Respect for Cultural Diversity and Pluralism

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Introduction

Our world is culturally, politically, and ethically pluralistic. Several major world religions, with numerous adherents, exist side by side in many countries, along with numerous smaller religious groups. Ethnic and cultural groups abound, with a wide variety of norms and customs. Countries – and even states or provinces within countries – have different political and economic systems, each with its own structure of laws and regulations. But it is not only in these respects that our world is pluralistic. Pluralism refers also to the ways different nations order the relations between state, religion, and citizens. Some nations, such as the United States of America, have a constitutionally protected separation between church and state. Others, such as Iran and Israel, have an official state religion, with formally recognized, state-supported religious laws and institutions, observances, and parochial education. The growth of multicultural societies and an increasingly globalized world have prompted a call for cultural sensitivity and respect for different traditions. With vastly increased immigration from developing to industrialized countries, nations that were predominantly homogeneous in the past have had an influx of immigrants from Africa and Asia. It is, therefore, uncontroversial to urge respect for cultural diversity and recognition of pluralism in a globalized world.

All cultures comprise members who adhere to their norms and practices to a greater or lesser extent, and individuals may have overlapping cultural identities. They may be members of an ethnic minority within a religious majority in a population. Alternatively, individuals may be members of an ethnic or a racial majority but a religious minority. The fundamental ethical principle, "respect for persons," implies that such respect includes recognition of the beliefs people hold and the actions they perform in conformity with their membership in a culture.

Several paragraphs in this chapter are extracted from my book, *Against Relativism: Cultural Diversity and the Search for Ethical Universals in Medicine*. New York: Oxford University Press, 1999.

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The UNESCO Universal Declaration on Bioethics and Human Rights makes reference to cultural diversity in Article 12, entitled "Respect for cultural diversity and pluralism." Article 12 states: "The importance of cultural diversity and pluralism should be given due regard. However, such considerations are not to be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this Declaration, nor to limit their scope." The caveat in this last sentence sets out the task for anyone seeking to comply with the UNESCO Declaration and at the same time express respect for cultural diversity. It requires determining which cultural norms and practices related to human health and medicine in our diverse world do not deserve respect or adherence because they violate human rights or universal ethical principles.

Several contexts related to bioethics exist where respect for cultural diversity may arise. The first is within a multicultural country or city characterized by large numbers of recent immigrants from other countries or cultures. Clinicians and biomedical researchers residing in the city or country face an immigrant population with values, beliefs, and practices that medical personnel may not have encountered previously. One example is the prohibition in some traditional cultures for a woman to undergo a medical examination by a male physician. A second context is that of multinational research, in which the sponsor is typically from an industrialized country or the pharmaceutical industry and the research participants are from a developing country with different cultural norms or values. A third context is that in which physicians from industrialized countries bring medical students or residents to a developing country to provide humanitarian aid and often at the same time, education and training for the students in a different cultural setting. Similar dilemmas or quandaries of cross-cultural conflict may arise in all three settings, and some situations may be unique to one or the other context.

Culture, Ethical Principles, and Moral Rules

Despite a very general understanding of the concept of "culture," it remains ambiguous and often means different things to different people. One critic of the sloppy use of the term writes that "most of the time, *culture* is a lazy, trendy substitute for a more specific word." The anthropological use of the term "refers to the total way of life of a discrete society, its traditions, habits, beliefs, and art…" (Clausen, 1996, p. 2). A culture, in this sense, is defined by certain features that differentiate it from other cultures.

Although it is indisputable that different nations, cultures, religious, or ethnic groups adhere to different norms of behavior, it is possible to provide an ethical analysis of social practices by seeing how they conform to fundamental ethical principles such as those embodied in the UNESCO Universal Declaration and to human rights provisions in United Nations treaties and covenants. However, this is no easy or straightforward task. Ethical principles require interpretation in their applications to specific actions or practices. The same is true for human rights provisions. Moreover, ethical principles and human rights are not the only features

that require interpretation in an ethical analysis of respect for cultural diversity. The very notion of what constitutes an ethical principle may be open to debate. Here are two illustrations.

The well-known "four principles" of bioethics – respect for persons, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2008) – are widely known in bioethics outside of "Western" countries, although they have been given various interpretations in different cultural settings. Yet, debates can arise over what should count as an ethical principle. For example, on occasion, one hears reference to the phrase, "respect for tradition," implying that it is an ethical principle. Does "respect for tradition" qualify as an ethical principle? If it does, is it on a par as a fundamental principle with "respect for persons" or the ethical imperative to strive to bring about more benefits than harms? "Maintain respect for tradition" is a customary norm in many societies and operates as a conservative force for maintaining the status quo. It also functions as a practical and possibly also a moral maxim for anthropologists conducting fieldwork. It is evident that "respect for tradition" can conflict with one or more of the well-known four principles, especially respect for autonomy.

