

A Decade After Cairo

Women's Health in a Free Market Economy

THE CORNER HOUSE

The 1994 UN International Conference on Population and Development in Cairo was heralded as a “quantum leap” forward¹ and a “paradigm shift in the discourse about population and development”.² Its Programme of Action, endorsed by 179 countries and intended to establish international and national population policy for the following two decades, was the first and most comprehensive international policy document to promote the concepts of reproductive rights and reproductive health. This was largely as a result of the concerted organising and lobbying of women’s groups.

The Programme’s recommendation – that population programmes provide reproductive health services rather than just family planning – assumes that women’s fertility will not drop until children survive beyond infancy and young childhood, until men also take responsibility for contraception, and until women have the right to control their fertility and enough political power to secure that right.

One decade later, however, maternal mortality worldwide remains high. Some 600,000 women die each year, 95 per cent of them in sub-Saharan Africa and Asia, and 18 million are left disabled or chronically ill because of largely preventable complications during pregnancy or childbirth. Such figures indicate that many women do not have access to essential and emergency obstetric care from skilled health workers, let alone access to more comprehensive reproductive health services.

Women in some countries are still coerced into being sterilised. During 1996, for instance, family planning providers intimidated and humiliated indigenous, poor and rural women in some towns in the Peruvian Andes into being surgically sterilised after offers of food and clothing had not persuaded them. In other countries, such as Indonesia, poorer women do not have access to contraception, even though these countries were held up at Cairo as exemplars of family planning provision.

Indeed, many positive trends in the health of women the world over, from North to South, East to West, have been reversed over the past decade, while reproductive health and rights remain threatened, particularly for poorer women, migrant women and women of colour.

Meanwhile, in several sub-Saharan African countries, infant mortality rates have increased. Some 70 per cent of young child deaths can be attributed to diarrhoea, pneumonia, measles, malaria and malnutrition, the incidence of which is on the rise. An estimated 330 million people are infected each year with sexually transmitted diseases of which HIV/AIDS accounts for six million; women and children are disproportionately affected.



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Many positive health trends all over the world have been reversed over the past decade.

The problem is largely neo-liberal economic and health policies.

These negative health trends can be attributed in large part to the implementation of neo-liberal economic and health policies over the past two decades, first by means of structural adjustment programmes (SAPs) and more recently by international “free” trade agreements and national-level policies. A retrospective look at these trends suggests some lessons for the next decade of women’s health organising and activism and avenues for more fruitful alliances with other social movements. It also suggests that the Programme of Action, together with the political organising that accompanied it, undermined itself by not challenging neo-liberalism sufficiently. In fact, it endorsed it in several respects.

This briefing first summarises the actions of several women’s groups to influence the outcome of the 1994 UN International Conference on Population and Development and evaluates with hindsight some of the successes and failures of the Programme of Action. It goes on to assess four processes that affect women’s reproductive and sexual rights and health:

- The decline and collapse in health services in many countries and their consequences for women’s access to reproductive health services;
- The negative impacts of neo-liberal economic policies on women’s health generally;
- The restriction of women’s rights due to such policies in combination with religious fundamentalisms; and
- The assault on women’s reproductive and sexual health due to development policies underpinned by neo-Malthusianism.

An Opportunity Presents Itself

The United Nations’ International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994 was the third population conference organised by the United Nations Fund for Population Activities (UNFPA).³

For the past 50 years and more, Western-educated or -influenced elites, governments, institutions and aid agencies have variously attributed a range of major social problems – poverty, environmental degradation, slow economic growth, hunger, war and conflict, threats to Northern security, unemployment or international migration – to the increasing number of people in the world, particularly those who are darker-skinned, poorer or from the countries of the South.⁴ Reducing population growth by reducing the number of babies women give birth to has been their chosen solution.⁵ Of all the development, economic, environment or social policies devised by think tanks, implemented by governments and funded by multilateral agencies, population policies tend to be the only ones that primarily focus on women from the outset rather than subsequently tacking on gender-oriented amendments under pressure from women’s movements. By 1991, 69 countries had officially-endorsed, comprehensive population policies providing contraception and sterilisation.⁶

Some had gone further than just providing contraception to those who wanted it, however. They had introduced quantitative targets of numbers of women to be sterilised each month or fitted with an intra-uterine device (IUD). Some had brought in financial incentives or disincentives for family planning providers and potential contraceptive users,

while some had employed outright coercion. Forced vasectomies in India in the 1970s, a one-child policy in China in the 1980s that pressured some women to have late-term abortions, and implantation of women in Indonesia with five-year contraceptive doses in “safaris” organised by the military forces were some of the more extreme measures that resulted.

