989). Talbot argues that "equality of opportunity is a minefield of

value-laden and emotive rhetoric" (Talbot, 1989, p. 1). She cites the principle of equal treatment and says it ignores the fact that people are different in their capacities. She points to equal outcomes and suggests that would reduce performance to the lowest common denominator. As for the argument for shared humanity or egalitarianism, she says, "Although it does not necessarily change our attitudes, it can provide us with an opportunity to confront our own assumptions and prejudices, and examine critically the ways in which our professional institutions informally or formally discriminate against certain people" (Talbot, 1989, p. 24). She sees a complex hidden agenda in the various interpretations of equality and presents findings which significantly affect the way in which physical activity and sports programs might be delivered, but which are rarely explicit and seldom explored. These six findings are referred to in the review of the literature.

The potential of feminist theory to alter access to health services depends not on the extent to which it is able to provide a more human and less alienating context in which women and girls may learn about their bodies but also on its role as a model for general health care. Its success may increase the awareness among health consumers of the deficiencies in other areas of health care and increase the pressures for a more human and humane reordering of medical priorities (Fee, 1983).

This is where feminist theory can seek the systemic inequality of women and girls. Feminist research is distinctive for its insistence on a political nature and potential to bring about change in women's lives. Since feminist theory insists on "diversifying and shifting ground in an effort to undercut the hegemony of male discourse" (Whelehan, 1995, p. 20), it is a useful tool for deconstructing the human rights documents that call for

access to health services for adolescent girls and in the reports of health care services that the two case studies will examine. Feminist theory, an alternative to both relativism and liberal human rights theory can be used to reconceptualize women's rights as human rights and examine whether existing human rights documents fail to remedy oppressive conditions for women (Kim, 1993). Because the case studies in this research include both Eastern and Western cultures, feminist theory is employed to look for patriarchal and cultural imperialist tendencies in the international legal regime to take account of the intersections of gender, culture, economic justice and international politics (Hom, 1996). The case studies will critically analyse the discourses of the human right to access to health services for adolescent girls in the documents and question the degree to which they contribute to the highest attainable health for girls; examine the socio-cultural factors that created the struggle around women's human rights to health and why it has been necessary to separate out a woman's right to health and now an adolescent girl's right to health from the right to, for example, hold citizenship or own property; and question whether the right to health can be implemented in terms of access to health services and proactive health policies that contribute to well being.

The case studies were selected for their seemingly diverse contexts. When analysed against the human rights documents, they will reveal the effect of implementing the right to access to health services in a third world country like Afghanistan versus a first world country like Canada and expose the consequences to young women in both countries.

The feminist cultural studies approach employed in this study will examine gender inequality and the inclusion or exclusion of women's experiences by comparing

girls' experiences documented in recorded case histories to the discourses in the international documents that call for the right to access to health services. The data can be used to question the range of assumptions about equality in the documents and the political positions of those whose task it is to implement the documents.

Since the purpose of this thesis is to critically analyse the international and regional documents that reference the right to the highest attainable health in terms of access to health services for adolescent girls, the method addresses the discourses of the documents as well as the recorded experiences and socio-historical contexts of adolescent girls. Health practices are part of cultural practices and beliefs that are historically produced, socially constructed and culturally defined. Accessing health services is bound up in concerns for power, representation and equity which are key to understanding oppression. The possibility for social change and political practice is the bridge between theory and praxis. This research will question the way the documents were written, the way adolescent girls are treated, and according to health services documents, the consequences of that treatment noted in the documents about the two case studies. It will question the assumption that human rights include a girl's right to access to health services. It will examine what it means to be an adolescent girl in terms of gaining access to health services, it will search for and analyse the barriers between the discourse of health rights and the experiences girls have in accessing those rights, and it will question when and why praxis is not realized in terms of rights discourses. This thesis will employ the Zoom Model of discourse analysis informed by feminist theory to examine key human rights and case study documents.

The Zoom Model

The Zoom Model developed by Barbara Pamphilon (1999) will be employed to analyse the two case studies. This model allows a multi-level analysis of meaning and power relationships in the documents that are analysed. Drawn from the analogy of a zoom lens in photography, it allows the researcher to focus on several and potentially contradictory perspectives within each of the documents to be examined. It focuses on the macro or sociohistorical dimension exploring collective meanings as they relate to individual experiences. It focuses then on the meso level that reveals the personal level of values, interpretations and positioning. Then the micro level focuses on the subtleties that create the interpretation (Pamphilon, 1999). For example, the macro analysis of the right to physical activity and health education for girls in Canada will focus on the evidence that supports physical activity and health education as prerequisites to health. The macro analysis will also focus on the international and regional documents that support the right to physical activity and health education. The meso analysis will focus on the struggle girls have to gain their right to physical activity and health education in their particular communities as well as the political decision making around the refusal to grant that right. The micro analysis will focus on the consequences for individual girls of a victim based health system that withdraws health services on the one hand and refuses proactive policies for well being on the other. This method zooms in and out from the data to reveal specific processes that impact the lives of adolescent girls. It also reveals complimentary levels in order to integrate the data. While the macro-zoom or big picture level focuses on the relationship between the documents and adolescent girls' right to health services, the meso-zoom turns the focus to the health needs of the adolescent girls

who rely on the human rights documents, and the micro-zoom focuses on the consequences of contradictory interpretations of economic, social and physical benefits of access to health services.

This methodology allows for the multiple and perhaps contradictory perspectives within the research. Like feminist cultural studies, this method draws on "poststructuralism, discourse analysis, narratology, textual analysis, psychology, anthropology and sociology – aiming for a synthesis that is transdisciplinary" (Pamphilon, 1999, p.395). This research will use several of those perspectives. For example, in using discourse analysis to examine the politics of meaning in the documents and the effect of voices that are privileged and voices that are silenced, the research can reveal the values and meanings of the documents as they relate to adolescent girls. This analysis can examine whether "language conspires to legitimate and perpetuate unequal power relations" (Willig, 1999, p. 10) and it can inform our understanding about the consequences of language use on the life experiences of adolescent girls (Willig, 1999). Illustrating the tensions in the documents suggests resistance from women and girls as well as empowerment for women and girls in terms of reforming the implementation of the documents.

This methodology will also code the human rights documents for the articles that refer to the right to access to health services. They will be coded for gender specificity: which documents refer specifically to women's right to access to health services, and to an adolescent girl's right to access to health services. The covenants and conventions will be examined for who informed these documents and what the sociological and political

theories were regarding women and girls and equality when each document was written. The eight documents to be coded include:

•The Universal Declaration of Human Rights, (1948)

•The International Covenant on Economic, Social and Cultural Rights, (1966)

•The Convention on the Elimination of All Forms of Racial Discrimination, (1965)

•The Convention on the Elimination of All Forms of Discrimination Against Women, (1979)

•The Convention on the Rights of the Child, (1989)

•The European Sport For All Charter, (1975)

•The International Charter of Physical Education and Sport, (1978)

•The Berlin Agenda for Action for Government Ministers, (1999)

While other documents discussed in the introduction to this research and in the review of the literature such as The United Nations Charter (1945) and The Canadian Charter of Rights and Freedoms (1982) can be used to promote health rights. Additional documents such as the International Covenant on Civil and Political Rights (1966), the European Convention for the Protection of Human Rights (1959), the American Convention on Human Rights (1969) and the African Charter on Human and Peoples' Rights (1981) also pertain to health rights. For the purposes of examining the adolescent girl's access to health services, the eight documents listed in the previous paragraphs have been selected for coding.

The two case studies were selected to include east and west ideologies and to examine access in terms of medical and preventative health services as well as proactive health services for well being. The documents for the case study on the adolescent girls of

Canada include. On the Move: Increasing Participation of Girls and Women in Recreational Sport and Physical Activity (1994). Women and Sport (1992). the Brighton Declaration on Women and Sport (1994). the Canadian Charter of Rights and Freedoms (1982). the Sport Canada Policy on Women and Sport (1986). the B.C. Provincial Policy in Sport (1992) and the Federation of Canadian Municipalities Resolution (1989). The documents for the case study on the girls of Afghanistan include, The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan Report by Physicians for Human Rights. (1998). Health and Human Rights of Girls in Afghanistan (1998) and The Health Situation of Girls in Afghanistan (2001)

Chapter Five

The Best of Intentions: International Laws for Health Rights are Written With Care, Monitored With Diligence and Failing to Serve.

"In many parts of the world, society devalues and neglects girl children. They succumb early to sickness, malnutrition and abuse; they perish never having experienced the protections written into their countries' statute books" (Cook, 1994b, p. 126).

Fifteen UN documents including the UN Charter and the World Health Organization constitution were examined in this research (see Appendix) to determine the intent of the United Nations to establish the right to health for women. Eight of those documents (noted below) contain a total of 123 Articles, sub Articles, recommendations and comments that are applicable to women's human right to health. Since this research paper seeks a connection between adolescent girls' right to access to health services and the wording and intent of the articles, five of those UN documents have been selected for analysis. And since it has been established that young women also have the human right to access to proactive health services that promote well being, three additional regional and international documents pertaining to physical activity were selected for analysis. In this chapter eight documents will be deconstructed for the language that was used, the debates that occurred, the status of women and girls when the documents were written, and the limitations and obligations State Parties have to ensuring the right of an adolescent girl to access to health services.

The WHO definition of health describes health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO Constitution declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being" (Mann et al. 1999). The International Covenant on Economic, Social and Cultural Rights stipulates in article 12(1): The State parties to the present Covenant recognizes the right of everyone to the highest attainable standard of physical and mental health.

The documents to be examined are: the Universal Declaration of Human Rights (UDHR) (1948), the International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979), the Convention on the Rights of the Child (Children's Convention) (1989), and the Convention on the Elimination of All Forms of Racial Discrimination (1965). The three additional documents to be examined are: the European Sport For All Charter (1975), the International Charter of Physical Education and Sport (1978), and the Berlin Agenda For Action For Government Ministers (1999).

This chapter will code each document for the presence of adolescent girls and for the use of the word access in the right to health services. It will also analyze the documents to expose the various aspects of the treaties that contribute to their interpretation by State Parties today. The chapter will contest the assumptions in the articles within the documents that call for health rights and their efficacy in the life experience of girls. The section on the UDHR will focus on the history and debates around the writing and language selection of the 1948 document that set the stage for documents that would follow. The section on ICESCR will focus on General Comment

#14. The section on CEDAW will focus on General Recommendation #24. And the section on the Children's Convention will focus on the reporting procedures of State parties to the UN. This section will also include the reference made to the Children's Convention in the ICESCR General Comment #14 because it addresses adolescent girls and their access to health services. The additional documents will be similarly coded for adolescent girls and access and an analysis of the effectiveness of these documents in terms of an adolescent girl's access to proactive health services for well being. The efficacy will be determined by comparing the wording of the documents to the documented reality of the lives of young women.

This research questions whether young women have been marginalized in the early human rights rhetoric and whether adolescent girls have been left in some sort of "no-girls-allowed-land" which is reflected in the fact that for the most part, their human right to access to health services is not observed.

The Universal Declaration of Human Rights (1948)

When the United Nations Charter was written in 1945, it stressed the equality of rights of men and women. The Universal Declaration that followed was the international Bill of Rights that would presumably give teeth to those promises. The health rights it contained are found in article 25 which states,

> 1. 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, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock shall enjoy the same social protection.

One can establish the status of women in 1948 simply by the wording of this article. It was accepted parlance that the word "man" meant "all people" (Morsink, 1999). But it would be a mistake to assume that the words were selected without regard to their far-reaching effects. In fact the drafting of the UDHR was a long, argumentative and thought-provoking process.

A widely circulated critique is that the UDHR was a Western-written, male-based document. Among the critics are Islamic scholar Abdullahi Ahmed An-Na'im, African human rights author Asmarom Legesse and writer William Alford who examines human rights in China (Morsink, 1999). This is an exaggerated and not entirely fair description of the process. In fact it is the single UN document referenced in the constitution of Amnesty International. The drafters of the Declaration came from a wide variety of ideological and philosophical backgrounds. Although there was only one participant from the African continent (Egypt) and indigenous people and minorities had no representation, the participants did come from most countries around the world. While the principles inherent in the document reflect many cultures and religions (Morsink, 1999), the debate reflected what the review of the literature points out: all the major religions have elements that point to human rights as well as principles that violate human rights. "Cultural practices from around the globe have likewise steered in both directions: respect for and denial of dignity and human treatment" (Eide, Alffredsson, Milander, Rehof & Rosas, 1992, p. 9). The Declaration was considered ground breaking for human rights at the time. It would be the

enacting of the Articles over the subsequent years and the changing status of women that would expose its weaknesses. Health rights, promised in article 25 for example, are still inaccessible for more than half the citizens in the world.

Although the language of the documents is often criticized today, there was in fact a struggle around choices of words during the drafting process. "Adequate" for example was debated against "decent" in terms of standard of living. The use of the word "born" rather than "created" was debated at length by those who were concerned about religious interpretations of the documents. And words like "everyone", "people" and "all" were encouraged (if not always used) to avoid gender specific language. The intent was to create an inclusive document that considered the rights of everyone. But none of it came about without a struggle. Eleanor Roosevelt, Chair of the Human Rights Commission for example, played a role in blocking some of the passages for rights and resources for women because she felt that women didn't need a separate document. The sub-commission on the Status of Women, chaired by Bodil Begtrup of Norway, was mandated to submit proposals, recommendations and reports to the commission on human rights but they had very limited power (Holmes, 1983). In the early days, Bodil Begtrup, aware that Roosevelt was ignoring her reports, complained that the line of authority didn't suit the women: that they didn't want to be dependent on the pace of other commissions. The council acceded to the request and the Status of Women reported directly to the Economic and Social Council. However Roosevelt did not stay in touch with the women's group. She ultimately was told they had to be present when the rights of women were being considered but they had to participate without voting (Morsink, 1999). Later, John Humphrey, the Canadian diplomat who was the chief drafter of the UDHR, would say that

although he was not always at ease with the Status of Women Commission. "More perhaps than any other United Nations body, the delegates to the Commission on the Status of Women were personally committed to its objectives ... act[ing] as a kind of lobby for the women of the world" (Humphrey, 1984, p. 30).

The struggles were mostly around language and reflected the privileged, white western experiences of Roosevelt and the collective experiences of the women from around the world who worked on the Status of Women Commission. For example, Roosevelt balked at their demand to change the wording "all men" to "all people" or "all human beings" because she argued, the term "all men" refers to "all people" (Morsink, 1999). From a feminist cultural studies point of view this production and consumption of meaning highlights the subsequent struggles with the Declaration. It illustrates the way representation is bound up with, in this case, a text in an unmediated reality prior to establishing meaning (Brooker, 1999). After much deliberation the committee agreed on "all people, men and women." But incredibly, due to an oversight, a previous draft using "all human beings" was approved and adopted in the final report. Morsink argues that "oversight" left the Declaration free of sexist language except for the phrase "himself and his family" found in articles 23 and 25 (Morsink, 1999). Helen Holmes begs to differ. She contests the language use and maintains there is use of the words "man", "mankind" and "he" in no fewer than 13 articles in the UDHR. She insists the language "reveals sexist practices... and the generic use of masculine terminology can be a perpetuator of sexist distinctions regardless of the intentions of the speaker" (Holmes, 1983, p. 259).