Some traditions are ethically neutral yet are intimately bound in cultural practices. These include ceremonies of various sorts at weddings and funerals; nonharmful rituals that may include prayers, dancing, chanting, and rites of passage; and adhering to dietary laws like kosher and halal. Most of the time, these sorts of activities are ethically neutral; that is, they do not give rise to harms or wrongs to those involved. Ethics deals with how people treat one another, how governments or nongovernmental institutions treat people, and whether human beings are harmed or wronged by these treatments. Adherence to a cultural tradition may be neutral; it may harm people or it may benefit them; it may support human rights or violate them. But "respect for tradition" as a norm does not by itself constitute an ethical principle.

A second illustration of a debate over what constitutes an ethical principle is an ongoing contrast between so-called "Western" and "Eastern" principles. The guest editors of a journal issue devoted to a discussion of this pair of principles wrote: "Much has been made of the fact that the so-called Western principles of 'autonomy, nonmaleficience [sic], beneficence, justice' do not address 'compassion' and professional 'competence' as has been the case in all healing traditions for centuries" (Sass & Zhai, 2011, p. 1). Presumably, the principle that embodies the concept of compassion goes as follows: "physicians should treat their patients with compassion." If that is a moral principle, it does not seem to be uniquely "Eastern." Physicians everywhere and throughout history have been enjoined to behave compassionately (as the authors of the article acknowledge). An article that appeared in an online publication of the American College of Physicians is entitled "Why compassion is such an important part of practice." The first sentence of the article states: "Amid the daily demands of teaching and practice, it's sometimes easy to lose sight of our primary purpose as physicians: providing compassionate care to our patients" (American College of Physicians, 2011). Nevertheless, "treat patients with compassion" cannot properly be considered a general ethical

principle. It is, rather, a norm of medical practice, a moral rule for physicians in caring for patients. Arguably, it is a specific example of a rule that falls under the general ethical principle, *respect for persons*. In any case, it is no more Eastern than it is Western. Alternatively, as one author notes, "compassion is more of a virtue than a principle to Confucianism" (Cheng-Tek Tai, 2011, p. 25).

The other example of a so-called "Eastern" principle that these same authors refer to is "physician competence." This can also be cast as a moral rule: "Physicians should be competent in the practice of medicine and not exceed the skills they can competently exercise in treating patients." Arguably, this moral rule falls under the principle of beneficence: "Act so as to maximize benefits and minimize harms (to patients)." An incompetent physician is unlikely to maximize benefits but is perhaps equally likely to maximize harms. Nothing peculiarly "Eastern" or "Western" characterizes this moral rule. In any case, like "compassion," it is not a general ethical principle but rather, a moral rule subsumed under a more general principle (Beauchamp & Childress, 2008). It would be difficult to find a so-called Eastern ethical *principle* that does not have an equivalent "Western" formulation, or else is better construed as a moral rule that can be subsumed under a more general principle.

According to one position, a rigid categorization of "Eastern" and "Western" values fails to accord with the realities of today's globalized world (Joseph, 2011). A fusion of ethical principles is one possibility, leading to greater harmony. But uncertainty or even occasional harm can occur when respect for autonomy is conjoined with cultural sensitivity. The case of a Hindu woman seeking a cesarean section is illustrative. The woman, a devout Hindu, asked her obstetrician for an elective cesarean section so the baby could be born on an auspicious day in the Hindu calendar. This required that the C-section be performed earlier than at the time of a full-term pregnancy. In many traditional societies even today, physicians make the decisions and patients willingly comply (this was, of course, also true in Europe and North America for most of medical history). But in this case, adhering to the principle of "respect for persons" and at the same time showing cultural sensitivity, the obstetrician acceded to the patient's request based on her faith-based reasons. The operation was performed at 35 weeks and resulted in harms: the baby had immature lungs, required a prolonged stay in the hospital, and at great financial cost to the parents (Joseph, 2011).

Increasingly, scholars in bioethics question whether "Eastern" and "Western" principles of ethics are mutually exclusive or even readily identifiable as such (Widdows, 2011). For example, a "Western" view in bioethics not unlike the "Eastern" value that put individuals in the context of family or community is the idea of "relational autonomy" in feminist theory. The difference between these values seems to be more one of emphasis than of radically different ethical principles.