Criticism was not slow in coming from women’s health groups. Many of them supported contraception that contributed to human health, welfare and self-determination by enabling women and men to have greater influence over the timing and spacing of births, but opposed contraception which harmed women’s health and welfare, especially when devised and provided without sufficient safety considerations. Betsy Hartmann, women’s activist and critical US academic, pointed out that:

“Married to population control, family planning has been divorced from the concern for women’s health and well-being that inspired the first feminist crusaders for birth control,”⁷

and, indeed, from the concerns that motivate many feminists today. While “women do want fertility control” concluded one study of Muslim women and childbearing in Hyderabad, South India, “what they object to is coercion, the lack of information and the poor quality of services offered,” as well as unexplained and untreated side effects.⁸

Some women’s health groups believed that working more closely with governments, international donor agencies or UNFPA might ensure better reproductive health and counter abuses. They decided to try to influence the direction and outcome of the ICPD so as to get governments to change their population policies to encompass women’s reproductive rights and gender equity.⁹

They also hoped to enlist help in reducing the influence of religious fundamentalists,¹⁰ some of who were striving to undermine women’s safe and legal access to abortion and contraception obtained in some countries during the 1970s and 1980s. Others wanted to counter a trend among environmentalists to attribute environmental problems to population growth. And some groups hoped that talking about “population” would get them additional funding for women’s health programmes. The President of the International Women’s Health Coalition, Joan Dunlop, for instance, in an interview in 1993 called attention to “money moving along a stream that is called ‘population’ . . . Women need to get access to that money.”¹¹ She had long held that:

“The threat of AIDS, which is renewing interest in barrier [contraceptive] methods [such as the condom and diaphragm], and the right-wing attack on family planning, which is encouraging liberal elements in the population establishment to seek allies among the feminist community, make this a historic opening for those of us who want to make reproductive rights the new cornerstone of population policy.”¹²

A Feminist Population Policy

To influence the ICPD process, some women’s groups sought to look for “common ground” with population organisations, governments and donor agencies.¹³ This meant that if they could not countenance straightforward attempts to lower women’s fertility, neither could they dismiss “the population problem”.

In the early 1990s, several women outlined the resulting “feminist population policy”,¹⁴ drawing on a reproductive/human rights agenda

Unlike other policies, population programmes focus mainly on women.

Contraception can contribute to health, welfare and self-determination . . . but can also harm women’s health and welfare when devised and provided without concern for safety.

Reproductive Health, Rights and Justice

The term "reproductive rights" began to be used, primarily in liberal feminist circles in Europe and the United States, during the 1980s. The aim was to broaden 1970s' demands for rights to safe and legal abortion to encompass women's rights to control their bodies in all matters of reproduction. It included access to contraception, but also freedom from coercion.

Women from the South and women of colour expanded the concept further to embrace maternal health and mortality, childbearing and child raising. Activists later began using the term to signify women's health rights throughout their lives.

Sexual health and rights are clearly linked with reproductive health and rights. After all, having sex can have consequences besides pregnancy, and being able to refuse sex is connected to both and to gender equality.

Women's movements in different countries have different reproductive health priorities stemming from different contexts and histories. Latin American women's health organisations have emphasised women's access to quality reproductive and sexual health services (in the face of religious and state opposition) as part of a broader democratic movement. In Asia, women's groups have been concerned with the coercive provision of contraception and sterilisation within population policies. Health activists in Africa, meanwhile, have been preoccupied with survival issues: high maternal and infant mortality rates, and high rates of reproductive tract infections and sexually transmitted diseases, including HIV/AIDS.

Reproductive health and rights also have different meanings for women at different stages in their lives, depending on age, marital status, economic conditions, sexuality, religious and ethnic identity, and other social circumstances.

In its May 1993 seminar on "Reaffirming Reproductive Rights", the Women's Global Network for Reproductive Rights stated that:

"Reproductive and sexual rights are about self determination in matters of procreation and sexuality. Reproductive rights are about us being in charge of our bodies/ourselves, our freedom to express ourselves sexually and to be free from abuse."

Two prominent reproductive rights activists, Sonia Corrêa and Rosalind Petchesky, describe the terrain of reproductive and sexual rights in terms of:

"power to make informed decisions about one's own fertility, childbearing, childrearing, gynaecological health and sexual activity; and the resources to carry out such decisions safely and effectively."