Interestingly, the most contested language is in article 25, the very article that refers to health, which is one of the most disputed human rights today.

Similar language battles were fought over the wording of the right to marry, the right to food, clothing, medical attention, and shelter. The arguments reflected the diversity of the drafters: socialist traditions of Latin America, the newly formed communist mandate of the USSR, the old school traditions of colonizers such as Britain and France who worried about gaps in their own constitutions on health rights, and governments such as China, Chile and Cuba who already had health care rights (or claimed they did). The WHO definition for the right to health was introduced and debated but ultimately rejected. In the process a similar argument ensued over the wording of mother and child. The women's lobby wanted to use "motherhood" to include pregnant women and had to fight to the finish to get it.

The drafters claim the initial focus of the article was the right to health and that it was to be determined not only as access to medical care, but also adequate food and nutrition, clothing and housing. In a prophetic comment that would be felt, particularly by girls and women for the rest of the Century, Roosevelt said, "no more detailed wording was practical as different provisions for the protection of health were established in different countries" (cited in Morsink, 1999, pp. 194, 195). Women and girls in the community of nations would learn that if the words aren't there, the rights aren't there. And even then, the rights would be contested.

Holmes argues the phraseology of many of the articles in the Declaration betrays unconscious bias of the framers that women are not actual persons. She says there is evidence that "when certain articles of the UDHR have been implemented by nations (or by global organs such as the World Bank), women in some parts of the world have even lost some of the meager rights they previously had" (Holmes, 1983, p. 250). Her concerns

are directed particularly to article 16 and the use of the word "family" which she suggests fosters patriarchy and hierarchy, and in the fact that the document does not confirm the right to one's own body. "If the right to one's own body is the first and greatest right, then surely this right should have been made explicit in the UDHR" (Holmes, 1983, p. 257). Holmes arguments are valid but in retrospect, are made 35 years after the Declaration was written. Just as CEDAW, written in 1979 failed to include issues such as violence against women and abortion rights, the Declaration was written before women's issues had gathered enough support for the attention they required in those years immediately following World War II.

There are also issues in the wording of the documents that delineate private acts from public acts. It is the private world where most women and girls suffer abuses of their human rights (Coomaraswamy, 1994). Even when the words are there as they are in article 25(2) which gives "motherhood special care," the doctrine of state responsibility which holds the state accountable for breaches of international obligations committed by or attributable to the state, doesn't protect "mothers". More than 500,000 "mothers" die each year in childbirth (Cook, 1994a). Most deaths are preventable with health services, but no one holds Mali, for example responsible for denying access to health services.

There is no mention of adolescent girls in the UDHR. Nor is the word "access" used.

The International Covenant on Economic, Social and Cultural Rights, 1966

The two Covenants written in 1966 were a result of a dispute among the members of the Human Rights Commission that was drafting the Declaration. They couldn't agree on a link between civil and political rights on the one hand and social and cultural rights

on the other. "The crucial difference between these two Covenants [the ICCPR and the ICESR] resides in the fact that ICCPR leaned toward a liberal perspective on human rights while ICESR moved toward a socialist agenda of human or 'solidarity' rights" (Ishay, 1997, p. xxxvii).

While article 7 regarding a decent living and safe and healthy working conditions, and article 11 regarding an adequate standard of living (for "himself" and "his" family) and to be free from hunger, address health, article 12 addresses the right to health and health care particularly and will be used here for that analysis.

<u>Article 12</u>

> 1. The State parties to the present Covenant recognize the right of everyone to the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the State parties to the present Covenant to achieve the full realization of this right shall include those necessary for: a) The provision for the reduction of the still-birth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Since the girl child is mentioned in 2(a), and since 2(d) calls for medical services and attention, it would seem that the adolescent girl's right to access to health services are covered. In spite of the wording, persistent neglect of the adolescent girl convinced the committee of the ICESCR to write General Comment #14, which addresses girls and comments in detail on access. The timing of this comment – August 11, 2000 – reflects

the status of girls described in the review of the literature. It was during a flurry of conferences held by The World Bank, the North-South-Institute and WHO in the mid-nineties that female children and adolescents were catapulted onto the agenda of human rights.

In its report titled. Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, the committee on economic, social and cultural rights addresses the issues of adolescent girls and access to health services. General Comment #14 (2000) which is based on the committee's experience in examining State parties' reports over many years, focuses on the normative content of article 12. It says:

> The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party: Availability, accessibility, acceptability and quality (paragraph 12).

Accessibility is described as follows: "Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisprudence of the State party" (United Nations, December 2000, p.4). It is the first statement regarding accessibility issued by the United Nations. Accessibility, according to this framework has four over-lapping dimensions.

•Non-discrimination: health facilities, good and services must be accessible to all, especially the most vulnerable or maginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

•Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially the most vulnerable or maginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.

•Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

•Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However accessibility of information should not impair the right to have personal health data treated with confidentiality (United Nations General Comment, paragraph 12[b] 2000.

It is questionable whether these dimensions deal with ideological barriers affecting women's discrimination. But by making accessibility an essential element of the right to health, the UN does address the failure of the ICESCR to serve young women. It also

makes access an interrelated part of the interpretation of health care. However. that access is still dependant on the will of State Parties for implementation.

The General Comment also addresses article 12.2 (d) which claims the right to health facilities. goods and services in paragraph 17.

The creation of conditions which would assure to all medical service and medical attention in the event of sickness, both physical and mental, includes the provision of: equal and timely access to basic preventive. curative, rehabilitative health services and health education: regular screening programs: appropriate treatment of prevalent diseases. illnesses, injuries and disabilities, preferably at community level: the provision of essential drugs: and appropriate mental health treatment and care. A further important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services. such as the organization of the health sector. the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

Referring to special topics of broad application. the General Comment, in paragraph 19 says.

> With respect to the right to health. equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities. and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health. Inappropriate health resource allocation can lead to discrimination that may not be overt. For example.

> investments should not disproportionately favor expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

As much as the UN uses this qualifier for accessibility, the reality of unequal access persists in the lives of citizens in countries all over the world. In Canada, for example, a country whose health care system is hailed as exemplary, a two-tiered approach to health care services is a fact of health services in Alberta and Ontario. Rather than being diminished since the General Comment was written in 2000, it is in fact increasingly available in other provinces.

Referring to Article 12.2 the comment says,

> Implementation of the principle of non-discrimination requires that girls as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children.

This is also a valuable addition to article 12 in the ICESCR. But it is also entirely dependant on the will of State Parties to not only change their laws but also to seek to change the historically produced, socially constructed and culturally defined practices and beliefs that are so detrimental to girls. The same argument applies to the writing of Paragraph 23 which says, "The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects

confidentiality and privacy and includes appropriate sexual and reproductive rights" (UN. December. 2000. p. 7).

The General Comment goes another step in describing adverse limitations when it says. issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. "The committee wishes to emphasize that the Covenant's limitation clause. article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States" (paragraph 28).

Regarding State parties' obligations, the point about access is made in paragraph 33 which says in part, "the obligation to fulfil [the right to health] requires States to adopt appropriate legislative administrative, budgetary, judicial, promotional and other measures toward the full realization of the right to health." Paragraph 43 reiterates the obligation to access by including access to health facilities, goods and services on a non-discriminatory basis. access to nutritionally adequate and safe food. to basic shelter. housing and sanitation. safe potable water and essential drugs. (United Nations. 2000. General Comment 14).

Although the General Comment is barely a year old. so far military budgets and State spending have not been altered in favor of the health care of girls. Moreover. while this recommendation is seen as the logical step in addressing the unequal access women and girls have to health services. when it is applied to States such as Afghanistan. the ICESR is as impotent as it was without the recommendation.

The Convention on the Elimination of All Forms of Discrimination Against Women (1979)

The women's commission that worked on the Declaration continued to struggle with the lack of protection of women's equal rights long after the Declaration was signed

and in fact throughout the subsequent Covenants signed in 1966. Fuelled by the women's movement during the Sixties and Seventies, the women who drafted CEDAW stated in the preamble of human rights promises made in prior documents. "Concerned however, that despite these various instruments extensive discrimination against women continues to exist." In that light, they proposed and achieved the ratification of CEDAW.

While 19 articles (and sub-articles) are applicable to women's health in this Convention, CEDAW stipulates the right to access to health services in articles 10(g) and (h), 12 and 14(b). article 10(g) calls for "The same opportunities to participate actively in sports and physical education." article 10(h) calls for "Access to specific educational information to help to ensure the health and well being of families, including information and advice on family planning." Article 12 says:

> 1. State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
>
> 2. Notwithstanding the provisions in paragraph 1 above, State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14(b) calls for "access to adequate health care facilities, including information, counseling and services in family planning."

When the Women's Convention was written in 1979, the women's movement was well under way but the laws had not been "feminized," issues such as abortion and

violence against women were not addressed by the framers of the document and the rights of adolescent girls had not been considered. While the review of the literature explains the difficulty of opening the Convention – fundamentalists States and the Vatican may cancel the hard-won rights the Convention had established – it was felt by the Women's Committee that something had to be done to address the denial of health rights. Accordingly, General Recommendation No. 24 was written and put into effect at the 20th Session of the United Nations in 1999. The General Recommendation addresses Article 12 in the Convention. (United Nations: 2000, General Recommendation 24).

Within the Recommendation, paragraphs address the denial of access to health care services and the systemic marginalizing of adolescent girls. The General Recommendation is the first international document to specifically identify adolescent girls in the human rights documents. Paragraph 8 says, "State parties are encouraged to address the issue of women's health throughout the woman's life-span. For the purposes of the present recommendation, therefore, 'women' includes girls and adolescents" (UN, 2000a, p.2). This is a major contribution in the human rights of the lives of young women because the exclusion in the past, reinforced the patriarchal assumptions in the documents and the powerlessness of women and girls.

Paragraph 13 explains that article 12 implies:

> State parties have the responsibility to ensure that legislation and executive action and policy comply with the obligations listed in the Article, namely access to healthcare services and respect, protection and fulfillment of women's rights to health care. It also requires State parties to "put in place a system that ensures effective judicial action. Failure to do so will constitute a violation of article 12.

The consequences of violating article 12 are not included in the document. In fact none of the UN documents include consequences that can assist young women in gaining their health care rights and therefore their implementation continues to be problematic. And even though Paragraph 19 says "In their reports. State parties should identify the test by which they assess whether women have access to health care on the basis of equality of men and women in order to demonstrate compliance with article 12" and that "reports should include comments on the impact of health policies, procedures. laws and protocols have on women when compared to men" (UN 2000. General Recommendation 24. p. 5) without clearly stated consequences. the well intentioned directives are not likely to be implemented. They do however take the debate to a new level simply by including the word access and by making sure that the word women means adolescent girls as well.

In an attempt to cover every angle of the debate about young women and health services. the General Recommendation includes a description of services in Paragraph 22 which says. "Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent. respects her dignity. guarantees her confidentiality and is sensitive to her needs and perspectives" (UN: 2000. General Recommendation 24. p.5) And it extends those services in particular to disabled women in Paragraph 25 which emphasizes "the needs of women with disabilities of all ages who have difficulty with physical access to health services" (UN: 2000, General Recommendation 24. p.5).

Paragraph 28 addresses the need to recognize the connection between article 12 and other articles in the Convention. In terms of access it points to article 10 that requires "State parties to ensure equal access to education thus enabling women to access health

care more readily" (UN: 2000, General Recommendation 24, p.6). Another connection is to article 10(h) which requires that "State parties provide to women and girls access to specific educational information to help ensure health and well-being of families" (UN: 2000, General Recommendation 24, p.6). And a connection to article 14 paragraph 2(b) which requires "access for rural women to adequate health-care facilities" (UN: 2000, General Recommendation, p.6). The Recommendation also points to article 16 paragraph 1(e) which requires "access to information, education and means to enable them to exercise their rights" (UN: 2000, General Recommendation 24, p.6)

Article 10(g) is not mentioned in the General Recommendation. This is a curious omission. It could be that the committee felt the word "participation" guaranteed access. Or it could be that sports and physical education are so ill considered in international human rights documents and the inclusion of pro-active health services so marginalized in the health care rhetoric, that the article was simply overlooked.

One of the problems with relying on these documents for protection of rights is that "States are seldom held accountable for ignoring their international obligations to respect women's human rights" (Cook, 1994b, p. 128). The Women's Convention for example, does not hold States absolutely liable to achieve certain results. It requires only that state parties exercise due diligence in implementing treaty provisions.

Some feminist legal scholars such as Kathleen Mahoney (1996) feel the Women's Convention may be a double-edged sword. Mahoney suggests it may even be responsible for the marginalization of women's human rights in international law. She argues,

> Institutions created to draft and monitor women's rights continue to be notoriously under-funded ... mainstream human rights bodies ignore or

> downplay the human rights of women by referring 'women's issues' to the Women's Convention ... and obligations in the Women's Convention are much weaker than those in other human rights instruments (Mahoney, 1996, p. 841).

It took 18 years for the treaty body to get a budget to act on a protocol (a mechanism to use the treaty to register a complaint). By comparison, it took the Children's Convention two years to get ratify the protocol. Even in Canada, a country renowned for its human rights advances, the protocol for CEDAW has not been ratified. That means that although Canada ratified CEDAW there is no mechanism to use it for a complaint. In practical terms we have a treaty we cannot use. The countries that did ratify the protocol can presumably bring the equivalent of a human rights complaint to an international body. Which "body" is a whole other area of concern. Presently there isn't an international body that can enforce human rights.

The Convention on the Rights of the Child (Children's Convention) 1989

Thirty-one years after the Declaration made ground breaking advances in human rights for world citizens, the actors at the United Nations came to the unhappy conclusion that the rights of children were not being observed, nor in fact had they been recorded in the documents. Forty-two countries spent the next 10 years drafting the Convention on the Rights of the Child while advocates for children's rights lobbied politicians to redress the status of children. At an international meeting in New York in 1990 (led by Canadian Prime Minister Brian Mulroney), the Convention on the Rights of the Child that was written in 1989 was brought into force. Although it is the Convention that was signed fastest and ratified soonest, it is also a Convention that State Parties have failed to honor.

In September 2001, the 22nd Session of the UN will devote the entire Session to children looking to redress the rising poverty and despair facing many of the world's children.

In this Convention, a "child" means every human being below the age of eighteen years. The articles in this Convention that reference the right to health care services, including proactive health services, are article 23(2), (3) and (4), article 24, article 27(1) and article 31(1).

There are three parts to the article that calls for health rights for disabled children. Article 23(2) says

> States parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

And, also dealing with the disabled child, Article 23(3) says,

> Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.

The third item dealing with disabled young people, article 23(4) says.

> States parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventative health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing counties (UN Convention on the Rights of the Child, March 21, 2001).

In effect, taking the needs of developing countries into account could cancel this right for disabled children in countries where economics interfere with health rights. The issues facing disabled girls are compounded by the low status of girls compared to boys, by State Parties that do not allocate funds for disabilities and by a patriarchal hegemony that favors boys over girls as well as able bodies over disabled bodies. Recording access for disabled children in this document does little for girls as long as gender sidelines them in the first place. But the inclusion of access to health services that these two articles specify, does highlight obligations that State Parties have.

