Reproductive Health, Gender and Human Rights: A Dialogue

Edited by
Elaine Murphy and Karin Ringheim

Women’s Reproductive Health Initiative (WRHI)

path
Program for Appropriate Technology in Health
1800 K Street NW, Suite 800
Washington, DC 20006
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One of the central challenges posed by recent international agreements and women’s advocacy movements is the application of both public health and human rights principles to reproductive health programs. The Programme of Action of the 1994 International Conference on Population and Development (ICPD), for example, calls on governments and international donor agencies to expand and transform existing programs, and to offer services that are comprehensive, integrated, universally accessible and delivered in a manner consistent with health and rights objectives.

Clearly, the implications of these changes for services alone are enormous, and even in the best of circumstances reflect goals that will require many years to realize. Yet even given the obvious challenges, evidence suggests that in practice, the application to existing programs of reproductive rights principles lags far behind the theory.

This paper explores these issues and argues that reproductive health programs have a pivotal but unfulfilled role to play in the promotion of rights, health and gender equity. It also suggests the parameters of a framework intended to be used simultaneously to provide guidance to governments and donor agencies on the practical implications for programs of the rights and health agenda, as well as to evaluate the degree to which specific programs promote health, rights and equity, and thereby promote accountability of institutional actors.

For the purposes of this analysis, programs are defined as the sum total of efforts aimed at changing social norms and health behaviors and providing health services, including research, public education and advocacy, behavior change interventions, social marketing, clinical services and community-based distribution. (This definition recognizes both the importance and limitations of client-provider interactions in promoting reproductive health and rights.) Reproductive rights include the right of individuals to bodily integrity and security of person; the rights of couples and individuals to decide on the number and spacing of children and to have access to the information, education and means necessary to do so; the right to attain the highest standard of sexual and reproductive health; and the right to make decisions concerning reproduction free of discrimination, coercion and violence.
The Rights and Health Agenda

The transformation of conventional family planning programs has been a major goal of women's health and rights movements for well over a decade. The historical limitations and critiques of such programs are well known and have been extensively documented elsewhere (Germain et al., 1994). In summary, these programs generally have been characterized by poor quality of care, limited choice of methods offered, and lack of attention to critical issues—such as sexual coercion and the risk of sexually transmitted infections—that are fundamental to women's health and rights.²

Many governments and donors traditionally viewed contraceptive delivery as a shortcut through the demographic transition. Family planning programs were isolated from broader efforts to change the cultural and economic conditions that contribute to the subordination of women and keep birth rates high. Such programs have unquestionably filled a latent need among women for methods of fertility control, but generally in a manner that was or is instrumental to the specific goal of reducing fertility and not to meet goals of promoting rights, equity and empowerment. While the rhetorical emphasis has been on the depth of “unmet need” for fertility regulation, in reality programs have exhibited a tendency to be selective in the information and methods offered to clients, especially women, and have used various degrees of persuasion and even in some instances coercion as the means to reduce both unwanted and wanted fertility (Jain, 1995).

In the 1990s, the global women's movement fundamentally changed the discourse of the population and health fields by asserting that social justice and individual rights must become central concerns of policy and program. Redefined along these lines, “population policies” are not merely family planning services but the aggregate of multi-sectoral strategies aimed at achieving, among other things, the equitable distribution of power between social groups and between women and men. Health services, including but not limited to contraceptive delivery, are essential assets that people use to meet a broad range of needs.

The rights movement recognizes that the ability of women and men to fully exercise their reproductive and sexual rights, to negotiate decisions about whether and when to have children, and to enjoy the highest attainable levels of reproductive health is not a function of reproductive health programs, or of access to services per se, but is contingent upon the social environment in which people live. Following from this, the ICPD calls for integrated efforts to increase women's economic and political clout, challenge prevailing social norms on reproduction and sexuality and combat gender violence—to create the “enabling conditions” essential to the realization of reproductive and sexual rights (Correa and Petchesky, 1994).

² See for example, Bruce, 1989; Germain and Ordway, 1989; Jain, 1995.
The rights and health agenda therefore rests on the following basic assumptions:

♦ Multi-sectoral strategies are essential to achieving broad goals, such as reproductive rights, gender equity, and population stabilization.
♦ Reproductive health programs must be nested within broader strategies, which in turn must reflect at every level the values and objectives of a health and rights agenda.
♦ Support for rights and equity must simultaneously be developed at the community and family as well as the individual levels.
♦ Quantitative measures of success alone are insufficient to indicate progress toward the promotion of rights and equity.