The definition of reproductive health in the 1994 Programme of Action resulting from the UN International Conference on Population and Development is more often cited:

"a state of complete physical, mental and social well being and not merely the absence of disease and infirmity, in all matters related to the reproductive system and to its functions and processes. People are able to have a satisfying and safe sex life and they have the capability to reproduce and the freedom to decide if, when and how often to do so. Men and women have the right to be informed and have access to safe, effective, affordable and acceptable methods of their choice for the regulation of fertility, as well as the access to health care for safe pregnancy."

The rights that the Cairo Programme of Action sets out include various human rights long recognised in national and international legal human rights documents:

- The right of couples and individuals to decide freely and responsibly the number and spacing of their children, and to have the information and means to do so;
- The right to attain the highest standard of sexual and reproductive health;
- The right to make decisions free of discrimination, coercion or violence.

The Programme did not create new rights, but aimed to extend the interpretation of existing rights into areas of the family and reproductive relations.

Many women today think of reproductive rights as encompassing in addition:

- The right to economic security through the opportunity to earn equal pay for equal work, so that women can adequately care for themselves and their families;
- The right to a safe workplace and environment for all, so that women are not exposed to hazards that threaten their ability to bear healthy children, or are forced to choose between sterilisation and jobs;
- The right to quality child care, so that women can enter the paid work force secure in the knowledge that their children will be looked after;
- The right to decent medical care;
- The right to choose how to give birth;
- The right to be free of all forms of violence;
- An end to discrimination, regardless of people's race, sex or class.

This broader understanding makes it clear that reproductive rights are predicated on achieving basic rights in almost every sphere of life.

Taken out of these contexts and construed as individual rights in a consumer society, "reproductive rights" are invoked by companies and institutions as a way of promoting pro-natalist reproductive technologies, such as in-vitro fertilisation (IVF), prenatal testing and sex selection. They argue that women have the right not only to bear a child but also to choose its sex, abilities and characteristics.

The US-based group Asian Communities for Reproductive Justice build on the concepts of reproductive health and rights to organise for reproductive justice: women (and by extension communities) having political, economic, social and cultural power to self-determination so that they can survive and thrive.

that had first been articulated in the 1970s and 1980s during campaigns, especially in the United States and Europe, to ensure women had safe and legal access to abortion.¹⁵ The policy had several features. First, it presented “population stabilisation”¹⁶ as a desirable ultimate goal, but one that did not warrant the use of compulsion. Second, it justified national population programmes providing access to contraception in terms of individual human rights and women’s health. Third, it presented women’s empowerment as a prerequisite for the enduring low fertility that population stabilisation requires.

An Alliance of Choice and “Common Ground”

A key player developing and promoting the combination of a neo-Malthusian agenda to reduce fertility rates and a reproductive rights agenda was the International Women’s Health Coalition (IWHC). The IWHC was set up in 1980 when the Population Crisis Committee,¹⁷ a US pressure group lobbying for the US government to grant public funds for population control, gave the US National Women’s Health Coalition, reconstituted as the IWHC, a grant to promote menstrual regulation and early-term abortion in Southern countries.

In June 1993, as part of its attempt to build an alliance between feminists and neo-Malthusians, the IWHC circulated “Women’s Voices ‘94: Women’s Declaration on Population Policies”, a statement drawn up by 25 individuals from a range of women’s organisations outlining the conditions to be met if women’s reproductive health and rights were to be realised.¹⁸

The Declaration’s goals were largely uncontroversial: better health for women and children, women’s rights, more justice and equality, less poverty, better social, sanitary and transportation infrastructure, education, and reproductive health programmes for men.

Its calls for reproductive health and rights, however, were made within a population framework so that it could “be used as a tool to influence governments and international agencies” and give the impression of a “political front” comprising a wide range of women’s groups worldwide who were ready to act “within the official [ICPD] process at international and national levels.”¹⁹ Although many women’s groups then as now were not concerned about reducing population levels, several more mainstream groups accepted the premise that population growth was the root cause of several problems, and that women’s fertility would go unchecked without outside intervention, even while they criticised population policies’ insensitivity to women. The Declaration’s initiators “sidelined [those] radical feminist views” that were critical of making demands for reproductive health within a population reduction framework²⁰ and marginalised those organisations and individuals that refused to sign the Declaration.²¹

The Declaration’s organisers also made concerted efforts to draw support from population organisations (most of which are US-based²²) as well as governments and international agencies such as UNFPA.²³ Many of these institutions were open to the idea of a “feminist population policy” because they had begun to acknowledge that coercion, mistreatment and poor services were driving women away from family planning clinics. Progressive demographers and bureaucrats, many of them women steeped in feminist ideals, wanted to improve family planning programmes and the quality of care that women received. By the early 1990s, a wide network of women in the South as well as the

Profound economic, social and political inequalities lead to reproductive injustice.

