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Statement submitted by Operation Smile, Inc., a non-governmental organization in consultative status with the Economic and Social Council*

The Secretary-General has received the following statement, which is being circulated in accordance with paragraphs 36 and 37 of Economic and Social Council resolution 1996/31.

* The present statement is issued without formal editing.

Statement

It is the view of Operation Smile, and the nearly 40 country foundations we partner with, that empowering women of all ages and strengthening healthcare institutions with a gender perspective requires affirming the moral value that a diversity of viewpoints brings. In this statement, we address some of this moral value from the frame of reference of the pediatric population our organization routinely cares for. We also do so in view of the organization's ongoing efforts to enhance the presence and perspective of women in healthcare globally through its 'Women in Medicine' initiative.

As an organization that has been committed to providing comprehensive cleft care and advancing global surgery for over four decades, we have observed the exceptional vulnerability of our pediatric patients. For clinicians and NGOs working to promote global pediatric care, this vulnerability stands in stark contrast to the near constant struggle for resources and funding. This situation is notable when considered in the context of widespread international ratification of historic documents that call for the prioritization of children, such as Article 3 of the Geneva Declaration of the Rights of the Child (1924), Article 25 of the Universal Declaration of Human Rights (1948), and Principle 8 of the U.N. Declaration of the Rights of the Child (1959). Additionally, the most widely ratified international instrument in history, the Convention on the Rights of the Child (1989), expressly states that the best interests of the child should be a primary consideration (Article 3). But of course, children frequently cannot advocate for either their own prioritization or their best interests; it must be done on their behalf. They require others to champion their cause. In communities around the globe, we have noted how these champions are frequently their mothers. Although we advocate for the sharing of this task between genders, women have often shouldered the responsibility of promoting both the prioritization and the best interests of children. It follows that their viewpoint should be represented in discussions of the values that underpin medical decisions, especially when these decisions affect children. In this way, Sustainable Development Goals (SDGs) 3 and 5 are closely linked.

The UNESCO Universal Declaration on Bioethics and Human Rights (UDBHR) has called for a respect of pluralism in ethical thought (Article 12), as this is a source of innovation and creativity that can be harnessed in addressing complex challenges. Pluralism is especially important in healthcare because underlying philosophical assumptions have tangible consequences, and a monistic ethical framework is vulnerable to blind spots. The harms of a monistic approach are particularly apparent in the case of vulnerable individuals, who are by definition unable to represent themselves, their values, or their best interests. Pediatric patients are an example of such a vulnerable category of patients, and 'pluralism' understood in the spirit of the UDBHR calls for perspectives of those who advance their best interests. As we noted, given that in many communities it is women who take on this responsibility, there is already an a priori argument for the moral value of female perspectives in medicine and – by extension – in work done by bioethical inquiry.

Certain concepts developed within feminist ethics serve as examples of how the moral outlook of women challenges dominant paradigms – to the advantage of vulnerable patient populations. Here we present three. First, the notion of relational autonomy challenges the wide-spread and individualistic reduction of autonomy to self-determination, which many children (especially poor children) are categorically incapable of. Relational autonomy acknowledges that persons are situated in specific contexts, such as social and gender contexts, from which they are not so easily abstracted. Relationships are therefore in many cases an integral component to the exercise of personal autonomy; an idea that also corresponds with the growing body

of literature on the rights of children. Second, and in alignment with the relational theme, discussions of an ‘ethic of care’ have emerged from feminist perspectives which challenge the tendency to reduce human dignity to independence. These perspectives argue that independence is more of the exception than the norm in human life, and that the ability to give and receive care in families or communities is just as much a hallmark of dignity. An ethic of care affords a baseline level of dignity to a large segment of patients in healthcare who depend on others, including children. Such patients would otherwise be relegated to an implied lesser standing, as the traditional libertarian emphasis on values such as independence and choice – championed by the dominant paradigms – disenfranchises patients for the very vulnerability that we ought to protect them for (UDBHR, Article 5). Third, feminist insights have long been sensitive to the importance of the body and psychosomatic unity. In rejection of a ‘Cartesian dualism’ of mind and body, such a framework sees personhood as an embodied phenomenon. This, once again, is the result of an awareness of the contextual existence of human beings and a refusal to ‘abstract’ personhood from this context. As an NGO dedicated to reconstructive surgery, Operation Smile is particularly sensitive to the intimate relationship between a person’s bodily integrity and their sense of self. The embodied view of personhood thus reflects a truth that we have witnessed as true ‘on the ground’ and drives home both the urgency and the moral significance of reconstructive work.

These are just a few examples of morally significant contributions that a feminist perspective has brought to the collective discussion of ethics, often against mainstream thinking. By being more attuned to those who are vulnerable, their insights more accurately reflect the clinical realities that we observe for our patients in practice. Enriching discourse with insight of this sort requires us to empower women to integrate their experiences with problems faced in various social domains such that they are able to advance underrepresented viewpoints. The presence of women in healthcare is, from this standpoint, imperative. Operation Smile has recognized the significance of explicit and systematic efforts to augment the inclusion of women in the healthcare workforce worldwide. As a healthcare NGO, we see SDG 3 and SDG 5 as intrinsically linked. In view of this, our ‘Women in Medicine’ is an explicit initiative to enhance our contextual understanding of women in healthcare in low- and middle-income countries (LMICs). Insights into their situations and the associated barriers are subsequently used to improve our design of initiatives which, in turn, work to enhance recruitment, retention, and progression of women in healthcare. Thus far ‘Women in Medicine’ has conducted five surgical programs staffed entirely by women, in countries as diverse as Morocco, Peru, and the Philippines. Data from these programs have demonstrated a positive shift in the perception of the value of women providing healthcare. Furthermore, human-centered design is being used to shape initiatives within ‘Women in Medicine’ by accounting for the end-user’s perspective. Examples of concepts important to women that this methodology has identified include the desire for exposure to other women in healthcare, the need of mentorship provided by all seniors regardless of gender, and the negative impact of the presence of overt and covert systemic misogyny in healthcare. Our ‘Women in Medicine’ working group is in the process of prototyping an educational initiative to meet these needs with the intent of ensuring the solutions generated are framed from the perspective of the people they are aiming to service. We believe that this is one example of the manner in which NGO’s can actively and systematically work to empower the women serving in their respective fields.

It has been the purpose of this statement to argue that pursuing gender equality, empowering women, and strengthening institutions with gender perspectives are worthwhile endeavors not only because they are better reflections of how things are, but because they serve guides for how things ought to be. They are goals that move beyond the realm of the descriptive and enter the realm of the normative. What we

have elaborated on in this statement is an illustration of why goals such as ‘a broader representation of women in medicine’ are morally valuable. We have done so from the perspective of an NGO that works to promote global pediatric care for extremely vulnerable patients. Finally, we have described our own systematic and explicit effort to augment and support women working in healthcare in low-resource settings. We call on other members of the Council to pursue similar initiatives, and to advocate for policy that allocates funding to such initiatives.