Pluralism

Just as the concept of culture can be vague or ambiguous, so too does confusion exist regarding ethical "pluralism." According to one author: "What we might call

'social pluralism' is the view that diverse and often mutually inconsistent ethical outlooks should be respected and that there may not be any single moral principle or set of principles, however basic, that all moral agents must acknowledge. Human rights, for example, may be widely acknowledged in the West, but not in other parts of the world; hence, from a social pluralist's point of view, for Western governments to try to impose standards of human rights upon non-western societies is inappropriate" (Callicot, 1995, p. 685). This author is mistaken in claiming that non-Western governments do not recognize human rights. The difference between acknowledgment of human rights by Western governments and some others lies in *which* human rights they recognize and acknowledge, not whether they recognize human rights at all.

A somewhat different concept of pluralism has been proposed in the context of multinational research. The authors of an article in the second edition of the *Encyclopedia of Bioethics* contrast ethical universalism and ethical pluralism: "Some contend that all research, wherever it is conducted, should be justified according to universally applicable standards. Those opposed to this position, while sometimes accepting certain standards as generally applicable, argue that most standards must be adapted to accommodate the mores of particular cultures; they argue for ethical pluralism. Pluralists commonly refer to the universalist position as 'ethical imperialism,' while universalists often call that of their opponents 'ethical relativism'" (Christakis & Levine, 1995, p. 1781). Although intended to be helpful in distinguishing two widely held views regarding ethics in the conduct of multinational research, this paragraph is rife with confusion. It refers to "universally applicable standards" and to "the mores of particular cultures." Nowhere are ethical principles mentioned. Are "universally applicable standards" ethical principles? If so, do pluralists reject one or more of the well-known ethical principles that govern research? And if so, do they propose to replace ethical principles with the mores of particular cultures? Do they maintain that cultural mores are on a par with general ethical principles? Without knowing what the "ethical standards" are, which mores, in particular, might override such standards, and where ethical principles enter the picture (if at all), we cannot understand what the pluralists will or will not endorse.

This conceptual confusion calls for clarification in what is meant by "ethical standards." Are all ethical aspects of research with human subjects properly considered *standards*? Should standards be universally applicable or are variations permissible according to economic, political, or cultural differences among nations? When different ethical standards exist and are potentially applicable, which ones should researchers adhere to? It is useful to distinguish between *substantive* and *procedural* ethical requirements in research. Substantive ethical requirements are those embodied in the fundamental principles of bioethics: respect for persons, beneficence, and justice. These substantive requirements are the ones that constitute ethical *standards* and should be applied universally. Examples are the requirement to obtain informed consent individually from each adult participant and the need to disclose complete information about the research maneuvers to be performed and the expected risks of those interventions. Procedural requirements,

on the other hand, may vary according to cultural and other differences in multinational research. Examples are the requirement that informed consent documents be signed and the composition of ethical review committees and their rules of procedure. Attention to the distinction between substantive and procedural ethical requirements shows that the same ethical standards can be applied across national borders, while permitting differences in specific procedures in order to respect cultural variations.

Even more problematic than confusion over the meaning of "ethical standards" is the use of the terms "ethical imperialism" and "ethical relativism" by the authors of the encyclopedia article. The charge of ethical imperialism is clearly a condemnation; it implies that the perpetrator is acting like a colonial power in imposing a governmental system or way of life on a conquered or subordinate state or population. "Ethical relativism," when used in this context, refers to a philosophical doctrine: the view that whatever a culture *believes* is ethically right *is*, therefore, ethically right for that culture. One application of ethical relativism holds that rules governing research practices may vary according to the cultural norms accepted in the country in which the research is carried out. Respect for diversity underlies this form of ethical relativism, which rejects the notion that a single set of ethical standards for research should prevail in our culturally diverse world. Ethical relativism has defenders and critics. However, no one is likely to come to the defense of "ethical imperialism," since the very concept of imperialism is one of denigration.