Article 24 also uses the word access but as well it uses softer words like "strive to ensure that no child is deprived" rather than stronger words like "requires" or "insists." Like the Declaration, the Children's Convention was written with the best of intentions but 10 years after it was ratified, children, the world over are poorer, exposed to more violence and in greater danger of health risks. Stronger words and stated consequences of non-compliance would perhaps convince State Parties to comply. Article 24 states

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right, and in particular, shall take appropriate measures:

a. To diminish infant and child morality;
b. To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
c. To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution:
d. To ensure appropriate pre-natal and post-natal health care for mothers;
e. To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene

and environmental sanitation and the prevention of accidents;

f. To develop preventative health care, guidance for parents and family planning education and services.

3. States Parties shall take all appropriate and effective measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 27 requires State Parties to "recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development" (UN Convention on the Rights of the Child, March 21, 2001). Article 31 requires States Parties to "recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts" (UN Convention on the Rights of the Child, March 21, 2001).

The word access is used in articles 23 and 24 but not in articles 27 and 31. Adolescent girls are not distinguishable from infants, toddlers and boys with the exception of article 28 (b) and (c) which refer to secondary and higher education but still uses the word "child." Article 23, which references the rights of disabled children, refers to access in 23(3) and 23(4). Article 24 refers to access broadly in 24(1) and passively in 24(2)(e).

The most contested issue in debates about the Children's Convention is the use of gender-blind language. As much as feminist theorists despair the use of male language in human rights documents in general, they also criticize the use of gender-blind language in the Children's Convention as it does not single out girls for the added protection they need from the systemic discrimination they endure. The word "child" is used throughout the document as a noun, although when an adjective is required the framers have used "he or she" and "his or hers." Frances Olsen questions whether the gender-blind language of the document is "consistent with and enforces its provisions against sex discrimination or rather serves to obfuscate and leave in place gender discrimination, such as the disproportionate share of childcare done by women and the severe discrimination against girl children in parts of the world" (Olsen, 1992, p. 194).

In fact country reports submitted to the UN Committee on the Rights of the Child support those concerns. The reports show that the concept of the child differs from one country to another. In many reports the child is identified with the male sex. There are very few countries that mention that boys and girls have equal rights (ISCA). Considering the effect civil and customary laws have on the value and rights of girls within each society, the gender-blind language may indeed be creating barriers for the girls.

While theories around the rights of children's health had obviously advanced from 1948 until 1989 when the Children's Convention was written, it was during the post-Convention 1990s that issues of access and adolescent girls gained prominence. General Comment #14 from the ICESCR, pays particular attention to the Children's Convention in paragraph 22. The Comment says,

> The Convention on the Rights of the Child directs States to ensure access to essential health services for the child and his or her family, including pre- and post-natal care for mothers. The Convention links these goals with ensuring access to child-friendly information about preventative and health promoting behaviour and support to families and communities in implementing these practices. Implementation of the principle of non-discrimination requires that girls, as well as boys, have equal access to adequate nutrition, safe environments, and physical as well as mental health services. There is a need to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage, female genital mutilation, preferential feeding and care of male children. Children with disabilities should be given the opportunity to enjoy a fulfilling and decent life and to participate within their community.

In paragraph 23 it adds,

> States parties should provide a safe and supportive environment for adolescents, that ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate

> information, to receive counseling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.

If the health of children is at stake, the issue that still needs to be raised is who is being served by the rights in the Children's Convention, the children themselves or the adults who are responsible for them. John Eekelaar argues that it seems unlikely the framers of the Children's Convention followed their own precepts and consulted with children (Eekelaar, 1992).

Another disturbing issue is most States that have reported to the committees have indicated they would set a lower marriage age for girls than for boys. The reasons for these differences in marriage ages are seldom mentioned or analysed in the reports. Although this issue is on the agenda for the 22nd Session of the UN in the fall of 2001, so far the country reports have not been heeded which raises questions about whether adolescent girls are benefiting from the Convention. It is not in the best interest of girls to marry early. Their education may be interrupted, their bodies are not physically mature enough to bear children and the health risks attached to their pregnancies and deliveries are much higher than for mature women (ISCA, 1999). They are often deprived of appropriate and accessible information and counseling concerning their own bodies, pregnancy and birth (ISCA, 1999).

Olsen has also argued, the language of the Convention is in conflict with the goals of choice in for example children's right to care, which conflicts with children's right to

autonomy; their right to formal equality with their right to substantive equality; their right to security with their right to freedom of action (Olsen, 1992). And she questions the use of the term "legal protection before and after birth" cited in the Convention as it could potentially be used by anti-abortionists to alter health care for women. She also finds false universalisms in the convention wording.

> White people think of themselves as universal and without a race just as men and women think of gender as a women's issue. To the extent that the Convention deals with children as unspecified, unsituated people, it tends to deal with male, relatively privileged children (Olsen, 1992, p. 195).

These false universalisms reproduce the hegemonic power that fortifies barriers for girls. Except for the socially constructed practices and beliefs that affect their lives so powerfully, there are few universalisms for girls in Asia, Africa, North and South America to rely on.

The Convention on the Elimination of All Forms of Racial Discrimination – 1965

Established early in the flurry of Conventions created after the Declaration, the Race Convention was the first to specifically address the right to public health and to medical care. Article 5 says, "State parties undertake to ... eliminate racial discrimination ... and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, ... the right to public health, medical care, social security and social services ..."

The word access is not used, nor is there reference to adolescent girls. But more importantly, 36 years after the Convention was signed minorities continue to be denied access to health services. The reasons are because they cannot afford to pay for them or in

some countries that cannot get to them. Even in Canada the de facto two-tiered health system denies many citizens the right to timely access to health care. Of increasing concern is the developing two-tiered physical activity system that therefore denies citizens the right to proactive health services that promote well being. Three treaties that call for those rights will be discussed next.

A Trio of Treaties On The Right to Physical Activity

During the last quarter of the 20th Century, the value of physical activity was recorded in The European Sport for All Charter (1975), The International Charter of Physical Education and Sport (1978) and The Berlin Agenda for Action for Government Ministers (1999).

While the right to participate in sports was emphasized with the general adoption of rights after the Declaration, Kidd & Donnelly argue "There were several precursors in the first half of the 20th century to subsequent international charters on sports and physical education" (Kidd and Donnelly, 2000, pp.136). They cite the rising popularity of mass participation in sport during the 1970s as the impetus that led to the first declaration of access to sport and physical activity as a human right (Kidd & Donnelly, 2000). This interest led to the European Sport for All Charter in 1975 and the International Charter of Physical Education and Sport – 1978. In the European Charter, Article VI states,

> Since the scale of participation in sport is dependent, among other things, on the extent, the variety and the accessibility of facilities, the overall planning of facilities shall be accepted as a matter for public authorities, shall take account of local, national and regional requirements, and shall incorporate measures designed to ensure full use of both new and existing facilities.

Article VII says, "Measures including legislation, where appropriate, shall be introduced to ensure access to open country and water for the purposes of recreation." The Charter uses access in its documents, not in terms of the right to access to health services but rather as access to participation. Accessing facilities, which will be addressed in more detail in chapters six and seven, is only one of the barriers to access to physical activity for young women. The historically produced attitude that girls shouldn't over exert themselves (except in labour associated with crop work and family care), the socially constructed role of girls as too weak to run a marathon and the culturally defined belief that hockey is for boys, are the systemic barriers that sideline women and interfere with their health status. Other barriers include equity theory, discussed in the review of the literature and the fact that girls have simply not been on the agenda in the discussion of the right to access to health services.

The International Charter of Physical Education and Sport states in article 1, "The practice of physical education and sport is a fundamental right for all. And in article 3, "Physical education and sport programs must meet individual and social needs." Of the 10 articles in this charter, which was proclaimed at the 20th Session of the UNESCO General Conference, none mention access and none address the adolescent girl.

Twenty-one years later at the World Summit on Physical Education, government ministers were reminded of the importance of physical activity for children and of the obligations to that end documented in the Children's Convention. The Berlin Agenda – 1999 documented a Call for Action that includes:

•Implement policies for physical education as a human right for all children.

•Recognize the distinctive role of physical education in health, overall

development and safe. supportive communities.

•Recognize that failure to *provide* (my italics) Physical Education. costs more in health care than the investment needed for physical education.

The call for action by Governments and Ministries responsible for education and sport does not include the word access. nor does it address adolescent girls (Berlin Agenda. 1999). Although these documents have been somewhat effective – in Canada for example the advent of public golf courses. tennis courts, ski hills and swimming pools have moved in that direction. But the numbers are entirely inadequate for mass participation and the introduction of user fees has created barriers that forbid some citizens from participation. Moreover. the documents do little to address the systemic problems girls face in accessing physical activity and sport.

Missing in Access

"Access" is a 1990s word in the human rights field. While missing in the major documents. it is very much present in General Comment 14 (ICESCR) and General Recommendation 24 (CEDAW). as well as the Beijing Declaration and the Beijing Platform for Action. Although governments' commitments to ensuring the human right to health were made at the Earth Summit in Rio (1992). the International Conference on Population and Development in Cairo (1994). the World Summit for Social Development in Copenhagen (1995) and the Habitat II conference in Istanbul (1996), these documents. considered the law for the international community. have failed to protect the citizens for whom they were written.

The ineffectiveness of international human rights law to alter the status of women has been an acute point of debate ever since CEDAW was signed in 1979. Changes for

women were achieved more by activist women's groups than by the use of international treaties. Between the Nairobi World Conference on Women in 1985 and the Fourth World Conference on Women in Beijing in 1995 this stubborn resistance to change was analyzed from a feminist cultural studies point of view and resulted in a major shift in thinking. From a feminist cultural studies point of view, the approach of the "Forward Looking Strategy" of Nairobi had limited success. While sending a message that women around the world are maginalized, and "excluded from the mainstream of economic and social life and as a result are likely to receive fewer benefits than men" (WHO, 1998, p. 7), and while the Nairobi policies were reasonably effective in terms of increasing access to health and education, in fact they did little to alter women's status in society. WHO reports women's economic, political and social status remained largely unchanged and in some communities it actually deteriorated. Since this conclusion was drawn after CEDAW had been signed, it was clear that a change in strategy was required.

Between the two conferences, the International Conference on Population and Development that was held in Cairo in 1994 adopted a perspective feminist researchers had been rallying around for more than a decade. Gender equity and power were issues that had been blanketed in the more palatable (to fundamentalist states and the Vatican) layers of improved health and education for women. At the Beijing Conference, participants echoed the themes of Cairo and put the emphasis on gender. Now gender equity and the empowerment of women were accepted as cornerstones for the planning of effective health and population programmes (Germain & Kyte, 1995).

This change in thinking post Nairobi also set the stage feminist legal scholars such as Charlesworth (1994), Cook (1994a, 1994b), Coomaraswamy (1994), Eberts

(1995). Kim (1993) and Olsen (1992) to analyze human rights theory in reference to human rights law and to reconceptualize women's rights as human rights. Nancy Kim argues that existing human rights theory, because of its adherence to liberal principles, fails to remedy oppressive conditions for women (Kim, 1993). Human rights organizations such as the International Centre for Human Rights and Democratic Development began to call for gender sensitive research. Since women's and men's daily work, access to resources, political participation, experiences of violence, ability to exercise their rights and indeed their right to life, differ because of their gender, the law and the work of human rights organizations need to take that into account (Callamard, 1999). "Discrimination against and oppression of women is systemic and reflected not only in individual relationships but also in the structure and functioning of public institutions de jure (according to law) and de facto (without lawful authority), family relations, access to economic resources and legal systems" (Callamard, 1999, p.10). Therefore, argues Agnes Callamard, a gender-sensitive perspective means acknowledging the existence of gender biases in international human rights law. It also means moving toward a gender-sensitive conception and interpretation of international human rights law.

To achieve this end, the Special Assembly of the UN adopted an Outcome Document on June 10, 2000 regarding the Beijing Platform for Action. Paragraph 21 cites gender discrimination as an obstacle to implementing the Platform for Action. Paragraph 103(c) calls on States to establish legislation relating to all forms of domestic violence, including marital rape and sexual abuse of women and girls. Paragraph 103(d) calls on States to establish legislation to eradicate harmful customary or traditional

practices including female genital mutilation, early and forced marriage and so-called honor crimes that are violations of human rights of women and girls. (Equality Now, 2000).

That's not the only barrier for women and girls in the international treaties. The documents are filled with words like "may be," "should be," "can be," and "pursue," but never "is." There is no ironclad accountability. They rely instead on the politics of embarrassment. The documents speak of states being accountable but not to whom they are accountable. The Vienna Convention on the Law of Treaties provides that each treaty shall be interpreted in good faith. The presumption is that good faith justifies the state parties will use the treaties effectively (Cook, 1994b).

While governments are generally reluctant to adopt interpretations of international law that generate international criticism, the fundamentalist states of for example, Pakistan, Saudi Arabia, the United Arab Emirates and Afghanistan have no problem flouting international law when it comes to women and girls. Moreover, some countries – Brazil, Jordan, the West Bank – for example, have laws on their books that permit a man to kill his wife or female relative when his so-called honor is at stake. Honor Killing of girls and women is a scandalous example of the ineffectiveness of international documents on the lives of girls and women (Cook, 1994b).

The documents used by the United Nations to protect human rights have generally failed to protect the rights of women. The Universal Declaration of Human Rights (1948), the ISESCR (1966), The Convention on the Elimination of All Forms of Racial Discrimination (1965), CEDAW (1979), the Convention on the Rights of the Child, (1989) are full of articles that call for the human right to health services. Although the

wording of the articles and the absence of adolescents (until the General Recommendation 24 in 2000 and the General Comment 14 in 1999) can be called to account for the lack of access girls have to health services. the will of State Parties. the hegemony that supports those States in their refusal to enforce the documents. continues to sideline young women. The European Sport For All Charter. 1975. the International Charter of Physical Education and Sport. 1978 and the Berlin Agenda for Action for Government Ministers. 1999 highlight the value of physical activity but don't address the systemic barriers for girls in accessing proactive programs for well being. Furthermore. "the special instruments for women have been ineffective because of limitations in their terms of reference and in their powers" (Holmes. 1983. p. 251). Aart Hendricks argues the mechanisms now in place for supervision and enforcement of the right to health are extremely weak. In fact better protection is currently offered through more classic human rights such as the right to life, the right to be free from inhuman and degrading treatment and the right to found a family (Hendricks, 1999).

Clearly current guarantees in human rights documents are not working. One of the reasons the promises made to "all peoples and all Nations" in the Universal Declaration of Human Rights in 1948 are not being realized for adolescent girls is they simply have not been on the agenda. The Beijing Conference in 1995 changed that and ultimately created a platform for action that included access to health services for adolescent girls (UN. 2001).

The caucus leading up to the Beijing Plus Five meeting in 2000 struggled with the fundamentalist states. including the Vatican. but ultimately called on governments to provide adequate health care services to women and girls specifically to ensure: that

women have safe access to health services, including safe abortions; that education is used to promote women's understanding of their health needs; that health care providers understand these needs and that women and girls live in environments that protect/promote their health (Preview 2000). The platform for action states:

> Existing discrimination against the girl child in her access to nutrition and physical and mental health services endanger her current and future health. An estimated 450 million adult women in developing countries are stunted as a result of childhood protein-energy malnutrition (paragraph 266).
>
> • Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescent girls to enable them to deal in a positive and responsible way with their sexuality taking into account the rights of the child to access to information, privacy, confidentiality, respect and informed consent, as well as the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child and in conformity with the Convention on the Elimination of All Forms of Discrimination Against Women (paragraph 267).
>
> •Facilitate the equal provision of appropriate services and devices to girls with disabilities and provide their families with related support services as appropriate (paragraph 278 [d]).
>
> •Promote full and equal participation of girls in extracurricular activities such as sport, drama and cultural activities (paragraph 280 [d]).