In sum, the promotion of reproductive rights and health depends fundamentally on the conditions in which people live, and on the tools, such as health services, that are at their disposal. The rights agenda recognizes that access to health services is a necessary but far from sufficient condition for ensuring rights and equity.

At the same time, however, the contribution of health programs toward these goals cannot be overlooked. Because health programs often reflect, replicate and reinforce the social climate in which they exist, they will either contribute to or detract from the fulfillment of individual rights. Applying a rights lens to reproductive health programs means such programs must be evaluated on the extent to which they—

♦ Adopt effective means or measures to promote and fulfill the reproductive health and rights of women and men, and address gender inequities directly relevant to decisions about sex, pregnancy, childbirth, contraception and infection prevention;
♦ Protect individuals from and immediately respond to violations by institutional actors or their surrogates.

Public Health and Human Rights: Different Perspectives

The integration of reproductive rights and health objectives presents a number of conceptual challenges that need to be considered at the outset. Traditional public health and human rights approaches are based on different conceptual frameworks and use different methodologies, with seemingly different implications for programs. Each of these approaches has to be rethought and reconciled on a practical level to promote rights-based health programs.

The field of public health is concerned with improving the health status of populations. Success is measured in terms of outcomes—births averted, lives saved—and the goal is to achieve the greatest good for the greatest number. Public health resources are allocated according to priorities that reflect the ability to
prevent illness and death on a large scale, and to reduce the prevalence and incidence of disease across a population. Public health theory weighs relative risks and recognizes that in the quest to improve the health of populations, some individuals will continue to face risks due to individual behavior, environment, economic conditions and lack of access to health care, among other things. It is understood that resources are finite, and that decisions need to be made to ensure that investments yield the greatest possible return.

Human rights concepts and methodologies focus on protecting the rights of individuals. Human rights standards are universal, indivisible and inalienable. Rights language refers to a “right to health” and a “right to health care,” which in the context of limited resources can leave the public health official at a loss. Although a rights framework theoretically seeks to promote rights as well as to protect individuals from violations, the focus for much of the past several decades has in fact been on documenting violations. During most of the 20th century, the human rights community focused on abuses of individual civil and political rights by public actors—the state and its representatives. Only in the last two decades have rights advocates and legal scholars established the basis for women’s human rights, and following from this, reproductive and sexual rights. These rights are now recognized in a number of conference documents, including the 1993 World Conference on Human Rights and the 1995 Fourth World Conference on Women, as well as the ICPD. Violations of women’s rights by governments are now documented through a variety of formal means, including through the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the U.S. State Department’s *Country Reports on Human Rights Practices*.

Traditional human rights documentation relies on reports from and interviews with key informants in a given setting. By its nature, such reporting often is based on small numbers of discrete cases; these reports frequently raise a red flag about problems that affect larger numbers, but do not prove that a given problem exists on a large scale. As a result, human rights findings often are not persuasive to public health practitioners who, in the absence of population-based data, often remain unconvinced that these findings represent more than a few isolated cases, or a new priority to be addressed. For this reason, proof of a small number of cases of sterilizations without consent, for example, may be viewed by public health institutions and program managers—especially those with a vested interest in the reputation of a program—as being more an exception than the rule, and therefore remedied through palliative measures focused merely on the individual case rather than on a systemic problem. In Mexico, for example, evidence gathered by human rights organizations that government doctors performed sterilizations without the client’s consent was largely dismissed until large-scale surveys conducted in the 1980s and 1990s by both the government and various donors showed the problem to be significant and pervasive.
On the other hand, by focusing only on blatant violations—such as sterilization without consent—human rights methodologies also can miss subtler, but more widespread and persistent violations of rights. In Mexico, for example, a 1996 United Nations Population Fund analysis of service delivery points throughout the country revealed that only a limited number of contraceptive methods were offered, and that providers were required to strongly encourage and persuade women with more than two children to adopt IUDs or undergo sterilization (UNFPA, 1996). Since most women were coming for and leaving with a method, and since there appeared to be “consent,” this type of practice might not be perceived as a violation of rights. According to the interpretation of a rights approach posed by this article however, these are violations. A program that offers limited methods in the interest of reducing women’s fertility takes advantage of women’s extremely limited sense of rights to achieve externally posed demographic goals. Such a program, which fails to instill a sense of broader choices and entitlement in its clients, does not meet the test of contributing to the promotion of reproductive rights.