Some women’s groups sought an alliance with population organisations, resulting in a combined neo-Malthusian/reproductive rights agenda.

The Programme of Action adopted at the International Conference on Population and Development puts women at its centre.

North in high-level policy and management positions in foundations, non-governmental organisations, and national and international agencies focusing on “population” conceded that education and jobs were more important in reducing women’s fertility than just modern contraception.²⁴

Many were also aware that if Cold War fears had generated political support for population reduction efforts, the collapse of the Soviet Union had dissipated it, and that an increasingly powerful “religious right” in the United States was opposed to abortion, contraception and women’s rights generally:

“Neo-Malthusians reacted to declining interest by reshaping their agenda and . . . by pragmatically casting around for possible allies . . . The new alliance that came to sustain the neo-Malthusian movement was with feminists, and was indeed largely initiated by feminists.”²⁵

It was not that “tactical compromises and unholy alliances” with “mainstream population organisations or neoliberal governments”²⁶ were hard for the women’s movement to avoid, but that they were actively sought out by some groups. One advantage to population groups of this alliance was that the critiques of feminists, long among their most vocal critics, appeared more muted.²⁷

The upshot was that many (but not all) population groups saw the advantage of abandoning demographic targets for national population policies (though not of dropping the goal of reducing women’s overall fertility). They accepted that until women’s status improved, population reduction was unlikely. They agreed that a gender equity strategy could stabilise population levels, and that family planning activities should be supplemented with reproductive health ones, even if this implied that the costs of population programmes would increase.²⁸

The Women’s Declaration was eventually endorsed by some 2,200 organisations and individuals, including the Population Council, the International Planned Parenthood Federation, and some 100 women’s organisations in 23 countries.²⁹ As the president of Population Action International, Joseph Speidel, observed in 1994:

“there is growing recognition that there’s a tremendous amount of common ground among what’s been loosely called the health advocates, coming from a more feminist perspective, and traditional family planners, who come from more of a demography, environment, and development perspective.”³⁰

Sociologists Dennis Hodgson and Susan Cotts Watkins point out that:

“By the time delegates met at the 1994 ICPD meeting in Cairo, a group of American reproductive health feminists had been successful in uniting a large bloc of feminists and much of the population establishment behind the carefully constructed ‘common ground’ agenda”.³¹

The Cairo Programme of Action

The Programme of Action adopted at the 1994 Cairo International Conference on Population and Development reflects this background. For instance, the Programme:

- ***Puts women at its centre.*** “Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of

violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes."³²

- ***Expressly rejected the use of incentives and targets in family planning services.*** "Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients",³³ and family planning should not employ any form of coercion or use incentives and disincentives.
- ***Stressed the need for comprehensive reproductive health services, not just provision of family planning methods.*** The purpose of population programmes is to promote reproductive health by ensuring that women have "the capability to reproduce and the freedom to decide if, when and how often to do so".³⁴ Reproductive health care services should be made accessible through the primary health care system to all individuals of appropriate ages as soon as possible and no later than the year 2015.³⁵ They were to be integrated and coordinated with each other and other health services rather than provided in isolation. They encompassed not only family planning but also safe and legal abortion, care during pregnancy (prenatal and postnatal care, safe delivery, nutrition, and child health), prevention and treatment of sexually transmitted diseases, basic gynaecological care (screening for breast and cervical cancer), sexuality and gender education, and referral systems for other health problems.³⁶

A Useful Lobbying and Advocacy Tool

Although the Programme of Action is "soft law" that is not binding on governments, its rhetoric has consequences. It has proved to be a useful lobbying and advocacy tool for women's reproductive rights and health activists in countries ranging from Brazil to the Philippines, from Argentina to South Africa. They have applied its guidelines and human rights framework to evaluating existing reproductive and sexual³⁷ health services in their countries more rigorously. They have used it to lobby for better quality and access, particularly in contexts where influential institutions, such as those of church or state, limit women's self-determination. Says Ugandan activist Ruth Ojiambo Ochieng, the ICPD:

"achieved a shift in thinking about sexual and reproductive health and rights from being merely about women having control over the number of children they should have, to adopting a life-span approach where sexual and reproductive health includes access to services for all aspects of reproductive health and rights."³⁸