•Provide public information on the removal of discriminatory practices against girls in food allocation, nutrition and access to health services (strategic objective L.5).

•Strengthen and reorient health education and health services particularly primary health care programs, including sexual and reproductive health and design quality health programs that meet the physical and mental needs of girls that attend to the needs of young, expectant and nursing mothers (strategic objective L.5).

The best of intentions are not enough for young women to realize their right to access to health services. As the following chapters on girls' health care in Afghanistan and the access to proactive health services for girls in Canada will show, the documents signed by countries around the world are not effective in the experiences of young women. Their access to health services is largely dependent on women's groups. And although studies have shown (World Bank, 1996) that elected officials could be fiscally responsible by promoting preventative, medical and proactive health services, politicians have instead created a victim-based health system that not only fails to serve young women, it blames them for any health problems they have.

Chapter Six

The Adolescent Girls of Afghanistan: A Case Study, Access Denied

It's hot in here. Shrouded in this body bag. I feel claustrophobic. It's smelly too. The cloth in front of my mouth is damp from my breathing. Dust from the filthy street swirls up under the billowing burqa and sticks to the moisture from my covered mouth. I feel like I'm suffocating in stale air.

It also feels like I'm invisible. No one can see me. No one knows whether I'm smiling or crying. My view isn't much better. The mesh opening in front of my eyes isn't enough to see where I'm going. It's like wearing horse blinders. I can see only straight in front of me. Not above or below or on either side of the path I take. Suddenly the road changes. I step on the front of the hideous bag that covers my body and tumble to the ground. No one helps me. It feels like no one in the world wants to help.

A young woman in Afghanistan six months after the Taliban came into power (Armstrong, 1997, pp. 16 and 28).

The young woman's story is in contravention with the Declaration, the ICESCR, CEDAW and the Children's Convention. She is one of half a billion young women in the world today whose human rights can be thwarted by governments that are never brought to account. This chapter will examine the consequences to adolescent girls when their right to access to health services is denied as documented in the Physicians for Human Rights Report (1998). Because access to Afghanistan is difficult and there is no constitution, rule of law, or independent judiciary, information about the effects of the

Taliban rules on the health of women and girls is scarce. Although journalists and non-government organizations such as UNICEF and Shuhada have reported a steady deterioration of health, only one formal study has been conducted on the health status of adolescent girls and women. Physicians for Human Rights (PHR) did this study during the first three months of 1998 (PHR, 1998).

This case study will use the results of that study published in The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan (1998) as well as the academic paper written in the *Journal of American Medical Women's Association* (JAMWA), titled Health and Human Rights of Girls in Afghanistan (1998) written by three members of the PHR study team to examine the efficacy of the documents. This chapter will also reference the report (for funding) titled The Health Situation of Adolescent Girls in Afghanistan, prepared by Dr. Sima Samar of the Shuhada Organization, a non-government organization in Quetta, Pakistan. It will also rely on my own journalistic reports published in 1997 and 2001 regarding the status of women and girls under Shari'a Law.

Background

When the Taliban took over the capital city Kabul in Afghanistan in 1996, the draconian decrees they installed included denial of health care for women and girls. Presently, they control more than 90 per cent of the country with a strict interpretation of Islamic rule called Shari'a Law. While most Muslim scholars dismiss these interpretations as political opportunism, and while the Taliban are bound by international human rights obligations signed by Afghanistan, the international

community seems to be helpless in the face of the human rights catastrophe facing the women and girls of Afghanistan.

In renaming the country the Islamic Emirate of Afghanistan, the ruling Taliban issue new edicts regularly. The first three edicts that altered the country's historical, social and cultural status have been translated into English and are contained in Appendix A, B and C in The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan (PHR, 1998, pp 113-119). These edicts demand that a woman, which means any female who looks like she has reached puberty and is often interpreted as any girl over the age of eight, must be totally covered, including her face whenever she leaves her home. She is subject to a host of draconian laws that at best keep her behind a purdah wall and deny her participation in society and at worst send her to the infamous Hall of Honor where public punishments include flogging, hanging or stoning a woman to death for alleged impropriety.

Women are forbidden to work. Girls are forbidden to attend school. Rules include no television or radio, no music, clapping, singing or dancing, no kite flying or any form of play or physical activity. Women have to cover the windows of their homes with paint and stay behind purdah walls so no man can see them. If they are caught in the company of a man who is not their husband, brother or son, the punishment is death by stoning. Makeup, nail polish and high-heeled shoes are anathema to the Taliban. Women are even forbidden to wear white socks – the only item of clothing that shows under the burqa because it's the color of the Taliban flag (PHR, 1998). In a stupefying response to international accusations about misogynist treatment of women and girls,

the leader of the Taliban. Mullah Mohammed Omar said the decrees were necessary. "Otherwise they be like Princess Diana" (Armstrong. 1997, p. 24).

The Taliban suggest this hegemonic domination is created by consent. But the research reveals a consent that is coercive rather than consensual, that many women hate being totally covered by a burqa and resent the refusal to employment and education and consent only because they fear for their lives. More research is required to examine the coercive versus the consensual consent but presently access to population studies is virtually impossible because the Taliban will not allow researchers into the country.

By all accounts these decrees contravene international human rights law. The Declaration. the ICESCR, CEDAW and the Children's Convention all contain articles as described in Chapter Four: The Best of Intentions, that describe these actions as illegal. Because of the political situation in Afghanistan under the Taliban and the sociological history of a country that has always embraced a conservative attitude for women and because of the current rise in feminism as women try to rescue themselves from the human rights catastrophe they endure under Taliban rule, a feminist cultural studies approach allows this research to be interpreted from multiple disciplines. The reproduction of gender inequality is evident at every stage of an Afghan girl's life but more so when the data around her access to health services is considered.

PHR found that additional edicts that contravene international human rights laws such as severe restriction on the movement of women, prohibition on interactions with expatriates. and the risk of summary punishment for acts which authorities consider threatening. presented considerable challenges to an effective study design. Their

strategy for documenting the health and human rights problems of Afghan women and girls included both qualitative and quantitative methods in researching three different sources of evidence. The three components of the study included: (1) a women's health and human rights survey of 160 Afghan women, (2) forty case testimonies of Afghan women and (3) interviews with 12 humanitarian assistance providers, health personnel and other experts. In addition the direct observation of the PHR investigator enhanced the documentation. The domains of inquiry for each study component included Afghan women's (1) physical health status and access to health care, (2) mental health status, (3) war-related trauma and landmine exposures, (4) experiences of abuse by the Taliban officials, and (5) attitudes toward women's human rights. For the purposes of this research document, the discussion will focus on #1, #2 and #5 because they are directly linked to the human right to access to health services.

Summary of Findings

Macro Analysis

The macro or socio-historical dimension to this research involves exploring collective meanings as they relate to individual experiences. In the case of the adolescent girls of Afghanistan the macro or big picture analysis questions the international right they have to access to health services and the facts of their lives under the ruling Taliban. The PHR results of the survey of 160 Afghan women indicated that the extension of the Taliban authority in Afghanistan has debilitating consequences for women's health and human rights. Seventy-one per cent of participants reported a decline in their physical health over the past two years. The majority of respondents (77%) reported poor access to health care services in Kabul

over the past year of residence there and 20 per cent reported no access. Both the access to care and the quality of health care services in Kabul were deemed much worse over the past year compared with two years prior by a majority of the participants (62% and 58% respectively). In addition 53 per cent of women described occasions in which they were seriously ill and unable to seek medical care. Twenty-eight per cent of the Afghan women reported inadequate control over their own reproduction (PHR., 1998, p. 6). The women consistently described high levels of poor health, multiple specific symptoms, and sixty-six per cent of women interviewed described a decline in their physical condition over the past two years. An Afghan physician described declining nutrition in children, an increasing rate of tuberculosis and a high prevalence of other infectious diseases among women and children (PHR, 1998).

The so-called religious edicts need to be factored into the macro analysis as they work in opposition to the UN documents signed by Afghanistan. When these edicts are linked to theory, politics and praxis, the analysis reveals that they are patriarchal and heterosexist and make women unjustly unequal to men to the point that they interfere with a girl's health status, her right to access to health services and in some cases with her right to life. For example, in Samar's verbatim report she highlights rules that lead directly to sexual violence:

> If a girl is raped by somebody she will be killed. The Taliban want the eyewitness of two adult Muslim, mentally healthy male for to condemn the man who raped the girl. Naturally it is very difficult to find these witnesses for a rape case. To kill the girl because of the pregnancy after she had been raped, they do not ask eyewitnesses because she already has the prove. She can not have legally

abortion. if her mother is willing to help her. she will take her to a traditional birth attendance. She will have an unhygienic abortion and most probably she will die from abortion. If she is very lucky her family is solidarity with her they must move to another town or village because of the honor. But in most cases the family will kill her for to safe their honor or at least the Taliban will kill her in the public (stoned to death or hanged. like they did recently).

There is no justice and law to protect her and no place where she could go and be safe. Sometimes the mother will be killed with the daughter (Samar. 2001. p.8).

Two stories highlight the macro analysis of the relationship between the international documents and the life experiences of young women in Afghanistan. One young woman who came to Samar's clinic in the refugee camp in Quetta had been menstruating for 11 months. Her blood pressure is dangerously low. She's as weak as a sparrow. The doctor says she needs a simple D and C (dilatation and curettage) but culture edicts interfere. She's a virgin. The simple operation would destroy her virginity. which in turn would destroy her life. So abdominal surgery is scheduled (Armstrong. 1997). Dr. Samar recounts another story that underlines the precarious position for women and girls in Afghanistan.

A 16-year-old girl came with her parents to my clinic. A quick urine test and cursory examination told me what I suspected. She was six months pregnant and terrified. She had been raped. This kid had kept her terrible secret until she could hide it no longer. I had to decide what to do. I don't approve of abortions unless there is no other way. But if I didn't do something for this girl. she would be

killed. I chose life ... Remember, most people here don't have any education, so I can get away with saying things they may not question. I told them their daughter had a tumor and needed surgery. I said she was too sick to have it now and she would have to stay at my clinic. I kept that girl for three months. When the baby was due, I did a caesarian section. The family waited outside the operating room because it is the custom here to show them what was found in the surgery. I put the placenta in the surgical basin, showed them the so-called tumor and told them their daughter would be fine. Then I gave the baby to a woman who was also in trouble because she is married and infertile" (cited in Armstrong, 1997, pp. 27-28).

She also reports that family planning is banned by the Taliban (except in a very few cases where the facilities are available and the women can get permission from their husbands) and says that's why the mother and child mortality and morbidity rate in Afghanistan is the highest in the world. Family planning is named in articles 12(1) and 14(b) of the Women's Convention as a human right for women.

Meso Analysis

In applying a meso analysis that reveals the personal level of values and interpretations of the young women who are affected by the edicts, the data reveals the struggle to gain the right to access to health services against the political decision making in the refusal to grant that right. The facilities for health care are not available to women and girls (they are available to men) and in the few cases where they are available, they are deemed unsanitary or unworkable. The PHR study reports the hospitals available to women and girls had no clean water, electricity, surgical or

medical equipment. They lacked basic medical supplies and equipment such as X-ray machines, suction and oxygen, running water and medications. Women housed there said they had received no medical attention; one had not been attended to for 10 days. But even these poor facilities are not available to most women and girls. Facilities for health services are listed in article 25 of the Declaration, article 12(2)(d) of the ICESCR, article 10(g) and 10(h) and 12(1) of CEDAW and article 24(1), (2)(b), (2)(e) of the Children's Convention.

In semi-structured interviews with 40 Afghan women, PHR explored access to health care services. Of the 40 women interviewed, 87 per cent reported a decrease in their access to health services. The reasons given included: no chaperone available (27%), restrictions on women's mobility (36%), hospital refused to provide care (21%), no female doctor available (48%), do not own a burqa (6%) and economics (61%) (PHR 1998, p. 7).

PHR investigators reported that the interference is not limited to hospitals. At medical facilities Taliban guards are ever present and intervene at will on behalf of the Department for the Propagation of Virtue and Suppression of Vice. The oppressive impact this has on women is key in maintaining the power and control of the Taliban. Nurses and other staff may be beaten when not covered completely, women fear leaving their homes to seek care, male physicians cannot properly examine a woman even if she is accompanied by a brother, husband or son because they cannot touch the women. One dentist described his fear of examining a woman's teeth because she would have to lift her burqa from her face and if he was caught they would both be beaten and jailed (PHR, 1998, p.8). Another woman was mourning the death of her daughter who had

suffered stomach pains for days but could not be taken out because the woman didn't own a burqa (PHR. 1998, p.8).

The wearing of the burqa itself may contribute to health problems. A female pediatrician noted "My activities are restricted. Walking with the burqa is difficult: it has so many health hazards. You can't see well and there is a risk of falling or getting hit by a car. Also for the women with asthma or hypertension wearing a burqa is very unhealthy" (PHR, 1998, p. 9). Another doctor informed PHR that the burqa causes eye problems and poor vision, poor hearing, skin rash, headaches, increased cardiac problems and asthma, itching of the scalp, alopecia (hair loss), and depression (PHR, 1998, p. 9). The total absence of vitamin D from sunshine along with the psychological harm done have created endemic levels of osteomalecia and depression among the women of Afghanistan (Samar, 2001).

The focus on the lack of health education facilities and the corresponding lack of knowledge about body functions in Dr. Samar's report raises issues for the meso analysis. "Since all the girls' schools has been closed there is no education facility in general but in particular there is no biology lesson. the girls can even not see their friends. and talk between them about the changing in their bodies" (Samar, 2001, p. 8). She reports that most mothers are not educated. don't know anything about their own bodies to tell their daughters and furthermore, the culture does not allow speaking about the female body. "The majority of the girls who reach puberty and have their first menses are shocked and do not know what is happening to their body so they try to hide and some of them even are getting depressed" (Samar, 2001, p. 8). Because of the repression by the Taliban and a poor economy most girls are married very young, soon

after their 12th birthday. They are denied the information promised to them in the Children's Convention and are counted as property by their husbands which is also in contravention to the Treaties Afghanistan has signed. Since virginity is very important in the religious and cultural values of the country, if the girl is virgin but does not bleed after the first intercourse she will be beaten or even killed (Samar, 2001). While there is resistance to these edicts, the Taliban count on hegemonic dominance and subordination to stay in power.

Micro Analysis

This analysis focuses on the consequences in the lives of girls, of contradictory interpretations of economic, social and physical benefits of access to health services. The socially constructed role of women in Afghanistan leads to the consequences of a victim-based system that withdraws health services on the one hand and blames the victim for poor health on the other. The socio-historical and religious circumstances of Afghanistan contributes to the hegemony that makes this treatment of women natural, accepted. The punitive power behind the Taliban make the ideological influence resistant to change.