Accordingly, applying a rights framework to reproductive health programs means focusing as much on the process as on the outcome, and opens the possibility of transforming not only programs but the essential discourse and practice of both public health and human rights.

From Theory to Practice: Minimum Criteria for Rights-Based Programs

A rights approach requires a fundamentally different analysis of the content and intention of what we now call family planning programs. To explore the practical meaning of a rights framework for current and future programs, it may be helpful to start from the act of heterosexual intercourse, the domain of conventional family planning programs. In the ideal world, sexual partners decide together whether or not they want to have children, and if not, how to protect themselves from unwanted pregnancy. They negotiate the timing and frequency of sexual encounters. If one partner suffers from a sexually transmitted infection, they work together on ways to protect the other.

The real world, however, is still far from this ideal and both women and men are at risk of the consequences of unsafe sex. Cultural and social norms may inhibit partners from talking openly with each other about having sex, sexuality, contraception and infection, thereby putting them at risk of unwanted pregnancy and of
disease. Taboos and traditional practices may prevent them from seeking health care even in dire circumstances. Women and men may know little about their bodies and how they work. Women may be particularly vulnerable because they face constraints posed by inequitable gender-based power relations that undermine their ability to negotiate sexual and reproductive decisions equally with their partners. An individual woman may sometimes—perhaps frequently—be forced to engage in non-consensual sex, or she may be raped by an intimate partner. Unwanted pregnancy may be a persistent concern, either because a woman cannot control the timing of intercourse and therefore protect herself, or because she lacks access to methods of fertility regulation that truly fit her particular needs. Access to safe abortion is likely to be limited if it is available at all. Emergency obstetric care may be equally scarce. All of these conditions contribute to high rates of reproductive morbidity and mortality among women.

Of course, women may be better able to control some of the outcomes of unwanted sex, such as unwanted pregnancy, by using contraception. However, they may still be forced to have sex against their will on a regular basis, perhaps even more frequently because the likelihood of unwanted pregnancy is diminished. These women remain at risk of STIs. These conditions and the failure of programs to adopt effective means to address them constitute violations of women’s reproductive and sexual rights.

Similarly, in the absence of efforts to change the gender dynamics of sex, encouraging men to use—or asking them to persuade their partners to use—contraception could yield higher rates of contraceptive use with little or no change in the prevalence of sexual coercion or increase in positive communication between couples, changes that would nonetheless be deemed a success under conventional measures of evaluation.

A rights approach starts from this reality and asks: What can and should be done programmatically to address these issues? Instead of offering a limited range of contraceptive methods because they are effective or efficient in meeting the program’s goals, a rights-based program is client-centered and offers several methods and reaffirms at every level the client’s right to choose among them. Instead of relying on providers to do all the work of informing and educating clients in the span of a few minutes, it offers community-based reproductive health education, builds community support for reproductive health and rights, and uses a variety of communication strategies to instill a sense of entitlement among people. A rights-based program is part of the process of establishing new social norms that encourage partnership, communication and cooperation. Instead of assuming that unwanted pregnancy is the only problematic outcome of sexual intercourse within their professional interest, it
recognizes that the risks of infection and coercion are—at the very least—of equal importance and are additional risks many women face each and every time they engage in the act of intercourse. A rights approach puts as much emphasis on the ethical and value-oriented aspects of a program as it does on technical skills. Finally, a rights approach acknowledges that health providers also are individuals with rights, and that changing the system is as important as changing the individual.

The primary test of success in the old model of programming is increased contraceptive use and reduced fertility. A rights-based model, by contrast, provides a means test to measure the intention and progressive achievement of program efforts—including research priorities, behavior-change communication and client-provider interactions—in advancing reproductive choice and rights while simultaneously addressing what might best be called the proximate risks of sexual relations. Because the proximate risks of sexual relations are indivisible—most women seeking family planning services simultaneously face the risk of sexual coercion, unwanted pregnancy and infection—the rights-based approach should address all risks. Concerns about sex, power, gender and rights should therefore be considered intrinsic to each aspect of programming—research, range of methods, service delivery, education, communication and client-provider interactions—and not be compartmentalized.