These same authors are clearer when they provide examples of the contrast they intend between universalists and pluralists. Again, addressing multinational research, they invoke the *Declaration of Helsinki*: "Pluralists call attention to the fact that the *Declaration of Helsinki* reflects a uniquely Western configuration of a number of key ethical points; in particular, the declaration has a largely Western view of the nature of the person and, as such, it does not adequately guide investigators to show respect for persons in non-Western settings" (Christakis & Levine, 1995, p. 1782). Much of the discussion that follows in the article rehearses the oft-repeated arguments about how different cultures have different concepts of what constitutes a person, with implications for informed consent to research. Not only the *Declaration of Helsinki* (World Medical Association, 2008), but every other document that addresses research with human beings requires that individuals provide their informed consent to be enrolled as research subjects except in cases where they lack capacity or have diminished autonomy. Cultural norms that might militate against this requirement exist in cultures in which adult women are not permitted to make health-care decisions or participate in research on their own. In some Islamic societies and other traditional groups, women's behavior is controlled by their husbands or other male guardians. If the so-called pluralists come to the defense of cultural mores such as this, they are not only in violation of international ethical standards for research, such as the *Declaration of Helsinki*, but they also transgress the most basic provisions of human rights treaties and covenants.

Human Rights

The most relevant human rights document with respect to cultural practices regarding women is the *Convention on the Elimination of all Forms of Discrimination Against Women* (United Nations, 1979). Article 2 of the Convention says:

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:... To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination; [and]... To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women (United Nations, 1979).

Several articles in the UNESCO *Universal Declaration on Bioethics and Human Rights* (2005) are relevant, as well. Article 5, "Autonomy and individual responsibility," states: "The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests." Article 6, on consent, is even more explicit in both the treatment and research contexts: "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information"; and "Scientific research should only be carried out with the prior, free, express and informed consent of the person concerned"; and further: "In no case should a collective community agreement or the consent of a community leader or other authority substitute for an individual's informed consent." One can only assume that the defenders of pluralism would say the same things about the UNESCO Universal Declaration that they have said about the *Declaration of Helsinki* – that it reflects a uniquely Western view of what constitutes a person.

It does not require a deep philosophical inquiry to conclude that in the context of medical practice and research, a *person* is the human being whose body may be harmed or benefited by the proposed intervention. The individual whose body may be harmed or benefited is the *person*, and that person should be the only one to decide whether or not to accept the proposed intervention. Of course, nothing in so-called Western medical practice or research precludes a person from consulting with one or more family members about a course of treatment or whether to participate in research. Informed consent documents for research frequently encourage potential participants to do just that. Those cultures that locate the *person* as an interconnected unit within the family or the community are not conflating the individual human being with the larger group. When the individual dies, only that person is mourned and buried – not the whole family or the community. That some non-Western cultures locate the individual human being as more essentially connected to the family or community than is true of European or North American societies does not mean they hold a different concept of "the nature of the person,"

to quote the sloppy formulation of the authors cited above. This conceptual confusion runs through the bioethics literature on ethical and cultural relativism, and it is time that some clarity is introduced to dispel the conceptual errors.

Skepticism about the concept of human rights and its universal application typically invokes the facts of cultural diversity. An anthropologist writing about female genital cutting asked: “Are there universal human rights that can be applied without cultural imposition? How is it to be determined what constitutes a violation of these rights?” (Slack, 1988, p. 473). In support of her contention that these are difficult questions to answer, the anthropologist cited a “Statement on Human Rights” published 40 years earlier in a scholarly journal in her field: “. . .what is held to be a human right in one society may be regarded as anti-social by another people, or by the same people in a different period of their history” (American Anthropologist, 1947, p. 542). Cultural anthropologists face great difficulty in reconciling the existence of human rights with the dictum in their profession to avoid making value judgments about beliefs and practices of the groups they study. In the case of female genital cutting, the World Health Organization – the United Nations global public health agency – has determined that the practice is a human rights violation.

The biomedical research enterprise today is global in scope. Can a coherent argument be made that because different countries or cultures have varying customs and traditions, different ethical standards based on those customs and traditions can be justified? To argue that different ethical standards are permissible because research in any culture is acceptable so long as it follows the customs and norms of that culture is either to sanction violations of human rights in the countries where those violations occur or else to deny that there are any fundamental human rights. Either view embodies a form of ethical relativism that comes down in the end to the position that “whatever is, is right.”

Violence, Culture, and Subordination of Women

If “respect for cultural diversity” requires an acceptance of deeply rooted traditions, it is important to see what some of these cultural traditions allow or even require. It is almost always the case that no culture is monolithic, and almost every country in today’s world includes members of different religions, ethnic groups, and subpopulations. It should not come as a surprise that some of the people who are harmed the most and whose human rights are most frequently violated are women. As UN Women (the newly established United Nations organization devoted to women’s concerns) points out: “Women throughout the world may be exposed to a wide range of ‘harmful practices’ across their life cycle, including prenatal sex selection and female infanticide, child marriage, dowry-related violence, female genital mutilation, so-called ‘honour’ crimes, maltreatment of widows, inciting women to commit suicide, dedication of young girls to temples, restrictions on a second daughter’s right to marry, dietary restrictions for pregnant women, forced feeding and nutritional taboos, marriage to a deceased husband’s brother, and witch hunts” (UN Women, 2010).