In Brazil, women's groups used it to demand their increased participation in national decision-making processes; in Kenya, to push for changes in property and other civil laws so that women were less disadvantaged; in the Philippines, to lobby for a human-centred health and development approach. Even countries such as China, infamous for its one-child policy of the 1970s and 1980s, has in part shifted towards a reproductive health approach, both in legislation and services provided, because of the Cairo event, contends Chinese feminist researcher Qiqi Shen.³⁹ The Indian government changed the title of its population programme from "Family Welfare" to "Reproductive and Child Health", and declared that it had abandoned the use of targets.⁴⁰

In general, governments now increasingly talk about "reproductive rights", "women's empowerment" and "women's rights", instead of

The Programme of Action adopted at Cairo in 1994 has been a useful lobbying and advocacy tool for many women's movements.

Yet a decade later, the Programme of Action is far from being implemented around the world.

World Bank Influence On Health Policies

The World Bank has long had a major influence on health and population policies through the conditions attached to its loans. Structural Adjustment Programmes (SAPs) usually require public spending, including health spending (but not military spending) to be cut. But even before SAPs were implemented, the Bank "began using its financial muscle to curtail health care delivery systems," says Indian public health researcher Imrana Qadeer.

From 1980, however, under criticism for SAPs, the Bank began lending money to governments specifically for their health services on the grounds that direct intervention in health would increase the "productivity of the poor".

By the early 1990s, the Bank's annual lending for health was averaging US\$1.5 billion, putting it ahead of WHO and UNICEF, the two UN agencies that had taken the lead in international health policies until then. Its loans were invariably tied to a country's

restructuring its health sector in favour of private interests, both for-profit and non-profit. The Bank also extended its influence through country-specific health sector analysis, issue-related research and "policy dialogue".

Underinvestment led to many public health services in Southern countries not being able to provide quality services to all who needed them. Facilities fell into chronic disrepair, essential equipment was missing or broken, drug and surgical supplies were erratic, and health staff were absent because of low and irregular wages.

The solution? More competition in the provision of services. The World Bank's 1993 World Development Report, *Investing in Health*, the Bank's most comprehensive document regarding the health sector, openly advocated one limited and under-funded health care system for the poor, and another high-tech one for those who could pay. It viewed health care not as a need, much less as a right, but as a demand, defined by consumers' ability and willingness to pay.

The report reduces the state's responsibility for health care to providing or financing targeted, discretionary and minimal programmes for the poor, together with those "public goods", such as immunisation, that the market will not provide. It leaves families – in practice, women – to bridge the widening gap between the retrenched state and the inaccessible market.

With reduced funding, the public sector may provide information about, for instance, the importance of eating well and having clean drinking water, but do little more. Says Imrana Qadeer, "the entire onus for public health is thus shifted to the individual".

An emphasis on reproductive rights as individual demands rather than social rights fits neatly with neo-liberal policies that make health an individual rather than collective responsibility. An individual has a right only to whatever health care she or he can afford, and the state has no responsibility to provide it.

"couple protection rates", "family planning methods" or "mother and child programmes". Interviews with national elites in Bangladesh, Ghana, Jordan, Malawi and Senegal indicated that by late 1997 virtually all the respondents were using "the catch-phrases of Cairo fluently", even if there were difficulties in understanding their meaning.⁴¹

International development organisations, meanwhile, have been "reframing family planning programs as reproductive health programs, and population control programs as gender equity programs".⁴² Institutions such as USAID, UNFPA and the World Bank now use language that does not explicitly imply population control and that advocates women's reproductive health and rights and an integrated approach to health services. Supporters of women's rights working within population and aid institutions, moreover, have been able to push a reproductive rights agenda within their agencies.⁴³

A Few Health Services for the Few

Despite these significant changes, the general consensus among women's rights activists is that, a decade later, the Cairo Programme of Action is still far from being implemented. This has variously been attributed to lack of political will on the part of governments or lack of donor funding. But other forces are also at work. Health services in many countries are in decline. The underlying conditions determining women's health and their control over childbearing are deteriorating. Fundamentalisms opposing women's rights are on the rise. And neo-

Malthusian thinking is as ingrained as ever in many development institutions, donor agencies and government departments.

The Cairo Programme of Action calls for family planning programmes to be broadened to reproductive health services provided within primary health care systems. But because of pressures to reduce government spending and service provision, this has not happened. Despite encouragement and support, the (usually unregulated) private sector cannot fill the gap: the commercial sector finds it unprofitable to do so; the non-profit sector does not have the resources to handle the job.⁴⁴ Many women therefore have little or no access to reproductive health services or even any decent health services at all, because they are not provided or are not affordable.