Participants in the PHR health and human rights survey reported extraordinarily high levels of mental stress and depression. Eighty-one per cent reported a decline in their mental condition. A large percentage of respondents (42%) met the diagnostic criteria for post-traumatic stress disorder and major depression (97%), and also demonstrated significant symptoms of anxiety (86%). Twenty-one per cent indicated they had suicidal thoughts "extremely often" or "quite often." It is clear from PHR's 40 interviews with Afghan women that the general climate of cruelty, abuse and tyranny

that characterizes Taliban rule has had a profound affect on women's mental health. Ninety-five per cent of the women interviewed described a decline in their mental health during the last two years (PHR, 1998, p.9).

Additional micro analysis is found in the paper written by three of the investigators for JAMWA that analysed the research gathered during the three-month study for the particular effect on the health and human rights of adolescent girls. Of the 21 adolescent girls PHR interviewed, two had suffered serious injuries from landmines resulting in loss of limbs. Neither had received rehabilitation for their injuries. All of the adolescents interviewed described feelings of anxiety, overwhelming sadness, fear about the future and hopelessness. Four adolescents described frequent nightmares, and two explicitly talked about their wish to end their lives. One 16-year-old girl interviewed in Kabul said, "Sometimes I think suicide may be a way out of this horrible life, but I feel sympathy for my mother since I am all she has in this world" (Rasekh, Heisler & Iacopino, 1998, p. 6). In the refugee camps surrounding the Afghan border, women and girls suffer all the ills that refugee camps are heir to: malnutrition, anemia, typhoid fever, malaria (Samar, 2001). Dr. Samar runs a clinic in the refugee centre of Quetta in Northern Pakistan and reports that most women she sees have osteomalacia. Their bones are softening due to a lack of vitamin D. They survive on a diet of tea and naan because they can't afford eggs and milk and, to complicate matters, their burqas and veils deprive them of vitamin D from sunshine (Samar, 2001). They can't even get sunshine in the privacy of their homes as the Taliban decreed that the windows had to be painted so that a woman could never be seen. She also cites the Taliban's view on family planning as a cause of Osteomalecia (a softening of the bones).

> Before Taliban took the power all kind of family planning was available. After the arrival of Taliban family planning has been banned and is considered an unIslamic action. This is worse for the young generation who does not have any information about their body. Most of them up to the age of twenty have 4 or 5 children. Most of the time the girl is pregnant and in the meantime feeding the last born. That's why most of these girls are suffering from Anemia and Osteomalacia (Samar, 2001, p. 9).

The added consequences of living under the rule of a government that thumbs its nose at its international human rights obligations is the rising incidence of mental and neurological disease.

Samar echoes the PHR study with her own calculations of the incidence of depression among girls between the ages of 10 and 20. She reports levels of depression in 100 per cent of her patients and says the reasons include, isolation, not going to school and seeing their friends, especially for girls who went to school before. The ban on entertainment, where they could see news about the world before now there is no television, no magazines, no music, no pictures. The poor economy, especially in the big cities where prior to the Taliban take-over, parents were working and the children were going to school. And fear of going to bed hungry coupled with the lack of hope that the situation will get better in the near future.

Using the Zoom Model allows the data to be refocused in multiple and even contradictory perspectives within the research. For example, although family planning is part of the Macro or big picture in this analysis as it stands along with the powerful rules the Taliban refer to as protecting the women and girls and in opposition to the

international laws that girls are granted by the UN, it can also be viewed in the micro analysis for its effect on the health of the girls. Dr. Samar's report says Tricomonasis (vaginal infection), Candidiasis (yeast-like parasitic fungus) and pelvic infection are common among the young women. "They have no information about their body and think that the blood coming from vagina is dirty blood so they usually try to hide their menses from the other members of the family" (Samar, 2001, p. 8). She reports they use dirty, old cloths as a napkin, because they haven't any money to buy soap to wash them and they can not dry the cloths (napkins) in the sun since such evidence of being female must not be seen by anyone. When they get sick they can't even discuss the reasons for their disease with a doctor because they can only go to the doctor with a male relative and they can not talk about menses in front of their male relatives. As well she reports, all kinds of diseases like polio, measles and tuberculosis as well as medical crises are high among the women and girls in general because of the edicts of the Taliban. For example, "recently a woman died because she has not been treated at the hospital after she had been burned because no female medical doctor was available to treat her" (Samar, 2001, p. 10).

Four and one-half years after the Taliban closed the health clinics for girls and women, the situation has deteriorated into a life threatening level. For example, an 18-year-old girl in the city of Hazarashat was in labour for 40 days. Her family tried to assist with old remedies such as putting half-baked bread dough and heated grasses on her abdomen. She was nearly dead after the 40th day of the ordeal when the doctor found her and says a midwife could have diagnosed the problem easily. The doctor did a caesarean section and found the baby had been dead for so long the fetus and the uterus

were mixed up with necrotic tissue and the woman required a hysterectomy. It's incredible that she lived through it, says the doctor. "But such needless agony is unacceptable. Furthermore, now the woman is infertile so her husband will take another wife and she'll be relegated to servant status" (cited in Armstrong, 2001, p. 136).

Dismissing the misogynist treatment of women as a cultural norm is taking a heavy toll on the physical and emotional health of the women and girls. This harsh interpretation of Shari'a law has for example created an obsession with the status of a woman's hymen. These fundamentalist states still cling to the notion that if a woman is a virgin she will bleed after intercourse on her wedding night. Women even take a small white sheet to the wedding bed so their husbands can have proof (in some rural areas he even waves the proof around the village the next morning). The consequences of a bloodless sheet are life threatening to a woman so hymen repair is a well-known medical secret to the women and girls. Dr. Samar says, "It's not unusual for a woman to bring her daughter and ask me to check that the hymen is intact. If it isn't, I repair it. Otherwise she will be killed" (cited in Armstrong, 2001, p. 136).

The human rights documents that are international law are worthless to the women and girls of Afghanistan and the world seems powerless to even keep them alive under Taliban control much less gain access to health services for them.

The State of Afghanistan and International Legal Obligations

There is a presumption that a rogue government, such as the Taliban is not obliged to observe the treaties the country signed. The PHR report states, "Under international law the Taliban is responsible for adherence to human rights law Afghanistan has ratified, notwithstanding the fact that its leadership

does not recognize the validity of these to the extent that they depart from the Taliban's particular interpretation of Shari'a" (PHR, 1998, p. 98). Moreover they report that the fact that the Taliban does not possess all of the attributes of a functioning and recognized government does not relieve it of accountability for the human rights violations it has committed (PHR, 1998).

Prior to the Taliban take-over, Afghanistan had become party to many human rights treaties without substantive reservations. For example, it was the first country to accede to the Convention on the Political Rights of Women in 1966. It also acceded to ICCPR and the ICESCR in 1983 without reservation. And it signed although did not ratify CEDAW in 1980. The committee that monitors CEDAW has specifically stated in observations that Shari'a itself gave equality to women, but the problem that had to be overcome was that of interpretation (The Women's Committee, 13th session, 1994). Afghanistan also signed the Children's Convention in 1994 but made a general reservation on all provisions of the convention that are incompatible with Shari'a Law and local legislation.

Freedom of religion allows for specific interpretations of and reservations under international law. But it doesn't permit the Taliban to take measures that directly contravene the object and purpose of treaties under which it has assumed obligations, nor to decline to uphold universally recognized principles of non-discrimination in the name of Shari'a. For example, article 6 in the ICCPR specifies the right to life, but the Taliban deny access to life-saving health care. Article 7 prohibits torture or cruel, inhuman or degrading treatment, yet the Taliban not only call for stoning a woman to death as a punishment but state that the stones thrown must not be so large as to kill her

quickly. Article 16 recognizes the right of everyone to be recognized as a person before the law but in Afghanistan today girls and woman have no rights. Article 18 establishes freedom of thought, conscience and religion, which is a non-starter for Afghan women and girls. However, these rights that the Taliban have denied to women and girls are non-derogable rights that cannot be suspended even during times of war.

Interpreting the Multi Levels of Data

By zooming in and out of the three levels of analysis the research reveals a process that impacts the lives of young women in sometimes contradictory ways. The treaties the government of Afghanistan signed uphold the rights of women and girls to bodily integrity, information, education, association, freedom of movement and health care. The Taliban have therefore committed gross violations of human rights, in both their imposition of severe restrictions on women and girls' activities and movement and their harsh punishment for failure to adhere to these restrictions. But because the Taliban is considered a rogue State, some say it is not responsible for previously signed treaties. "Even though the Taliban is not an officially recognized government of Afghanistan, it is still accountable for the human rights violations it has perpetrated against Afghan women" (PHR, 1998, p. 103).

Factoring in the micro analysis, one needs to consider that since WHO defines health as "a state of complete physical, mental, and social well being and not merely absence of disease or infirmity," health care requires protection and promotion of human rights. The Taliban restrictions on women and girls obviously denies those rights. PHR's research demonstrates that the violations of these rights and dignity of women and girls have had deleterious mental and physical health consequences. The

experiences and concerns of Afghan women and girls documented in PHR's studies illustrate that the promotion of their health is inextricably linked to the protection of their human rights. And they demonstrate that the Taliban in Afghanistan are in contravention of The Declaration of Human Rights as well as all the other treaties they signed by denying girls and women health care and in promoting laws that damage their health. The case of Afghan girls makes it obvious that access to health services is influenced by cultural and ideological factors such as the subordination of girls and the systemic inequalities they experience.

In terms of the micro analysis, the results of the PHR studies reveal that the health status of the girls of Afghanistan is severely compromised by the Taliban's refusal to grant them access to health services. Although not helpful today to the girls of Afghanistan, during the last two decades, feminist interventions have begun to alter the grossly unequal status of girls in both the developing and the developed worlds. But there remains a great deal of progress to be made. Considering the multi levels of data, an encouraging point of reference is found in *Gender and Health: Technical Paper*, which was prepared for the World Health Organization (WHO) in 1998. It offers a useful framework for the examination of a girl's access to health services, primarily because it begins with a shift from an exclusive focus on women to focus on gender. In itself that shift exposes the socially constructed differences and power relations between women and men, as a determinant of health. At the Fourth World Conference on Women in Beijing in 1995 this was the point of view urgently expressed by participants and promoted for the Platform for Action so that a gender perspective would be mainstreamed into all policies and programmes of the United Nations system. By

adopting gender perspectives into these policies and programmes. WHO made a broad reaching attempt to inform the actors in the business of public health including the researchers, policy makers and programme planners about the value of gender analysis. (WHO, 1998).

The shift in thinking to gender equity and access to health services may be the way forward for the players in the health care business. But they need to employ better methods that search for what Hilary Charlesworth calls the silences in the data that point to ways that international law factors out the realities of women's lives (Charlesworth, 1999). Thus far, the international treaties and the combined scholarship of feminists, activists and health care experts have been of little use to the adolescent girls of Afghanistan.

Samar reports, "My personal experience as a female medical doctor working in and out of Afghanistan since 1982 shows that the health situation of the girls is getting worse and worse" (Samar, 2001, p. 8). She closes her report with a commentary from Afghan feminist author Nawal El Saadawi. Her words underline the feminist cultural studies position that assumes cultural practices and beliefs are historically produced, socially constructed, and culturally defined.

> All children who are born healthy and normal feel that they are complete human beings. This, however, is not so for the female child. From the moment she is born and even before she learns to pronounce words, the way people look at her, the expression in their eyes, and their glances somehow indicate that she was born "incomplete" or "with something missing". From the day of her birth to the moment of death, a question will continue to haunt her: "Why?" Why is it that

preference is given to her brother. despite the fact that they are the same. or that she may even be superior to him in many ways, or at least in some aspects? The first aggression experienced by the female child in society is the feeling that people do not welcome her coming into the world. In some families. and especially in rural areas. this "coldness" may go even further and become an atmosphere of depression and sadness, or even lead to the punishment of the mother with insults or blows or even divorce.

Chapter Seven

The Adolescent Girls of Canada: A Case Study of the On the Move Program

> Equity does not necessarily mean that all persons must be treated exactly the same. Where discrimination exists, people may need to be treated differently, in order to be treated fairly (cited in Fenton, Kopelaw & Lawrence, 2000).

On the other side of the world from Afghanistan and seemingly at the opposite end of the human rights pole, a group of women in Canada decided to tackle the systemic discrimination that was denying adolescent girls their right to physical activity and the proactive health benefits access to such programs would provide.

As opposed to the gender apartheid policy practised by the Taliban in Afghanistan, the rights-based approach to access to health was raised by a government body in Canada. In a federal report about access to physical activity in Canada, the authors of Sport: The Way Ahead (Fitness and Amateur Sport, 1992) admonished the sport community, "In accountability for public funding, national sport organizations must understand the legal definition and intent of gender equity and implement it through legislation, constitutions and policies. National Sports Organizations must work toward equality by removing systemic barriers and discrimination." (Fitness and Amateur Sport, 1992, p. 151).

This chapter examines the On the Move program in Canada. The documents used include: Janice Graham's 1992 report titled Women and Sport which launched the On the Move program; the On the Move Handbook prepared by The Canadian Association for the Advancement of Women in Sport and Physical Activity and authors Jennifer Fenton,

Bryna Kopelow. Claudia Viviani and Sydney Miller (2000). This handbook for increasing participation of girls and women in recreational sport and physical activity is a compendium of information gathered from the research surrounding the early years of the On the Move program. It was written in 1994, revised in 1997 and reprinted in 2000. The work of Wendy Frisby in Leisure Access: Enhancing Recreation Opportunities for Those Living in Poverty will also be examined because it was used in establishing an On the Move program in Kamloops, B.C. Unfortunately since this very insightful research only includes adult women, its findings are limited for the adolescent girl. The On the Move web site, which is the major link for the OTM programmers was followed for six months beginning in December 2000. International, national, provincial and local documents pertaining to access to sport and physical activity and informing the OTM program were also examined. They include the Brighton Declaration on Women and Sport (1994), the Canadian Charter of Rights and Freedoms (1982), the Sport Canada Policy on Women and Sport (1986), the B.C. Provincial Policy in Sport (1992) and the Federation of Canadian Municipalities Resolution (1989).

This chapter will analyze the need for programs designed specifically for girls in terms of their human right to proactive programs that enhance well being. It will examine the effectiveness of the On the Move program in reaching girls in Canada in terms of the numbers who attend and the effect of the program on their health and well being. The macro analysis looks at the documents that call for access to proactive health and zooms in on the sociohistorical dimensions of sport for girls in Canada and explores the collective meanings of access to physical activity as they relate to the experiences of girls. The meso analysis examines the political decision making around access and zooms

in on systemic problems. such as access to facilities associated with girls and sports programs. And the micro analysis will concentrate on the consequences to girls' health created by cultural practices and beliefs in sport that are historically produced. socially constructed and culturally defined.

Background

The benefits of regular participation in physical activity to physical. social and mental well being are well documented (Theberge, 1987, Talbot, 1989, Vertinsky, 1994). But the disturbing low level of fitness among Canadian adolescents and the negative attitude girls share about sports is cause for examining the reasons young women drop out of sports at the rate of 90 per cent after the age of 12 (Hay & Donnelly. 1996).

The On the Move program began with an evaluation of the women and sports program in 1992 in the Ottawa Parks and Recreation Department. It was a response to the increasing evidence that the "If we build it they will come attitude" wasn't working in attracting adolescent girls to physical activity programs. Given the mounting evidence about the effects of physical activity on self-esteem. self-confidence and empowerment. the leaders decided they had to address the barriers that kept young women away (in droves) from physical activity programs (CAAWS. 1991. Dahlgren. 1988. Lenskyj. 1991). They found that "the existing programs for sports and recreation are. with few exceptions. based on male models of competition, physical power, and individual excellence reflecting male priorities. beliefs and values" (Graham, 1992, p. 1). And they questioned whether women-centred values – nurturance, compassion and cooperation – were being integrated into the existing programs.