While it is true that many cultural practices are not located within medical practice or research, they may still be relevant to bioethical inquiry. To cite one situation, physicians and other health personnel from North America or Europe provide humanitarian assistance and conduct research in places where harmful traditional practices are prevalent. How should they react when they witness or are called upon to treat victims of these practices? Does respect for cultural diversity require that they remain silent in the face of evident violations of human rights? In the context of research, studies in population health today focus at least as much on social determinants of health as they do on the provision of health care by physicians and other health practitioners. Research on the social determinants of health has mainly centered on disparities in wealth and income both within countries and between industrialized and developing countries. That focus has tended to obscure health inequities between women and men, especially as those inequities exist in developing countries. These latter inequities typically stem from adherence to cultural traditions of one sort or another rather than from differences in wealth or income between women and men.

Although major causes of women's health inequalities compared to men are related to women's inability to access reproductive health services or the availability only of poor quality health services where they do exist, other inequalities are unrelated to health care services. While the circumstances that give rise to these latter inequalities may not be among the most statistically prevalent causes of women's mortality and morbidity, they are nevertheless symptomatic of the enduring widespread subjugation of and discrimination against women. Leading the list is sexual violence against women, due to the prevalence of this factor. Every country in the world experiences civilian rape in varying degrees. However, in South Africa, one in four men admitted to having committed rape, and many confessed to attacking more than one victim (Jewkes, Sikweyiya, Morrell, & Dunkle, 2010). This astounding statistic is hard to believe and leads to speculation that perhaps men in the study who reported this result were exaggerating their exploits. But if that is true, it would hardly be comforting. If men find it appropriate to boast about their violent behavior toward women, it indicates the value they place on domination and subjugation of women.

Physical violence against women occurs everywhere. A WHO study covering 15 countries reported that between 20 % and 64 % percent of women experienced violence by men. Some of the women admitted that before being interviewed for the study, they thought being beaten by their husband was "natural" (World Health Organization, 2005).

As is true of poor women in industrialized countries who suffer from intimate partner violence, abused women in developing countries remain with their husbands because they have no other source of income. But in most developing countries, police and other authorities do not intervene in domestic disputes, no shelters exist for battered women, and courts do not issue orders of protection. Another difference lies in the training of medical professionals in democratic countries committed to gender equality. Where intimate partner violence is openly criticized and condemned, medical associations make recognition of such episodes

part of the training of physicians. Where husbands may beat their wives with impunity, physicians look the other way. Would European or North American physicians working in such places fail to respect cultural diversity if they questioned women patients whom they suspected had been beaten?

Culturally sanctioned violence is an undeniable source of harm to women in many parts of the world (Niaz, 2003). It is beyond doubt that some customs and traditions are not only harmful to women, but violate their human rights as well as existing laws. Consider the following examples. In India, the dowry system continues to give rise to bride burning by husbands or members of the husband's family if the bride's family provides too little dowry money. India passed the Dowry Prohibition Act back in 1961, making dowry a punishable offense. Yet, the practice has continued five decades later despite the law. When such cases are reported to the authorities, the husband or his family claims that the stove exploded and that is why the woman was burned. Corrupt officials and loopholes in the law have mostly favored offenders (Vindhya, 2000). This is a clear example of an existing law that is not enforced.

A different custom that remains surprisingly frequent in some cultures is honor killings. Women are killed by male family members for reasons including their refusal to enter into an arranged marriage, seeking a divorce – even from an abusive husband and allegedly committing adultery (the allegation is made but is typically not followed by an evidence-based inquiry). Perhaps, most egregious is the practice of family members killing a woman after she has been the victim of a sexual assault. The cultural value of maintaining honor and avoiding shame to the family extends to situations in which a female member of the family has engaged in sex outside of marriage, even if the sexual act was coerced.