Even before the Cairo conference, influential policy makers such as the World Bank were advocating changes in the role of governments in financing, providing and regulating health services. They were urging cuts in public health services, the introduction of “user fees” for the public services that remained, and incentives to create a “free market” in the health care sector.⁴⁵ The World Bank’s 1993 World Development Report, *Investing in Health* (note the title), proposed that the public sector should provide essential services only as “clinical packages” for the needy and that governments should open up the rest to full global competition. The model health service was like that of the US: a combination of privately-run and -financed curative services with public health programmes targeted at certain classes of patients. The Bank’s report included family planning services in “essential” public health activities, but suggested that “constraints” on the availability of contraceptives should be removed.⁴⁶

In the past decade, “health sector reforms” in many countries have followed the World Bank’s approach: vertical, disease-oriented programmes,⁴⁷ limited public expenditure on a narrowly-defined package of services; user fees for public services; and privatised health care and financing.⁴⁸ “Reform” has focused exclusively on the cost and economic value of public health services⁴⁹ to the detriment of ensuring that everyone has access to the health care they need, and often has “little or nothing to do with economic justice or human rights”⁵⁰ or “health care for all”.⁵¹ The basic package of health services that public health systems now attempt to provide – family planning (primarily to women), prevention and treatment of sexually-transmitted diseases, child health, control of communicable diseases and some curing of diseases – is much narrower than the essential services outlined in the Programme of Action.⁵²

Meanwhile, the goal of gender equality, women’s empowerment and reproductive and sexual health outlined in the Cairo Programme of Action is conspicuously absent. Health researcher Meredith Turshen comments that women’s health care has been reduced:

“to services during childbirth, showing once again that women are valued only for their reproductive role. Governments will subsidise family planning services, but, because little money is intended for physician services (or the training of nurses and midwives in these tasks), women will receive contraceptives without medical supervision.”⁵³

Cairo Undermines Itself

The Cairo Programme of Action went along all too readily with the World Bank approach. It accepted the neo-liberal economic approach

Many women have little or no access to decent health services: they are either not provided or not affordable.

The Programme of Action's neo-liberal economic approach undermined its groundbreaking principles and rights agenda.

to the detriment of its rights agenda, and urged governments to introduce user fees in health services and social marketing schemes⁵⁴ aimed at distributing contraceptives. It encouraged governments to “promote the role of the private sector in service delivery and in the production and distribution . . . of high-quality reproductive health and family planning commodities and contraceptives”⁵⁵ and urged countries to “review legal, regulatory and import policies . . . that unnecessarily prevent or restrict the greater involvement of the private sector”.⁵⁶ These aims undermined the Programme’s own groundbreaking principles and goals of reproductive health, as did its recommendations that the bulk of available resources should be allocated to family planning within publicly supported services while the market should be relied upon for everything else.

Introducing competition and new costs into the health sector, after all, discriminates against the poor and sick who are most dependent on publicly-provided health care.⁵⁷ Studies from Ghana, Swaziland, Zaire and Uganda suggest that user fees result in decreased use of public health services, especially by poorer people and women. One outcome has been a rise in maternal and infant mortality rates.⁵⁸

In Zimbabwe, for instance, one of the first African countries to “reform” its health sector, user fees have been linked to a marked fall in women’s attendance at ante-natal clinics and a doubling in rates of women dying in childbirth.⁵⁹ Similar results have been observed in Tanzania and Nigeria. In Swaziland, attendance at government facilities to treat sexually transmitted diseases dropped when fees were introduced, without an accompanying increase at mission hospitals.

User fees come on top of other costs. In Uganda, for instance, poor rural communities had to consider not only user fees, which were relatively low, but also a wide range of informal, illicit payments to health staff – effectively subsidies to underpaid health workers.⁶⁰ Women going into hospital to give birth had to take their own latex gloves, water, soap, syringes and plastic sheets.⁶¹ Medicines, food and transport to hospital are other considerations. In Bangladesh, even though

Unregulated Health Care, Unavailable Insurance

The deterioration in public health systems over the past two decades has encouraged the creation and expansion of private primary health care in many low income countries in sub-Saharan Africa and Asia (sometimes with government support). Involved are not just for-profit groups but also traditional healers, non-profit women’s groups, churches and local pharmacies.

Much of this largely informal, small-scale market for health services is unlicensed, uninspected and unregulated, and involves the widespread sale of drugs without prescriptions.