The study conducted with 469 women and girls found the following:

•Equal participation of all team members was important to 97% of the participants.

•Personal safety (relating to unsafe areas of the city, poor neighborhood lighting and isolated areas for participating in physical activity) was a concern to 48% of the participants.

•Fun, recreational exercise, social aspects of recreation, the type of activity offered and a women-centred program were the four leading reasons for choosing a program (Graham, 1992, p.9).

Clearly change was needed if young women in Canada were to take advantage of their right to health through proactive programs (Graham, 1992). In fact in a study of 50 young women in grades 9 through 12 in an urban highschool located in a mid-size Canadian prairie city, researcher Louise Humbert supports that claim. She examined the importance of a physical education environment that respects and accepts individual differences. The results indicate that the young women in this study frequently experience an environment in coeducational physical education classes that is filled with ridicule, embarrassment and limited opportunities to participate in physical activity. Given these findings, physical educators were encouraged to create environments that are equitable, respectful and understanding of the challenges young women face in physical education programs (Humbert, 1995). The work of Graham and Humbert, conducted in two different areas of the country concur that the outstanding issue for young women and physical activity participation is in the atmosphere pervasive in patriarchal physical education programs.

As Scraton (1992) and Hay & Donnelly (1996) have noted, the atmosphere in the gymnasium has been one that supports boys as athletes and as participants, and girls as unathletic onlookers who prefer to be sidelined. Studies by Coakley & White, 1992; Evans, 1984; Leaman, 1984; Scraton, 1992 also support this conclusion.

Sport and physical activity is based on decades of traditions and practices that favor male participation. So the rules and conventional practices in sport favor the physical strength and development of boys. The evaluation of the women and sport program in Ottawa by Janice Graham paved the way for new programming, new ideas and an altered attitude to physical activity and sport.

Since a decline in women and girls involvement in physical activity may result in a reduced fitness level over the life cycle (absence of strength, poorer cardiovascular levels, diminishing bone density, a poor sense of body image and low self-esteem) the Ottawa leaders decided to do something about it.

On the Move's beginnings go back to a trial program in Ottawa called Women and Sport which was launched in 1985 to increase the physical activity participation of girls between the ages of 13 and 17. It was a response to a two-year study done by the Ottawa Department of Culture and Recreation that examined the recreational services and community participation rates for males and females and exposed the male-bias in services and low participation rates for women (Graham, 1992). A follow-up study done in 1987 showed an increase in participation rates of girls and women as a result of the program. Through a consultation process with the Canadian Association for the Advancement of Women in Sport and Physical Activity (CAAWS, 1991), OTM initiatives began in Ottawa and Port Coquitlam, B.C. in 1992. The program was designed

specifically to increase opportunities for non-active girls and women ages. 9-18 to participate in fun-filled, supportive, female-only, recreational sport and physical activity. The overwhelming success of the programs in Ottawa and Port Coquitlam convinced Sport Canada to fund CAAWS in their support of this initiative. Promotion Plus, a B.C. organization for girls and women in physical activity and sport piloted the program in 10 communities throughout B.C. Since then it has spread across the country with successful programs running in every province and territory. Surprisingly, there is no record of how many programs are operating, how many young women they serve, and thus no evidence of the impact access to this program has on the health of adolescent girls.

The program is based on the premise that there is a sector of the population missing out on recreational opportunities due to various overt and covert societal barriers. On the Move (OTM) provides an alternative program model that can reach out to those populations the current system is not serving. The mandate is to provide programs that encourage the development of sport and physical activity skills, healthy lifestyles and increased self-esteem, self-confidence and self-efficacy. It does this through programs that are designed by the participants in a non-competitive environment. The activities include team sports such as volleyball, floor hockey and baseball, group discussions about team building, family relations and personal issues raised by the participants, and other activities such as baking, watching movies and group outings.

The underlying premise of OTM is to work toward gaining gender equity in physical activity and sport. Margaret Talbot's work has contributed a great deal to the understanding of gender equity in physical activity programs. She says the concept of equality of opportunity needs to be examined before it will be useful for girls and women.

She calls it a "minefield of value-laden and emotive rhetoric" and says, "There is a complex hidden agenda in the various interpretations of equality, which significantly affects the way in which physical education or sports programs might be delivered, but which is rarely explicit and seldom explored" (Talbot, 1989, p. 12). Talbot's framework for analyzing equity was noted in Chapter Three.

The OTM handbook explains, "Gender equity means providing girls and women in your community with access to a full range of opportunities to achieve the social, psychological and physical benefits that come from participating in recreational sport and physical activity," (Fenton et al., 2000, p.8). Coupled with Talbot's equity framework, this description responds to the concerns raised by women in the studies done by Graham and Humbert. Gender equity which is key to the provision of access to health for adolescent girls is the process of allocating resources, programs and decision-making fairly to both males and females. This requires ensuring that everyone has access to a full range of opportunities to achieve the social, psychological and physical benefits that come from participating in sport and recreation. It does not necessarily mean making the same programs and facilities available to both males and females. Gender equity requires that girls and women be provided with a full range of activity and program choices that meet *their* needs. Therefore some activities may be the same as those offered to boys and men, some may be altered, and some may be altogether different.

An analysis of this program exposes its macro relationship to the documents that call for the human right of young women to proactive programming that enhances well being, its meso relationship to the structures that enhance or deny access to sport, and the

micro relationship girls have in terms of the consequences they pay when their right to well being is encouraged or discouraged.

Macro Analysis

Despite the social and cultural reproductions of male hegemony in sport that perpetuates inequalities for girls, the founders of OTM relied on the mantra "women's rights are human rights" and based their plan for funding on human rights law. They cited, The Canadian Charter of Rights and Freedoms (1982), The Brighton Declaration on Women and Sport (1994), the Sport Canada Policy on Women and Sport (1986), the B.C. Provincial Policy on Sport (1992) and the Federation of Canadian Municipalities Resolution of 1989. They could have used other treaties including the ICESR and article 12(1) and General Comment 14; CEDAW and articles 10(g)(h), 12 and General Recommendation 24; The Children's Convention and articles 23(2)(3)(4), 27(1) and 31(1) which are international in scope. And they could have referred to the European Sport for All Charter, The International Charter of Physical Education and Sport and The Berlin Agenda for Action for Government Ministers which reference physical activity precisely. But they chose the other documents and made particular reference to the following selections:

The Canadian Charter of Rights and Freedoms, section 15 which states

1. Every individual is equal before and under the law and has the right to the equal protection and benefit of the law without discrimination and, in particular, without discrimination based on race, nationality or ethnic origin, color, religion, sex or mental or physical disability.

2. Subsection one does not preclude any law, program, or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, nationality or ethnic origin, color, religion, sex, age, or mental or physical disability.

This section of the Charter can be used to argue a multiple disadvantage perspective as could section 28 which argues equal access and equality as well as quality of result. The Charter itself brought sports into federal and provincial human rights codes. "These in turn have given girls and women a number of important victories in the area of sport and physical activity" (Kidd & Donnelly, 2000, p. 139) such as access to male only sports clubs.

The Brighton Declaration on Women and Sport was produced following the first International Conference on Women and Sport held in Brighton, UK, May 5-8, 1994. The conference specifically addressed the issue of how to accelerate a process of change that would redress the imbalances women face in their participation and involvement in sport. Its overriding aim is to develop a sporting culture that enables and values the full involvement of women in every aspect of sport.

The Brighton Declaration asserts that it is in the interests of equality, development and peace that a commitment be made by governmental and non-governmental organizations and all those institutions involved in sport to apply the Principles set out in the Declaration by developing appropriate policies, structures and mechanisms which:

- Ensure that all women and girls have the opportunity to participate in sport in a safe, and supportive environment which preserves the rights, dignity and respect of the individual;

•Increase the involvement of women in sport at all levels and in all functions and roles;

•Ensure that the knowledge, experiences and values of women contribute tot he development of sport;

•Promote the recognition of women's involvement in sport as a contribution to public life, community development and in building a healthy nation and;

•Promote the recognition by women of the intrinsic value of sport and its contribution to personal development and healthy lifestyle (1994).

Like the Canadian Charter, the Brighton Declaration protects affirmative action. This is particularly useful for girls in Canada as it allows a shift from equality to equity. "Whereas 'equality' means treating persons the same, 'equity' means giving all persons fair access to social resources, while recognizing they may well have different needs and interests." (Kidd & Donnelly, 2000, p. 139).

Sport Canada Policy on Women in Sport (1986) states, "Equality is not necessarily meant to imply that women wish to participate in the same activities as men but rather to indicate that activities of their choice should be provided and administered in a fair and unbiased environment." This policy also supports the needs for the girls in the OTM handbook document. And women and girls can reference the Charter of Rights and Freedoms for the clout of national law as it applies to the Sport Canada policy.

The BC Provincial Policy states in part, "The provincial policy for girls and women in physical activity and sport provides a direction and framework for action in addressing issues in British Columbia. The situation must be viewed as part of the larger societal commitment to promote gender equity." This is a policy that has been used

successfully in a provincial human rights complaint in British Colombia. For example, a father registered the complaint when his daughter's gymnastic team failed to receive funding while boys' ice hockey was funded. "When the human rights commission accepted his complaint, the city was persuaded to compile gender equity statistics, establish a gender equity committee, hire a gender equity coordinator, establish a gender equity fund and require all users of public facilities to establish a gender equity policy..." (Kidd & Donnelly, 2000, p. 144). The OTM handbook also advises using municipal governments to gain access to facilities needed.

The Federation of Canadian Municipalities says,

•Whereas the Government of Canada adopted a policy on women and sport in October 1986; and

•Whereas the Provinces of Ontario and British Columbia are developing a policy on women and sport; and

•Whereas municipalities must take a leadership role at the local level to encourage sport opportunities for girls and women;

•Be it resolved that municipalities review facility use in their communities vis-a-vis male and female participation; and

•Be it further resolved that municipalities initiate an awareness campaign promoting the benefits of physical activity targeted to girls and women; and

•Be it further resolved that the inequalities in the accessibility of program opportunities be addressed particularly in the area of team sports for girls and women.

Using these policies to back up human rights challenges has already been effective in Canadian municipalities. In Ontario for example, the interuniversity women's sports teams at the University of Toronto threatened such a challenge and received funding equal to that of men's teams (Kidd & Donnelly, 2000). Making Canadians aware of the Charter laws and policies available to them for sport and physical activity for girls would be beneficial for the enhancement of health care and therefore access to proactive programs that provide that care.

Today the OTM programmers also rely on the 1995 Canadian Parks and Recreation Association National Policy on Gender Equity. It states in part, "the gender equity policy is to provide motivation, direction and guidelines to the Association, its partners and its membership to enhance the recreation and leisure opportunities available to girls and women." Placing women and girls in the documents is key to changing the patriarchal policies that sideline young women.

Feminist theory reconceptualizes women's rights as human rights by acting as an alternative to liberal human rights theory and in the case of OTM, shifts the ground in order to undercut the hegemony of male discourse (Whelehan, 1995). By using international, national, provincial and local documents that call for gender equity in sport the OTM founders challenged the assumptions of political power versus justice in these policies and gained the funding they needed to redress the access to sport for young women.

Meso Analysis

The meso relationship to the structures that enhance or deny access to sport were isolated by the OTM founders. The positioning and interpretation of organizational

practices and policies revealed the barriers young women have in their struggle to gain access to the right to proactive programs for well being. Accordingly the OTM philosophy calls for service providers to examine the practices that hinder the participation of girls (Fenton et al., 2000). A meso analysis of these practices exposes five areas that can promote or deny access to sport for girls. They are: facility bookings to ensure that both females and males have access to prime slots and prime facilities; resource allocation – to determine which activities are receiving the program budget; participation rates – to identify whether co-ed programs are truly co-ed; activity programming – to assess the types of activities offered for males and females; and promotional materials – to ensure girls and women are not being excluded or stereotyped (in picture and language).

The analysis at the meso level also reveals that the goal of the On the Move project is to create programs that meet the needs of the girls they serve. Using studies about female-only programs (Fenton et al., 1999, Humbert, 1995 and Kippen, 1999), the planners of On the Move included the provision of same-sex role models and the creation of a supportive environment where participants feel comfortable trying new things. It is the philosophical underpinning of the program that girls prefer participating in female-only programs, that females feel uncomfortable participating in front of males and that often prevents them from becoming involved. The leaders feel that girls and women deserve an opportunity to participate in sport and recreation in their own way and that they should be provided with choices that will ensure their needs and interests are being met.

The objectives of the OTM program also contribute to the personal level of values, interpretations and positioning of sport for girls. The objectives in OTM are: to increase the types of recreational sport and physical activity programs offered specifically for girls and women; to provide an opportunity for girls and women to have an enjoyable and positive recreation experience, while increasing their comfort level in physical activity environments; to increase girls' and women's awareness of the benefits of regular physical activity; to increase the physical activity skill level, self-esteem, self-confidence and self-efficacy of girls and women; and to provide a supportive forum for girls and women to voice their opinions and ideas and encourage their participation in program planning and decision-making (Fenton et al., 2000).

Contributing to the personal level of these values, interpretation and positioning, the program leaders asked the participants to list the success factors and found the top ten are (1) fun, (2) a mix of physical and social activities, (3) input into program design, (4) girls and women only, (5) a safe and supportive environment, (6) peer age groupings, (7) basic skill development, (8) role model leader, (9) food, (10) choice of clothing and music (Fenton et al., 2000).

Micro Analysis

The micro relationship girls have in terms of the consequences for them when their right to well being is encouraged or discouraged is made clear in the research used by OTM to design and promote their programs. The research found that girls are expected to be gentle, non-assertive and dependent and it discovered that expectations about female body image includes a strong disapproval of muscular females (Graham, 1992). As Ann Hall has argued, the relevance of female sporting bodies and their relationship to

empowerment has received scant attention (Hall, 1996). But OTM seeks to establish this relationship by promoting physical activity for girls. The socially constructed disapproval of a girl's physicality is exacerbated in the gender insensitive language of physical activity itself. The program addresses language which supports male hegemony: man to man defense, instead of one on one; five man team, instead of five player team; slimnastics, instead of exercise, (Moving: P.E. News, 1993) but the effect of this attention to language has not been examined. This social construction of language exposes the meanings assigned to girls and the dominant ideologies of male power in sport. It also explains the effect of patriarchal power in terms of representation. If young women have no representation in the language of recognized sport, their position tends to remain stable (sidelined), their oppression continuous and their culture in sport defined as cheerleaders rather than participants (Brantlinger, 1990). OTM programs are trying to defeat these assumptions.

Interpreting the Multi Levels of Data

This Zoom Model allows the researcher to zoom in and out of the three levels of analysis to reveal specific processes that impact the lives of adolescent girls. It uses complimentary levels as well as contradictory levels of the analysis to integrate the data. The historically produced, socially constructed and culturally defined lives of girls is reflected in the highly competitive male-model programs they tried to avoid. Resistance by women such as the founders of OTM is also evident in their decision to take female ownership of physical activity programs and make change. By referencing historical data, discourse analysis, textual analysis as well as psychology and sociology, the data reveals

the politics and meanings of the human rights documents as they relate to young women. And it allows for multiple and sometimes contradictory conclusions.