The United Nations Commission on Human Rights reports that honor killings have occurred in Bangladesh, Great Britain, Brazil, Ecuador, Egypt, India, Israel, Italy, Jordan, Pakistan, Morocco, Sweden, Turkey, and Uganda (Mayell, 2010). In the developed countries, the killings take place in immigrant communities. India has seen a rise in the past several years of honor killings of young people who seek to marry outside their caste (Yardley, 2010). Such killings have included men as well as women, since both members of the couple are viewed as transgressors. Although many people in India claim to have abandoned the caste system, and the government has required that the legislature include members from the "lower" castes, adherence to traditional attitudes and practices remains, mostly in the northern states of the country. An uncle of a slain couple justified the killing, saying: "What is wrong in it? Murder is wrong, but this is socially the best thing that has been done." Five sets of couples were killed in 1 week in India in June 2010 (Yardley, 2010). Here again, the situation reveals the strength of the cultural value of family honor. Parents feel they have to act against their own children – most often daughters – to save the family's reputation. A spate of honor killings in 2010 resulted in the Indian government convening a cabinet-level meeting to discuss imposing a harsher punishment than now exists. It remains an open question whether this could be a successful deterrent, especially in a country that has failed to enforce its laws against dowry.

Still another practice harmful to women is early marriage. In traditional societies where marriages are arranged by families, the age at which girls are married can be as low as 13 or even younger. Being a child or even a young teen is a condition of vulnerability because of physical and emotional immaturity and limited worldly experience. Furthermore, children and teens are not granted decision-making autonomy in most societies, especially in traditional cultures. In almost all such cases, they cannot refuse to enter the marital arrangement. More often than not, in family-arranged marriages, the young girl is wed to an older man, who will exercise power and authority over her decisions and actions.

Being thrust into marriage at a young age places adolescents at physical risk. When girls have reached puberty but their bodies are not fully mature, pregnancy and childbirth can be hazardous. A frequent consequence of pregnancy in very young women is obstructed labor, an actual physical harm. In resource-poor settings and most rural areas where performing a cesarean section is not possible, the result is sometimes the death of the woman; more often, the woman survives but with an obstetrical fistula – an opening between the vagina and the bladder, which results in constant leaking of urine. The women become foul-smelling, are ejected from their marriage by their husbands, and even their own families will not take them back. Unless medical repair of the fistula is available and a woman has access to it, her condition will continue to render her an outcast for her lifetime. According to the World Health Organization, "It is estimated that more than two million young women live with untreated obstetric fistula in Asia and sub-Saharan Africa. Obstetric fistula is preventable; it can largely be avoided by delaying the age of first pregnancy, the cessation of harmful traditional practices, and timely access to obstetric care" (World Health Organization, 2011a). Although some medical practitioners in countries where obstetrical fistula exists are capable of making repairs, many more women remain untreated. Since obstetrical fistula is virtually unknown in industrialized countries, physicians from those parts of the world lack the knowledge and skills to provide medical assistance.

Early marriage, along with the cultural tradition of arranged marriages, violates human rights related to reproductive health. According to the World Health Organization, men and women have the right "to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (World Health Organization, 2011b). This reproductive right has its basis in several articles of the United Nations Women's Convention (United Nations, 1979). All countries that have signed and ratified the women's convention are therefore obligated to abide by its human rights precepts. Those countries include many in which forced early marriage continues to place adolescent girls at risk of obstructed labor, obstetrical fistula, and even death. The relevant article in the UNESCO Universal Declaration is Article 8: respect for human vulnerability and personal integrity. That article states: "In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special

vulnerability should be protected and the personal integrity of such individuals respected." Although the article refers explicitly to scientific knowledge and medical practice, it also can apply more broadly to those contexts in which obligations of public health are the responsibilities of governments.

Son preference, still very common in China and India, is based on customs and traditions in these countries and persists despite economic development and modernization in other aspects of society. The preference for male children has harmful physical consequences, as well as social consequences for girls and for women who do not bear sons. In poor families, girls may be malnourished as boys are fed first, and girls may be denied medical care as well as education, resulting in fewer opportunities open to them in the future. The single most important cause of the excess mortality rate among females in these Asian countries is thought to be systematic neglect of the health and nutrition needs of girls and women, especially among girls from birth to 4 years of age (Cohen, 2000, p. 1369). The imbalance in the sex ratio in India is attributable to female infanticide, better food and health care for boys, maternal death at childbirth, as well as prenatal sex determination and the abortion of female fetuses in the past 20 years. Selective abortion of female fetuses is believed to result in about half a million "missing" female births each year (Jha et al., 2006). Despite the passage of laws in India that prohibit prenatal sex determination, both the value and the practice of son preference have shown no sign of abating.