Jain and Bruce (1994) sought to provide concrete guidance on the transformation of family planning programs to policymakers and program managers by suggesting a shift from a focus on fertility objectives to “helping individuals to achieve their reproductive intentions in a healthful manner.” To achieve this goal, they argued, programs must include the following elements:

♦ Choice of contraceptive methods
♦ Safe abortion
♦ Diagnosis and treatment of reproductive tract infections and other conditions that would make the use of a particular contraceptive method unhealthful
♦ Diagnosis and treatment of unhealthful effects of contraceptives.

They further note that determining which of the above services should be the highest priority depends on the local conditions and felt needs of clients. Taking these steps would in itself represent a major advance in what is available to the vast majority of women and men worldwide. Applying a rights framework to this constellation of services takes us several steps further, and at a minimum includes efforts at every level of programming to—

♦ Address sexual violence and coercion, especially as it relates to restricting women’s choices, and exposes women and girls to higher risks of morbidity and mortality
♦ Incorporate multi-source reproductive health and rights education strategies, and seek to instill a sense of entitlement among people and a rights-based ethos within programs
Incorporate communication and behavior change interventions encouraging the prevention of disease, the practice of safe sex, and changes in social norms that encourage equitable partnerships.

Establish means of ensuring the accountability of programs to the population, and means of redress for violations of rights.

**Obstacles to Change**

On the face of it, the rights agenda is now a mainstream idea. Today, a majority of governments (and by extension, key institutions such as donor agencies) are signatories to international agreements that recognize reproductive and sexual rights as human rights. The terms “health,” “rights” and “gender” are now ubiquitous in the rhetoric and the policy statements of the population and health fields, suggesting that institutional actors at least nominally support this vision. But evidence suggests that on the whole, progress in making the fundamental changes in family planning programs required by a rights framework is uneven at best. There are a number of obstacles to the transformation of family planning programs, some of which are explored briefly below.

1. Social, economic and political conditions undermine rights and entitlement.

The most important obstacles to the realization of the reproductive rights and health agenda are the continued lack of attention to enabling conditions, and the absence of institutional and political environments that support, promote and protect rights. Poverty, lack of social investment and the dislocation caused by rapid globalization and privatization worldwide, among other things, continue to undermine individuals’ rights and sense of entitlement. Fundamentalist religious and political movements pose particularly profound threats to women’s health and rights.

In Mexico, where national reproductive health policies extol the ICPD agenda, data from the late 1980s through the late 1990s show that problems with both informed choice and informed consent are embedded in the public sector’s family planning program. Complex contextual and social issues that are at the core of truly informed choice and consent include women’s low sense of entitlement to choose their own contraceptives due to the power imbalances between clients and providers—as well as between women and their partners.

Lack of transparency of institutional actors severely undercuts the ability of civil society to monitor progress and ensure accountability on the rights agenda.

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3 Based on research conducted by the Center for Health and Gender Equity (CHANGE) in cooperation with Monica Jasis, Co-Director of Centro Mujeres in Baja California Sur.
Governments and donor agencies have their own political agendas and institutional imperatives that diverge from ICPD principles. Their internal systems often are set up to protect these agendas, making it difficult for civil actors to gain access to information on programs or spending.

2. Support for a rights agenda at the national level may be weak.

National politics plays a pivotal role in the reproductive rights agenda. The U.S. government, for example, remains among the leading contributors to international family planning programs in both financial and technical terms. The strong influence of political ideologies that come from opposite ends of the spectrum on issues of population stabilization and reproductive rights have impeded progress toward a rights-based agenda within U.S. international assistance.

On one hand, traditional supporters of international family planning programs within the U.S. Congress back these efforts largely because of their concerns with population growth and demographic threats to the environment, economy and international security. On the other hand, a quite small but powerful counter-constituency seeks to eliminate population programs altogether. In a sense, U.S. assistance confronts three competing paradigms—the demographic, the reproductive rights and the anti-choice/anti-rights paradigms. The first two seek to expand services, but for different reasons and with different implications for services, and the third seeks to eliminate them altogether.