For example many adolescent girls in Canada are participating in this well thought-out. equity based program that offers access to health services in terms of proactive health programs. But millions of other adolescent girls in Canada are not being served. The OTM coordinators do not keep statistics on participation and can only offer a guess of about 1500 girls who are involved in approximately 100 female-only programs. many of which are OTM programs. Just as the international documents are not serving the girls of Afghanistan. all the documents Canada has signed has not put the right to access to proactive health services into the hands of the majority of young women.

Regardless of the fact that programmers have tried to resist the dominant sporting cultures by providing separate alternatives for girls and women, the cultural hegemony of dominant groups in society continues to prevail (Hall. 1996). The socially constructed inferiority of girls and women that's presented as natural difference continues to create an unequal status that interferes with their human right to health through access to activity. From the muscular Christianity movement at the turn of the 20th century to the current "healthism" at the turn of the 21st century. the state has played an active role in encouraging or discouraging and affirming or banning physical activity (Kidd. 2000). The struggle to gain the human right to access to physical activity is therefore centred in political decision making as well as patriarchal hegemony. And yet evidence suggests young women want to be active. In her two-year study of 541 students. Margaret MacNeill found 93% of youths in grades seven and eight like being physically active (MacNeill. 2000). She identified more than a dozen barriers to activity that include cost,

regimentation of gym classes, fear of violence, older boys controlling the rinks and playgrounds, narrow choices in community programming and competition eliminating the opportunity to play.

Those barriers may contribute to the demise of "gym" classes but the privileged white male hegemony of provincial governments such as the Mike Harris Tories in Ontario has made politics the more powerful barrier. The last decade has seen physical education as a core subject in schools across Canada go into free-fall, even the extra-curricular (after school) programs have fallen to the fiscal knife, at the same time as the results of one study after another herald the benefits of physical education. For example the top female executives in a Fortune 500 study had one thing in common, they were physically active and team players as girls. Student athletes do better academically than non-athletes, says a 1997 survey of Alberta schools. And "Youngsters are most likely to develop physically active lifestyles if they are provided with physical activity experiences they enjoy and with which they can be successful," says the President's Council on Physical Fitness and Sport in the U.S. (President's Council, n.d.).

> We face the absurd paradox of stepped up cutbacks in health care, welfare payments, and support to higher education, culture, sport and recreation while millions of tax dollars swell the profits of franchise owners in cartels like Major League Baseball and the National hockey League (Kidd, 1995).

Despite the medical profession's hue and cry about fit, healthy bodies to reduce health costs, despite the call for fitness in the 1990s, despite the mantra of community recreation clubs that espouse fair play for all, the over-riding philosophy of physical activity for too many adolescent girls in Canada contributes to a loathsome body image

and keeps them on the sidelines. This is contrary to the call by States for holistic health as a solution to problems related to health (Crawford, 1980).

Sport is still embodied in the sleek body of an Olympian or professional athlete (Donnelly, 1996). Health is embodied in the image of the weight-controlled, rosy-cheeked, blissfully serene female body. And recreation is at best something to sign the kids up for and at worst winning soccer teams that keep half the players on the bench. This is also contrary to the self-help to health movement called for more than a decade ago (Crawford, 1980).

Although there is resistance and indeed the feminist movement has provided the biggest changes to sport in this century, there is little evidence in current health, physical education and recreation practices that women's body imaging problems are going to be solved. Physical educators may have cancelled military style marching that was foisted upon the classes of the fifties but physical education is still about punching volleyballs over a net into a square to get marks. It's still about wearing uniforms and lining up in squads and dancing with other girls to corny tunes like the Tennessee Wigwalk. And that unhappy consequence is only in schools where physical activity hasn't been cancelled. This is in light of a national policy that is "elevating health to a super value, a metaphor for all that is good in life, healthism reinforces the privatization of the struggle for generalized well being," (Crawford, 1980, p. 365).

As much as the OTM leaders are dedicated to effective and equitable municipal programming to promote proactive health benefits, schools boards across Canada are not. Physical activity programs have been on the decline and in fact cancelled in school board policy decisions in one province after another. Not surprisingly, considering the evidence

that involvement in physical activity has both a direct association with health outcomes and an indirect effect insofar as it is associated with obesity. (Mann et al., 1999). a new study reported in the Canadian Medical Association Journal, calls the rising state of obesity among Canadian children "a staggering rate of change" (Branswell, 2000, p. 4). Co-author Mark Tremblay says, "I think there's a growing agreement among the scientific community that physical activity is the prominent issue" (cited in Branswell, 2000, p. 4). The study found that obesity more than doubled for girls and nearly tripled for boys between 1981 and 1996. What Tremblay says is not so much news as it is an oft-repeated cautionary tale.

Moreover, the new-style ideology called "healthism" compounds the guilt women and girls experience because it suggests one has a moral obligation to be fit (Crawford, 1980). This ideology is reproduced throughout the physical education and activity realm and further victimizes women (Ingham, 1985). Interestingly, healthism is promoted by the same actors who reproduce the hegemony of middle class, successful men who can afford the self help gimmicks and dismiss the needs of disadvantaged. Also interesting is that a version of the OTM program has been incorporated on a trial basis at Victoria Senior Secondary school in British Columbia. Instead of relying on daffy folk dances that have occupied the curriculum for decades, the programmers need to find ways to get OTM programs into the schools. The empowerment the OTM programs bring to young women may be the route to changing the minds of the school board officials who have cancelled physical activity.

But blaming young women for being inactive and eating too much continues to dominate the discourse around health. Whether it is through exercise, diet or stress

management, the avoidance of disease through personal effort has become a dominant cultural motif. "Crucially the ideology of healthism also tends to place responsibility for body vigilance solely on the individual, and deflects attention away from the social and cultural conditions, which shape and constrain health" (White, Young, & Gillett, 1995, p. 160). In fact "failure to be self-surveillant about health is becoming increasingly defined as deviant" (White et al., 1995, p. 160).

Physical activity and sport helps reproduce that hegemony. It also reproduces an inequitable status quo. Sport is about ability so it marginalizes disability. It's about being powerful so it marginalizes the less powerful. It's about being masculine, so it marginalizes women. (Donnelly, 1999). As well, sport is about achievement which is the orientation of males as winners and leaders and women as obedient and docile (Luschen, 1967). Modern sport and activity is regressive in the sense that it's still masculine, it supports attitudes such as boys will be boys, women are cheerleaders and black athletes are gladiators, their bodies for sale to entertain the rich (Donnelly, 1999).

Defeating that hegemony requires an exposure of the consensual power relations in civil society. Relying on coercive government power is not enough. Trevor Hancock argues, "While the initial leadership and support of the federal government was very important in establishing health promotion as a concept and in supporting health promotion programs at the community level, the federal commitment to health promotion is now drastically diminishing." (cited in Pederson et al., 1994, p. 367). And yet "the modern concept of health includes yet goes beyond health care to embrace the broader societal dimensions and context of individual and population well being." (Mann et al., 1999, p. 8).

The proven positive outcomes of physical activity on the health of adolescent girls and the deleterious effects of denying physical activity, clarifies why the realization of the right to health is necessary for human well-being. "Only when health impacts are described, measured and named as violations can the full extent of this relationship between health and human rights be realized" (Mann et al, 1999, p. 74).

This is the major fault with the On the Move program. No formal evaluations have been conducted on the outcomes to health. The only exception is the Kamloops Women's Action Project that provided an On the Move program for women living in poverty. In *Leisure Access: Enhancing Recreation Opportunities for Those Living in Poverty*, Wendy Frisby found "In comparison to the control group of low income women who did not participate, women in the programs reported higher levels of self-esteem and improved physical health. They also reported significantly lower levels of depression, stress, disturbed sleep, and loneliness (Frisby, 1998, p. 33). Her results also showed decreased eating disorders, benefits such as seeking adventure and taking risks, being able to defend one's self, being a good role model and improved physical fitness. Unfortunately for this research, the data were gathered only on adult women.

With OTM programs operating across the country, evaluations regarding the effect of these programs on health could be used to establish a direct link between proactive programs for well being and the health status of girls. There is evidence in OTM concepts and objectives that human rights documents can be used to enforce the human right to access to health services and to enforce a policy that promotes well being for girls. In chapter eight, recommendations will be made to bring this concept to praxis.

Chapter 8

Conclusions and Recommendations

> A male dominated society is a threat to the public health. Public health and human rights are powerful modern approaches to defining and advancing human well being and so are potentially powerful tools in generating change. Yet public health and human rights have also at times. been powerful tools for maintaining the status quo, reinforcing hierarchies of power and domination based on race, gender and class. (Women and Aids Conference in Boson in April 1991. Dr. Jonathan Mann.)

The human right of adolescent girls to access to health services is recorded in international law and promoted by countries around the world including Canada. But the law has failed to grant young women their right to health services in most countries. and States like Canada are not fulfilling the obligation they made when signing international treaties.

This feminist cultural studies approach to the examination of an adolescent girl's human right to access to health services has linked the theory of the right to health care as described in international documents. the politics of delivering those services to young women and the praxis in the everyday experiences of girls, particularly in Afghanistan and Canada. The macro analysis exposes international laws that are ineffective in promoting full access to health services for girls. The meso analysis discovers a layer of

barriers that confound the delivery of health services that do exist. And the micro analysis reveals consequences to young women that range from life-threatening in the case of Afghan girls to inequitable in the case of Canadian girls. From the macro level of refusal to honour the documents countries signed to the micro subtleties that deny girls the opportunity to lead full lives, the results of this research suggest a patriarchal hegemony is sidelining adolescent girls. The culturally produced representations of women, the socially constructed oppression assigned to them and the culturally defined power relations they live within are part of the hegemony that women have coped with for centuries. While some progress has been made, particularly since the 1995 Beijing Conference, adolescent girls do not have adequate access to the health services international human rights documents promise.

The final chapter of this thesis draws conclusions about the stubborn refusal of patriarchal societies to honour the documents they signed. And it suggests five courses for changing the status quo: participation, equity, a Charter challenge, research and efficacy.

Conclusions

Although it's fair to say the documents were written with the best of intentions for the people they are to serve, they appear to be written without a view to implementation. Gathering countries from all over the world together and having them agree to sign a document is an extraordinary task in itself. Getting the leaders of those countries to agree to actually enforce the document was an impossible task and one that the authors of the documents knew they could not accomplish. Accordingly, there is no ironclad accountability in the documents. They rely instead on the politics of embarrassment.

As this research has pointed out, adolescent girls are vulnerable to the pressures of patriarchal hegemonic ideas, practices and relationships in terms of their physical, social and mental health. Although there is always the possibility of resistance, the rights of girls to survival and development in its fullest sense are violated at the adolescent stage of the life cycle. This violation generally goes unrecognized or unopposed. The committee for the Rights of the Child needs to examine these violations in terms of an adolescent girl's right to access to health services and the financial and social cost to States who refuse this right.

A confounding corollary is that even WHO is failing adolescent girls. The organization that coined the term "the right to the highest attainable health" is unable to enforce its own decisions. The research they call for provides powerful evidence of the plight of the girl child in the health care business. But their do-not-offend policies invariably dilute the research results and their programs carry no clout with the institutions struck with implementing them.

Rebecca Cook sees human rights in health as the new paradigm. But she says, "WHO is not comfortable with an adversarial approach that holds governments accountable" (Cook & Dickens, 2000). In fact WHO's approach is in line with all the other international conventions and covenants. For the sake of not confronting States and basing success on a collection of signatures, WHO is sacrificing fairness and justice in health services. Cook argues, "Disparity and access is becoming so glaring, if WHO doesn't pay attention to it, WHO risks losing its legitimacy" (Cook & Dickens 2000). Brian Dickens adds, "WHO regards itself as a service agency and is careful not to use the

word 'should', instead it will advise, inform and hope that governments will be aware" (Cook & Dickens, 2000).

Cook's comments need to be heeded. Although WHO is dependant on governments for funding, health issues cannot be yoked to the whims of socially constructed practices and beliefs. Preventable diseases are crushing the economies of some nations and denying young people access to proactive programs for well being is creating a future of formidable health costs. For example, WHO calls for youth-friendly health centres, including convenient locations and working hours, short waiting times, privacy, confidentiality, staff sensibility, community support, and no requirements of parental consent (WHO, 1998). But such centres are not available for most young women and when they are, it is not because WHO enforced them, it is almost entirely due to local initiatives. One only needs to compare the funding costs for these centres to the cost of coping with the AIDS pandemic to understand the need for WHO to take action regardless of a State's unwillingness to provide such access to young women.

While documented failures such as, the maternal mortality rate rising during a five-year intensive intervention program and the collapse of physical activity education in Canada in light of ever-increasing evidence of the correlation between poor health and lack of activity are evidence of systemic problems in health services for girls and women, there have been some successes. For example, under pressure from the women's international conferences, WHO now defines violence against women as a health issue. And as the review of the literature points out, Native women's issues and immigration issues have been used to successfully challenge the international documents as well as the Canadian Charter. But for the most part countries that don't want to comply don't. If a

State such as Afghanistan (and dozens of others) decides to spend its budget on arms rather than health care, it will. If a government such as the provincial legislatures in Canada decide to cancel physical activity access in the name of fiscal responsibility, it does.

If there is no duty in the law to provide access to health services, what is the way forward for adolescent girls in gaining their human right to health? This thesis draws a number of conclusions about the ways and means of addressing the failure to uphold the human right to access to health services for young women. Equity is an issue that needs to be better addressed. It doesn't mean treating all people the same, it means treating people differently if necessary so that they can be treated fairly (Fenton et al., 2000). Finding new methods to enforce implementation of the human right to access to health services requires a shift in thinking. The committee on the Rights of the Child need to examine new ideas for implementing the treaties as the current methods are failing young women in countries all over the world. A Charter challenge could be launched to test case the issue of access to physical education in Canada. Adolescent girls need to be put on the research agenda. And the terms used for measuring success in programs for young women need to be reassessed. Each of these conclusions will be addressed separately.

But first, the two case studies used in this paper highlight the draconian denial of access to health services for girls in Afghanistan and the innovative approach used in Canada to draw girls into a proactive health program. The recommendations lead to a course of action that could be a new panacea in the struggle to gain access to health rights for adolescent girls.

Participation

As much as human rights in health is the new paradigm, the use of physical activity to access those rights can be the key that opens the door to access for girls. Physical activity is more than a matter of gaining physical health through sport and activity. It is the least recognized and the most documented strategy for boosting self-esteem and self-confidence and creating leadership in adolescent girls (Melpomene Institute,1996, Frisby & Fenton, 1998, Reid & Dyck, 1999). It is therefore a source of empowerment. If international Treaties, State governments, religious and cultural leaders will not grant girls their rights, the girls need to find a way to lasso those promised claims themselves. Signing up for soccer may seem so innocuous to the accepted hegemonic power, the girls, if they can be convinced to join the program, can help themselves to increased self-esteem, increased self-confidence and consequently personal empowerment in spite of the actors who seek to control them. Paying attention to the reasons why girls stay away from physical activity programs (cited in Chapter Nine) is increasingly important as international bodies such as the Population Council are examining sports as one way to improve the sexual health of young women and to reduce pregnancy risks.