The cultural traditions and practices just described are clear violations of the UNESCO Universal Declaration's Article 11: non-discrimination and non-stigmatization. The Article says: "No individual or group should be discriminated against or stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms." It would belabor the point to specify the details of the discrimination, stigmatization, violations of human dignity, human rights, and fundamental freedoms embedded in these cultural traditions and practices. Improving public health interventions alone can do nothing to prevent the types of violence against women stemming from custom, culture, and tradition. All governments that have ratified the International Covenant on Civil and Political Rights have an obligation to respect, protect, and fulfill the human rights of the many women in their countries who are killed, maimed, raped, disfigured, or rendered disabled. Injustice in women's health inequalities can be remedied only by gaining control of the social factors that are causally responsible. It can be done, but it requires courage and political will in those countries in which women suffer the greatest health inequalities.

Globalization and Transformations of Values

Cultures are not static. Although harmful traditional practices remain prominent in some societies, in others, they have begun to change or even been altogether eliminated. Numerous examples exist in which harmful traditional practices are condemned by members of societies in which they are practiced. For example,

a transformation has been occurring in Senegal, in which a movement against the practice of female genital mutilation (FGM) has been gaining ground. Not only have individual women – older as well as from the younger generation – abandoned the practice for their daughters, but also, some religious figures have begun spreading the word that FGM is not a religious requirement in Islam (Dugger, 2011). Why the practice of FGM has begun to be abandoned in Senegal but not in Somalia or Sudan, among other places, requires further study.

Governments are accountable for some harmful traditional practices by failing either to enact laws or to enforce existing ones. As noted earlier, India is a case in point with regard to violence against women in the form of bride burning and dowry deaths. One example where the rule of law to honor killings is applied is Kurdistan. The prime minister of the Kurdistan Regional Government (KRG) in Iraq took the initiative in a campaign to eliminate the practice. One step was to establish a Commission on Violence Against Women in 2007. The initiative included calls for open debate, reforms in the law, education and training, and greater support. In this situation, as in many others, the first steps were taken by women's nongovernmental organizations (NGOs), which start their campaigns by raising awareness. Kurdistan saw a rise in honor killings in the past two decades. How much real progress has been made, however, is open to question. In response to a query about why some perpetrators of honor killings received only short prison sentences in spite of an amended law in 2002, a women's rights activist replied: "Reform takes time. The judicial systems, even in progressive countries like the UK, are based on patriarchy and often fail to protect women.... Honour killing is deeply rooted in a traditional mentality and requires changes to the law, strict implementation of the law and awareness-raising programmes for the judiciary and the police, and for the public through the education and cultural systems, as well as the media" (KRG.org, 2008). It is hard to say whether good news about reform of the laws here, as elsewhere, will give rise to even better news that these laws will be successfully implemented and will yield judicial reform. The more difficult challenge is to change the cultural views of a public that adheres to traditional norms and beliefs.

As noted above, a preference for sons remains strong in India and China, with serious health consequences for female infants and children. However, what has occurred in South Korea signals that change is possible. After decades of widening increase in the sex ratio in South Korea, a country with the same basic cultural and historical traditions as those of China and India, a reversal has now occurred. A report issued in 2007 by the World Bank Development Research Group (Chung & Das Gupta, 2007) documents these changes in South Korea and suggests implications for China and India as well regarding the still robust preference for sons and imbalanced sex ratio in those countries. Unlike China and India, a reversal began in the mid-1990s, with the sex ratio beginning to approximate that of European and North American countries. The authors of the World Bank report argue that this reversal came about as a result of changes at the societal level rather than the individual level. The explanation is that ideational change occurred, based on alterations in the economic and social conditions in the country.

Conclusion

The role that social determinants play in the health of individuals, as well as that of economically disadvantaged groups, women, and children, is undeniable. When poor health of such individuals and groups is a consequence of low economic status, governments have a clear obligation to seek ways of changing social and economic factors to improve the health of the public. When the social determinants of poor health, deliberate injury, and death are cultural factors, governments are often reluctant to act for fear of offending traditional religions or cultures. However, since governments play the predominant role in respecting, protecting, and fulfilling the human rights of all people who reside in their countries, the state above all has a responsibility to act. Respect for cultural diversity, whether within a multicultural society or across national borders, must give way when cultural practices violate the human rights of any segment of the population.

References

American College of Physicians. (2011). Why compassion is such an important part of practice. *From the December ACP Observer, copyright © 2003 by the American College of Physicians.* http://www.acpinternist.org/archives/2003/12/president.htm. Accessed 30 November 2011.

Beauchamp, T. L., & Childress, J. F. (2008). *Principles of biomedical ethics*. New York: Oxford University Press.

Callicot, J. B. (1995). Environmental ethics, overview. In W. T. Reich (Ed.), *Encyclopedia of Bioethics* (Rev. Ed., pp. 676–687). New York: Simon & Shuster Macmillan.