Many people are now faced with heavy out-of-pocket spending for health care, whether for public sector charges (formal and informal) or to gain access to

private providers and commercial medicines. In 2002, the government of India noted that just 17 per cent of health expenditure is public, while 83 per cent is from patients’ pockets.

More private health insurance is now touted as the answer. In low-income countries, however, there has been negligible development of insurance schemes or hospitals, either private or social, to pay for such health care. Private sector suppliers tend to be individuals and small firms; the market is too small for corporate capital.

Private health care insurance is becoming more prevalent in middle income countries, but women often have less access to it than men because they are more likely to be dependants, not to be in formal employment or to have chronic

illnesses (and thus to be refused cover).

Insurance schemes vary greatly in their reproductive health cover. Many do not cover preventive care, while maternity cover varies considerably. Under most private schemes, either childbirth is not covered, or women pay a higher premium than men. Under some schemes, however, women have more Caesarean births and hysterectomies without valid medical indications.

Source: Mackintosh, M., “Health Care Commercialisation and the Embedding of Inequality”, RUIG/Unrisd Health Project Synthesis Paper, September 2003, www.unrisd.org.

maternity care is free, the average cost for a normal delivery in the capital, Dhaka, has been estimated at one-quarter of the average monthly household income; one-fifth of families surveyed spent from half to all of their monthly income on a hospital delivery.⁶² Poorer people have to set all these health care costs against other goods and services they need to buy, such as food. Moreover, women who do not have their own access to cash find it harder to access health care services for themselves or their children.

Out-of-pocket expenditures by individuals and families now account for more than half of health care spending in many countries. Families are going into debt, consuming less food or taking girls out of school. One of the most common causes of rural indebtedness in India is now the cost of medical care.⁶³ If not having health care is one of the causes of poverty, so is having to pay for it.⁶⁴

Many people may simply not use health care services at all – and it is women of reproductive age who are most likely to leave untreated conditions, such as reproductive tract infections, that are chronic but not incapacitating, contributing to greater disease and cost burdens at a later stage.⁶⁵

Reproductive Health Services Within A Free Market

Country surveys carried out by several women's organisations conclude that one reason the Cairo Programme of Action's recommendation for comprehensive reproductive health care services to be provided within the primary health care system is far from being implemented is that health infrastructure, particularly in Southern countries, has deteriorated so rapidly in the past decade. In many areas, there are no primary health care facilities through which reproductive health care services could be implemented, or only shambolic ones. The Programme of Action did nothing to reverse the damage to primary health care that SAPs were causing, even with funds continuing to flow for family planning.⁶⁶

A 50-country survey of government action on women's health carried out in 1999 by the Women's Environment and Development Organisation (WEDO), a network of women's groups and activists around the world, pointed out:

“All respondents . . . cite economic reforms as paramount constraints in implementing the ICPD Programme. Health sector reform in particular is emerging in most countries as a challenge to expansion of reproductive health services.”⁶⁷

Another survey found that widespread cost recovery schemes and privatisation of health care services “keep the poorer populations (rural, women, old persons) away from hospitals and health centres”.⁶⁸ Most of the 23 countries surveyed in five geographical regions were dependent on international aid, but aid donors were reluctant to fund health infrastructure, while structural adjustment requirements were curtailing domestic investment in them.

Moreover, according to the Asia-Pacific Resource and Research Centre for Women:

“The new global economic context has badly affected sexual and reproductive health worldwide causing a decline in health education, [increased] delivery of reproductive health services

The 1994 Cairo conference promoted the privatisation, commodification and deregulation of reproductive health services that had diminished women's access to them in the first place.

Having to pay for health care can cause poverty – and so can lack of health care.

by private doctors, overpriced drugs and the ineffective self treatment of reproductive tract infections to name a few”.⁶⁹

Women’s groups around the world are now well aware that health sector reforms are affecting women’s access to health services – and that many policymakers are either unwilling or unable to integrate reproductive health services into national health systems.⁷⁰ Yet merely calling upon policymakers to do so is ineffective in challenging the interests behind the reforms. Nor does it clarify the reasons why

Women and Structural Adjustment Policies

The debt crisis in the early 1980s, triggered by reckless lending by Northern banks and the prospect of instability in the international banking system, provided the backdrop for Structural Adjustment Policies (SAPs). The International Monetary Fund and the World Bank stepped in to pay off developing country loans and provide new loans on the condition that the countries adopted economic policies that, they claimed, would generate “economic growth”.