Efforts to curtail or eliminate spending on contraceptive delivery have taken many forms. Since the 1980s, the far right has persistently worked to diminish the capacity of organizations receiving U.S. international assistance to work on expanding access to safe abortion overseas, even in countries where abortion is legal and even in instances where funds for work on safe abortion were obtained from other sources. In the mid-1990s, Congress imposed a harsh and costly system of metering of funds on international family planning programs in a failed attempt to eliminate the overall program. More recently, Congress passed a new global gag rule, requiring U.S.-funded organizations to sign pledges renouncing all work on safe abortion—including data collection and dissemination of information on unsafe abortion—in order to be eligible to receive U.S. funds.

In recent years, the far right also has used the human rights agenda to its own ends. In 1999, leaders of the conservative right crafted a law—the Tiarht Amendment—mandating monitoring of U.S.-funded programs for violations of informed consent, and requiring that funding be withdrawn from any program in which such violations are found. While seemingly in accord with the rights agenda, this law can actually shut down many imperfect programs that are receiving rights-oriented training and are in the process of making positive changes—before they have a chance to fully implement the improvements. Instead of funding activities to enhance informed consent and other rights-based principles in family planning programs, the effect of this legislation is to diminish choice altogether.
Despite these setbacks, several initiatives intended to incorporate concern for gender and rights perspectives into USAID's family planning/reproductive health programs are underway. In 1997 the Office of Population formalized an Inter-Agency Gender Working Group (IGWG) composed primarily of representatives of USAID cooperating agencies and a few USAID staff. This group has done important work in reviewing the Agency's strategic objectives and exploring the practical implications of male involvement. It has now issued guidelines for the incorporation of gender-sensitive indicators into the Agency's “Request for Proposals,” the mechanism by which it funds new or continuing projects. The long-term impact of the IGWG work remains unclear; however, the Agency has now mandated consideration of gender issues for all new proposals.

3. Key concepts remain ill-defined.

The failure to go beyond the level of rhetoric to clearly articulate the operational meaning of terms such as “comprehensive” and “integrated”, and to demonstrate understanding of the financial and technological implications to creating comprehensive programs in the short run, has hampered progress on many fronts. Lacking guidance on what to do and how to do it, many in the public health community feel unclear about how to proceed toward a rights-based reproductive health program. The lack of clarity can hinder progress on the part of governments and donors who perceive that they are being asked to provide everything to everybody simultaneously. Faced with pressure to do something, some institutional actors make superficial changes in programs; others just go on with business-as-usual. For example, the oft-repeated “right to choose freely” is still seen by many institutional actors as being fulfilled if an individual woman with an “unmet need” receives a contraceptive. This narrow interpretation also ignores risks of infection or sexual coercion a woman may have, or her lack of knowledge about reproductive functioning.

The sense that ICPD is too overwhelming an agenda appears even greater among those politically or otherwise disinclined to support the overall objectives of the ICPD. Adherents of conventional family planning programs, for example, argue that such programs are efficient and cost-effective, and that the public health impacts are easily measured. This group, which is still represented at high levels of both governments and donor agencies, often dismisses the call for comprehensive, integrated services as grossly unrealistic, arguing that a public health approach “cannot do everything” and demands choosing strategic, cost-effective actions in the interest of increasing general health. Many in this group view “gender,” “empowerment” and “rights” concerns as costly add-ons that may dilute family planning program effectiveness.

In fact, ICPD is a 20-year program of action and the rights framework does allow for progressive realization of goals. However, the interim steps needed to achieve priority ICPD goals over time have not yet been fully explored by the rights and health communities in specific settings to provide sufficient guidance to
even its strongest supporters on how to move forward. Realizing this, women’s health and rights advocates are taking on these issues. For example, a groundbreaking article by Alicia Ely Yamin and Deborah Maine (1999) suggests a methodology for marrying human rights and public health standards in efforts to measure progress in reducing maternal mortality and morbidity. The article examines in detail how international human rights principles, concrete data collection and measurable indicators of progress can be used simultaneously to analyze the scope of a problem, set achievable goals and mark progress. Similar work in other key reproductive health and rights, such as STIs and unsafe abortion, can be used to design or improve programs.