Cheng-Tek Tai, M. (2011). An Asian perspective of Western or Eastern principles in a globalised bioethics. *Asian Bioethics Review, 3*(1), 23–30.

Christakis, N. A., & Levine, R. J. (1995). Multinational research. In W. T. Reich (Ed.), *Encyclopedia of bioethics* (Rev. Ed., pp. 1780–1787). New York: Simon & Shuster Macmillan.

Chung, W., & Das Gupta, M. (2007). *Why is son preference declining in South Korea?* Policy Research Working Paper 4373. The World Bank Development Research Group. http://tinyurl.com/7amkvh5. Accessed 30 November 2011.

Clausen, C. (1996). Welcome to postculturalism. *The Key Reporter, 62*(1), 2.

Cohen, A. (2000). Excess female mortality in India: the case of Himachal Pradesh. *American Journal of Public Health, 90*, 1369–1371.

Dugger, C. W. (2011). Senegal curbs a bloody rite, African-style. *New York Times*, October 16, 1.

Jewkes, R., Sikweyiya, Y., Morrell, R., & Dunkle, K. (2010). Understanding men's health and use of violence: interface of rape and HIV in South Africa. Medical Research Council, South Africa. http://www.mrc.ac.za/gender/interfaceofrape&hivsarpt.pdf. Accessed 30 November 2011.

Jha, P., Kumar, R., Vasa, P., Dhingra, N., Thiruchelvam, D., & Moineddin, R. (2006). Low male-to-female sex ratio of children born in India: national survey of 1·1 million households. *Lancet, 367*, 211–218.

Joseph, R. (2011). A clinical view of Western or Eastern principles in a global bioethics. *Asian Bioethics Review, 3*(1), 3–13.

KRG.org. (2008). Nazand Begikhani: A women's rights activist discusses honour-based crimes. http://www.krg.org/articles/detail.asp?lngnr=12&smap=02010100&rnr=223&anr=23266. Accessed 30 November 2011.

Mayell, H. (2010). Thousands of women killed for family honor. *National Geographic News*. http://news.nationalgeographic.com/news/2002/02/0212_020212_honorkilling.html Accessed 30 November 2011.

Niaz, U. (2003). Violence against women in South Asian countries. *Archives of Women's Mental Health, 6*, 173–184.

Sass, H. M., & Zhai, X. (2011). Global bioethics: Eastern or Western principles? *Asian Bioethics Review, 3*(1), 1–2.

Slack, A. T. (1988). Female circumcision: A critical appraisal. *Human Rights Quarterly, 10*, 437–486.

Statement on human rights. (1947). *American Anthropologist*, *49*(4), 539–543.

UN Women. (2010). *Supplement to the handbook for legislation on violence against women: Harmful practices against women*. New York: United Nations. http://www.un.org/womenwatch/daw/vaw/v-handbook.htm#handbook_supp. Accessed 30 November 2011.

UNESCO. (2005, October 19). *The universal declaration on bioethics and human rights*. http://unesdoc.unesco.org/images/0014/001461/146180E.pdf. Accessed 30 November 2011.

United Nations. (1979). *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW). http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article12. Accessed 30 November 2011.

Vindhya, U. (2000). Dowry deaths in Andhra Pradesh, India: response of the criminal justice system. *Violence Against Women*, *6*(10), 1085–1108. http://vaw.sagepub.com/content/6/10/1085. Accessed 30 November 2011.

Widdows, H. (2011). Western and Eastern principles and globalized bioethics. *Asian Bioethics Review, 3*(1), 14–22.

World Health Organization. (2005). *Multi-country study on women's health and domestic violence against women*. http://www.who.int/gender/violence/who_multicountry_study/en/. Accessed 30 November 2011.

World Health Organization. (2011a). 10 Facts on Obstetric Fistula. http://www.who.int/features/factfiles/obstetric_fistula/en/. Accessed 30 November 2011.

World Health Organization. (2011b). Reproductive health. http://www.who.int/topics/reproductive_health/en/. Accessed 30 November 2011.

World Medical Association. (2008). *Declaration of Helsinki*: *Ethical principles for medical research involving human subjects*. http://www.wma.net/en/30publications/10policies/b3/. Accessed 30 November 2011.

Yardley, J. (2010, July 9). In India, castes, honor and killings intertwine. *New York Times*. http://www.nytimes.com/2010/07/10/world/asia/10honor.html?scp=1&sq=honor+killing+New+Delhi&st=nyt. Accessed 30 November 2011.