In a commentary in Studies in Family Planning in March 1998, Martha Brady examines sports and girls' health with the view that physical education and sports programs may play a role in achieving improved health and self-image, better education about sexuality and even reduced pregnancy risks. Evidence in the two case studies and the literature review in this research project suggests this may be an important locus for intervention. For reasons cited in the chapters on adolescent girls and the On the Move

case study, sports programs offer girls the opportunity to develop an identity unrelated to sexuality and to experience their physicality in a non-sexual way, allowing them more control and autonomy over their bodies (Brady, 1998). Moreover the increase in self-esteem gained from participation gives girls the confidence to make better choices about their health. Another valuable benefit is that fundamentalist regimes that refuse girls the right to healthcare and continually fail in their obligations to observe the laws in international documents, could be persuaded to promote physical activity as a health right if only because "playing games" appears at the outset to be harmless in the politics of control. The hoped-for end result would be young women empowered to make change in their own lives and in State laws as well.

It is known that girls, particularly in developing countries, often arrive at adolescence with little factual information about sexuality and too little access to health care. The extent to which sports might serve as an entry point in providing them the information they need has not been examined. However, evidence suggests that sport and physical education programs are a natural means for providing girls with basic information about their bodies and about selected reproductive health issues. Addressing these issues in both school and community settings could offer a holistic view of health, rather than a narrow focus on contraceptive services and may, therefore be politically acceptable for policy makers, program managers and communities.

While the link between sports participation and lowered risk of pregnancy has not been formally or systematically researched, Sabo and Melnick (1996), formulated several hypotheses about how biophysical, psychological and social processes may link sports participation and the decreased risk of pregnancy among adolescent girls. One of their

hypotheses is that elevated self-esteem derived from participation in sports may influence girls' sexual decision making and enhance their ability to negotiate use of contraceptives.

In countries such as Canada, when a girl participates in team sports, she's automatically drawn into a health care system because physical examinations are usually required for participation. As well, the On the Move program has pointed out that girls feel they can freely discuss health issues in this setting. Once in this loop, she has access to information as well as opportunities to ask questions about various health issues. These and other theoretical links need to be investigated. Programs in other countries are already using sports to enhance access to health information. In Kenya for example more than 3000 girls from age 10-18 are involved in a soccer program which also incorporates HIV awareness training and has now embarked on a gender-equity program. In Mali, girls' basketball programs have been established with a similar intent. In Vietnam, a community based soccer program that targets out-of-school young people provides recreational opportunities as well as information about HIV and other key reproductive issues (Brady, 1998).

The value of these programs and the experiences of the participants may be significant, but the evidence is undocumented. Evaluating such programs would be useful to discover more about how to increase girls' participation in physical activity, how to provide girls with vital health information and new skills and the consequences for their health. Ignoring the value of examining the effectiveness of physical activity for girls on a global scale would be a missed opportunity for WHO and for all the actors in the business of providing health services.

Recommendation: The next step is to launch a research project that examines physical activity as a potential panacea for access to health services for girls. The questions that need to be asked include: Does participation in activity programs broaden the perception about the appropriate roles and behaviors of girls in developing countries? Can sports programs serve as vehicles through which key health messages can be transmitted to girls and help them develop healthy perceptions about their bodies? Can the increase in self-esteem and self-confidence gained through physical activity programs enhance a girl's ability to make healthy sexual decisions for herself? Research that ethnographically observes and questions this assumption is needed to understand the relationship between physical activity, and achieving the human right to access to health services.

Recommendation: Examine the effect of OTM on the physical, social and mental health of the young women who participate in the programs. This research would be a valuable contribution to the theory of using physical activity as a key to opening the door to access to health rights for girls.

Equity

One of the ways to alter the interpretation of the law is to ensure a gendered approach to health in all policy making. The Gender Budget Initiative launched in Paris on January 7, 2001 set a goal to have every country in the world use a gender lens to scrutinize all government spending by the year 2010. "A gender approach in health while not excluding biological factors, considers the critical roles that social and cultural factors and power relations between men and women play in promoting and protecting or impeding health" (WHO, 1998, p. 6).

A gender analysis of health allows the research to show that men and boys are favoured over women and girls in every aspect of the health care system and "unless these divisions are taken seriously, policies designed to improve the situation for women are likely to offer only limited and often short-term solutions" (WHO, 1998, p. 8). But the particular needs of girls would offer valuable and presently missed information that would add to the seriousness of this call for change.

Recommendation: Make equity a budget issue in all policy planning. If policies cannot be accepted without equity considerations, then the needs of girls cannot be ignored in policy. Equity means realizing that people are different and have different needs. The historically produced, socially constructed and culturally defined roles assigned to women have interfered with their access because equity arguments have not been used when preparing programs to suit their needs.

Implementing the Treaties

States are seldom held responsible for ignoring their international obligations to respect women's rights. "Instead they deny that these criticized practices occur, deny that the international obligations are binding, that proven outrages are attributable to them, that tribunals have jurisdiction over them, that claimants have standing to launch legal proceedings." (Cook, 1994b, pp. 127-128).

State compliance with treaty obligations for implementing human rights is monitored by the committees established under the various treaties. The members of those committees serve in their capacity as experts and not as representatives of governments. State parties are required to make periodic reports to the treaty bodies on

the steps they have taken to implement their obligations and the difficulties they have experienced.

But these reports have not been effective in altering the access of health services for girls. When a country submits a report to CEDAW for example, outlining all the wonderful things their country has done for women in compliance with the CEDAW Convention, there is a parallel truth-telling process generated by the tenacity of women's NGOs, known as submitting a shadow report. These reports provide the committee with alternative facts and figures on the situation of women in the country. But if there is no penalty and in the case of Canada, the number one country in the world, the optional protocol for CEDAW hasn't been ratified and therefore Canada can't be held accountable, what good is any of the reporting (McPhedran, Bazilli, Erickson & Byrnes, 2000)? The only thing available to them is the politics of embarrassment. There's nothing in the treaty that says "or else." The quest to serve women's human rights in health is not informed by awareness of internationally recognized claims to respect human rights, says Cook (1994b).

Recommendations: Educate health professionals – doctors, nurses, aid-workers – about human rights law; educate human rights activists about how to acquire and interpret health data and extract the elements that are legally significant. Recommend that the committee on the Rights of the Child examine their reports with a critical view to the content and meaning of the right to health for adolescent girls. Cook points to the need for a set of guidelines developed for the legal promotion of women's health in particular areas, such as women's occupational health, the health of girl children, and reproductive health care. "It has been pointed out by some that enactment of a comprehensive

reproductive health care law would greatly facilitate women's human rights to health care" (Cook, 1994b, p. 39).

Civil society also needs to be made more aware of the specifics in the laws if their protests are to gain ground. Awareness can be built through government programs, school curricula and media campaigns.Canadians need to come forward to take on their own government's inaction on the rights treaties they have signed. And girls need to be made visible.

Attitudes toward girls must change, the Rights of the Child Convention must be implemented in gender-specific ways at national and international levels. Regardless of the fact that many countries face economic difficulties that constrain their ability to provide services, the Convention does not allow for even temporary discrimination between groups of children in relation to access to health and education. For example, Save the Children Fund reports that in the village of Bikaner District of Rajasthan while health services are available, women and girls don't use them because their cultural beliefs deny such use.

Preparing a Court Challenge

Since the United Nations requires all signatory nations to make regular reports regarding compliance, these Conventions provide an ideal opportunity for interested citizens to challenge the government regarding limitations on the rights they have been promised. The adolescent girls of Canada have been denied access to physical activity education. There is reason to suggest a court challenge.

Although CEDAW's article 12 and article 10(g) which specifically states "the same opportunity to participate actively in sports and physical education," cannot be used

because Canada still has not signed a protocol for CEDAW, the Canadian Constitution, section 15, could be referred to from a "multiple disadvantage" perspective as could section 28 which argues equal access and quality of result (McPhedran et al., 2000). The Charter itself brought sports under the ambit of federal and provincial human rights codes (Kidd & Donnelly, 2000). Certainly the United Nations Convention on the Rights of the Child could be used to argue a child's right to physical education instruction since 18 of 41 articles in the convention touch on issues related to sport and physical activity participation. Also useful in a Charter challenge is the report from the Canadian Coalition for the Rights of the Child which says that, "While healthy living and physical education are generally part of the curriculum, [not anymore] two national studies found that the health of 63 per cent of Canadian children is at risk due to high levels of physical inactivity" (Canadian Coalition on the Rights of the Child, 1999).

The problem is that these legal obligations are difficult to enforce. That said, international agreements do carry enormous moral weight (Kidd & Donnelly, 2000). Embarrassing a country for its non-compliance has been very successful when for example a country attends an international meeting and groups such as The Feminist Alliance paper the walls of the meeting with non-compliance issues. Governments of countries such as Canada which is currently enjoying its sixth consecutive number one ranking on the United Nations Human Development index (the best place in the world to live), are also highly susceptible to criticisms and publicity about their treatment of women, children and minorities. A well thought out charter challenge regarding access to sport and physical activity is likely to have some impact (Kidd & Donnelly, 2000).

The right to participate in sport and active leisure and therefore the right to learn how to be able to participate, are rarely gained easily and are much more likely to be won through human action (Donnelly, 1993). Recent history abounds with cases that suggest legal action is the obvious and appropriate course to regain the right Canadian children have to health and well-being gained from a curriculum that contains physical education. Court cases against discrimination in sport, against private clubs for racial discrimination or leagues for gender discrimination and successful lobby tactics to include women's events in the Olympics, set precedents for such a legal challenge (Donnelly, 1993).

Recommendations:

•Challenge the Canadian Charter of Rights and Freedoms.

•Physical activity professionals and sports sociologists need to be present at the UN table while health rights are being debated. The issue of physical activity as a health right needs champions at the United Nations. While the Brighton Declaration and the Berlin Agenda are valuable, they don't carry the clout of international law. The newly formed Centre for Sport Policy Studies in the Faculty of Physical Education and Health at the University of Toronto could take this on as a task.

•Apply pressure to countries that signed the UNESCO Sport for All Charter to make sure they are delivering those promises to young women.

•Those who teach and train physical activity professionals must be made acutely aware of the mandate in physical activity programs: to teach the concept of activity for health and fun rather than competition and elite performance.

Research

In general girls are not visible in research work. There is a lack of child specific data and information in particular about girls. Very little socio-cultural and socio-economic analysis focuses on girls. Research methods have generally not been adjusted to obtain knowledge about girls. Girls themselves are not involved in the research, their opinions and views are frequently not heard.

Recommendations:

- Review and develop research methods and train researchers to allow for adolescent and gender centred research.
- Collect age and gender specific data to understand the girl's situation at various stages of her development. Promote the development of sex and gender specific statistics in all relevant fields.
- Analyze the perceptions and prevailing views on girls. Look into the socializing process of girls and boys, noting specific differences and practices.
- Analyze the tasks and roles of girls in their families and communities from a social, economical and political perspective.
- Involve girls themselves in the research and promote participatory methods.

A Caveat: As long as the definitions and roles ascribed to women and girls (and men and family for that matter), are determined by economic structures, the nature of the state and its social projects, religion, culture and the changing interrelationships between all these elements, health research will continue to create unequal results.

Efficacy

One of the reasons that current programs aren't improving the status of girls' health is that the way we currently measure success is not necessarily applicable to the meanings and lives of girls. A new management style dictates the need to have verifiable indicators if programs are to be accurately accessed (Kerr, 2000). For example indicators are linked to objectives so they can be used to hold governments, institutions and project managers accountable to those objectives. "If a government program has committed to gender equality, the indicators to measure this progress should explicitly define the outcomes that are expected from the policy (Kerr, 2000, p. 3). For example, a promising success indicator to measure gender equality in education would be equal numbers of men and women graduating in the sciences. "A poor indicator (though commonly used) would be the equal number of boys and girls enrolled in primary school" (Kerr, 2000 p. 3). In many countries the girls are enrolled but never finish primary school. Similarly the number of health clinics available does not measure the number of girls who have access to those clinics – who can physically walk to them, who are allowed culturally to frequent them. Using quantitative indicators of health are not adequate for measuring the success or failure of a program in the experiences of girls.

Recommendation:

•Use new knowledges and understandings gained from feminist cultural studies such as the meaning of health, inactivity, equality, and access for girls as well as verifiable indicators to test the efficacy of programs for young women.

Finally, the documents make it clear enough that health rights are a State's responsibility. In the more recent General Recommendation 24 (CEDAW) and General

Comment 14 (ICESCR). it is clear that access to health rights are a State's obligation. What isn't clear is how to implement the documents. While explicit in the "what" in terms of what needs to be done. there are no clear consequences for States that do not comply. International tribunals have proven effective and the International Criminal Court may be an avenue that will serve to resolve some cases in the future.

States have been held to account for violations before international tribunals at The Hague for example where rape became a war crime at the International Criminal Tribunal for the former Yugoslavia. These tribunals are few and far between but the International Criminal Court may change that. In the meantime, violating the treaties only casts doubt on a state's membership in the international community. Enforcement which has so far eluded the international community. is likely in the hands of civil society. in particular. women's groups. Since presently both groups are unable to alter the lives of girls in Afghanistan for example. urgent attention needs to be devoted to examining new ways to force treaty compliance.

Lynn Freedman points to action by women's groups as the way to "expose and challenge the configurations of power that create the conditions that spawn ill health and that work their power by appearing natural. inevitable and immutable" (Freedman. 1999. pp. 437). She also quotes Lock and Kaufert from their work in Pragmatic Women and Body Politics (1998) who point out:

> As a result of globalization. hegemonic power ... is a shrinking domain. In other words. common sense – the unspoken authority of everyday life – becomes increasingly subject to disputation. Orthodoxy – that which is naturalized. hegemonic. and taken as self-

evident – is brought into consciousness and made recognizable as ideology, and is therefore laid bare to criticism.

Human rights has become an enormously popular concept. Civil society is more involved than ever before (i.e. The Post Seattle summits, in particular The Summit of the Americas April 20-22, 2001). Economic, political and cultural change in the status of adolescent girls is required before their human right to access to health services can be realized. To make that change a reality, research conducted on health needs to include girls, and in particular, research on self-empowerment through physical activity programs needs to be done. The measurements used to analyse the success of programs for girls needs to include equity as well as outcomes rather than statistics that only mark numbers registered and attendance. And finally, a precedent-setting court challenge either in Canada, using the Charter of Rights and Freedoms, or in the international criminal court (when it is established), would encourage states to honour the documents they sign and find the girls who are missing in access.

Chapter Nine

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Appendix

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The International Convention for the Elimination of All Forms of Racial Discrimination (the Race Convention) (1965)

The International Covenant on Civil and Political Rights (known as the Political Covenant and first generation rights) (1966)

The International Covenant on Economic, Social and Cultural Rights (known as the Economic Covenant, second generation rights) (1966)

The Convention on the Elimination of All Forms of discrimination Against Women (CEDAW, the Women's Convention) (1979)

The Convention on the Rights of the Child (the Children's Convention) (1989)

The European Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention) (1950)

The American Convention on Human Rights (the American Convention) (1969)

The African Charter on Human and Peoples' Rights (the African Charter) (1986)

The European Sport For All Charter (1975)

The International Charter of Physical Education and Sport (1978)

The Berlin Agenda for Action for Government Ministers (1999)