4. Insufficient funding and health-sector reform are major challenges.

Identifying priorities and indicators of success to address reproductive health and rights incrementally is necessary in light of static or declining expenditures on health care. The rapid changes underway as a result of health-sector and other reforms make priority-setting even more urgent. There is little concrete evidence on how health reforms are affecting access to and the quality of care, whether positively or negatively—or both. We need to know much more about the implications for reproductive health and rights of efforts to decentralize, redistribute staff, institute user fees, privatize services and overhaul drug management systems in various settings. It is essential that rights advocates actively engage in health reform efforts to ensure that they advance, rather than undermine the ICPD agenda. However, the capacity of civil actors to monitor progress and ensure accountability on the rights agenda is constrained in several ways. Insufficient funding and lack of institutional transparency are critical obstacles that limit the capacity of civil society groups concerned with reproductive health and rights to shape debates, conduct research, collaborate with institutional actors in setting priorities, monitor programs and engage with communities. In some cases, such as the devolution of power to district and village councils under the Panchayati Raj Act in India, the authority to design and implement health programs is now vested in groups whose understanding of and willingness to address reproductive health and rights issues is limited at best.

5. Insufficient human capacity exists.

Finally, lack of capacity in the women’s movement is another constraining factor. Over the past two decades, the capacity of the international women’s movement to influence rhetoric and policy, lobby, use the media and engage with international bodies to advance women’s rights has expanded dramatically.
However, now that we have won globally, we have to act locally. The real transformation of programs occurs at the national, state and district levels and the burden of monitoring has therefore increased enormously. However, given the critical importance of monitoring programs, including the impact of health-sector reforms, the numbers and skills of women’s health advocates will have to grow correspondingly. This requires financial support and training.

**Towards a Framework for Advancing the Reproductive Rights Agenda**

To ensure progress toward the goals of the reproductive rights agenda, a framework is needed that encompasses the technical aspects of quality of care, but goes beyond it in several ways. First, the framework must ask: In what ways must existing family planning programs be transformed so that they help to ensure that women and men can engage in sexual intercourse free from the fear of unwanted pregnancy, infection, sexual coercion and with equal negotiating power with their partners?

Second, the framework must take a “systems” approach to program development, and provide guidance on the integration of both public health and human rights principles at each stage of program development and execution, including the conceptualization of programs, research to gather baseline data, service delivery, evaluation and measurement. A systems approach also implies development of an overall plan for the evolution of programs that can act simultaneously as a guidepost for institutional actors and as a means of holding them accountable for moving forward.

Third, the framework must be universally relevant but specifically applicable. It must be useful in transforming existing programs so they are consistent with broad goals, such as integration and gender equity, but in a step-wise manner that reflects local realities. It must articulate clear and specific objectives aimed at addressing a core set of priority issues and the achievement of measurable changes in a given setting over a given time period. Understanding both what must be done ideally and what can be done relative to a given situation is crucial to encouraging and recognizing good-faith efforts and the progressive realization of a rights framework within reproductive health programs.

Fourth, the framework must go beyond the purely technical aspects of training to improve clinic-based service delivery; it must also incorporate the means to infuse programs and staff with a rights perspective at every level. For example, when offering family planning methods to women, providers need to take into account the potential interplay between contraceptive use, sexual coercion and risk of infection. It also means working with providers in recognizing the gender, class and other constraints that not only affect their relationships with clients, but also influence their own lives and health. The framework should
include support for the rights of providers, particularly female staff, as actors and potential agents of change within institutions, as it supports the rights of clients.

Finally, the framework must include meaningful avenues for community participation in identifying priority issues and shaping, monitoring and evaluating programs. It must also provide effective and meaningful avenues for investigating and legitimizing claims of abuse, and means for accountability and redress.

The rights agenda requires a fundamentally different perspective on reproductive health programs and service delivery, with correspondingly different goals and objectives, strategies and evaluation. While the vision of the rights agenda is broad and encompassing, the means “to get from here to there” can be incremental and achievable. What is needed are long-term commitments by institutional actors to working with civil society to achieve these goals, and a reciprocal commitment by civil society actors to engage with institutions proactively, while maintaining their independence and ability to advocate for change from outside the health system.

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