SAPs were first introduced in Latin America in the late 1970s, then in Africa and, during the late 1980s and 1990s, much of Asia. They required a range of public services and utilities, including health care, energy, water, food distribution, transport, price controls and education, to be reduced, closed down, sold off or commercialised in various ways. Lifting price controls, freezing or lowering wages, devaluing local currencies and reducing subsidies on basic essentials all made it harder for ordinary people to obtain food, transport, education and health care.

SAPs also required countries to import and export more: to let more goods and food in and to produce more goods and food for sale abroad to earn foreign exchange, particularly dollars, to pay back their debts (even though commodity prices were falling and have continued to do so). Reorienting peasant agriculture toward exports created a scarcity of locally-produced food – the only nutritious foods readily available for many people in Africa, particularly for women, children and the elderly.

Women in many countries found it harder to keep up with subsistence provisioning and feeding their households.

In many countries, more

women than men tended to lose their jobs when public expenditure was cut back as more of them were employed as teachers, nurses or in public administration. Women were displaced from domestic industries, such as textiles, by the import of cheaper goods and services.

Many of the new jobs they took up in export industries were unskilled and low-waged. Women make up 90 per cent of the 27 or so million workers in Free Trade Zones. When low-skill and labour-intensive manufacturing industries become more capital- and skill-intensive, men or machines tend to be employed instead of women, who are left in subcontracted, home-based or informal jobs.

Women certainly gained some freedoms from becoming cheap labour in factories, but they also became more exposed to machine-related accidents, dust, noise, poor ventilation, exposure to toxic chemicals and sexual abuse. Such stress can lead to miscarriages and poor foetal health. Whether jobs mean increased power for women depends on whether they control the income and whether the jobs are regular, contractual or seasonal; self-employed or waged; factory or home-based; and full-time or part-time.

Many women left their homes in huge numbers to look for work; rural-to-urban, and urban-to-urban migration began to rise.

More women began to travel abroad to find work as well. Many women from the Philippines and Nigeria, for instance, went to the Middle East, Europe or Japan to work as nannies, domestic help or sex workers.

In many countries, women engaged more in “transactional sex”, making them more vulnerable to sexually-transmitted diseases. Many commentators link the increasing commodification of

sexuality, trafficking in women and girls, and prostitution with the neo-liberal economic agenda, as women and girls have fewer options to earn livelihoods. All of these processes facilitate the spread of HIV and AIDS, undermining women’s reproductive health and rights still further.

An estimated two million people worldwide are trafficked each year, the majority of them women and children.

In the late 1980s, UNICEF produced a striking series of studies documenting the negative impact of structural adjustment policies on employment, poverty, nutrition, health and school enrolment rates among the poor in the countries of Latin America and Africa. In nearly all countries, standard public health indicators such as life expectancy, and infant, child and adult mortality, had begun to drop.

UNDP reports that about one in three of the world’s people are malnourished – including 55 million people in industrialised countries. On current trends, some 3.7 billion people will be malnourished within 30 years.

Cuts in public expenditure have led to a drastic decline in disease control and prevention measures and a resurgence of cholera, yellow fever and malaria, for instance in sub-Saharan Africa.

Economist Michel Chossudovsky attributes the outbreak of bubonic and pneumonic plague in India in 1994 directly to:

“a worsening urban sanitation and public health infrastructure which accompanied the compression of national and municipal budgets under the 1991 IMF-World Bank sponsored structural adjustment programme”.

governments have less money for health care,⁷¹ why politicians believe free markets are the best way to provide health care, nor that the reforms are linked with other global financial and trade processes, agreements and interests.⁷²

Neo-Liberalism's Impacts on Health

As Peggy Antrobus of Development Alternatives with Women for a New Era (DAWN), an international feminist network of Southern activists, has argued, neo-liberal economics depends upon the exploitation of women. The problem is not just that it assumes women are “outside of development and need to be brought in (via accompanying compensatory programmes)” but that it is “grounded in a gender ideology which is deeply and fundamentally exploitative of women’s time/work and sexuality.”⁷³

Since women tend to be more economically disadvantaged than men in many countries,⁷⁴ they also tend to suffer more from Structural Adjustment Programmes (SAPs) and the requirements of bilateral, regional and international neo-liberal trade agreements, such as those of the World Trade Organisation, that reduce their access to food, clean water, sanitation, decent housing, livelihoods, quality education, and a healthy working and living environment (*see* Boxes: “Women and Structural Adjustment Policies”, p.12, “Trade Encroaching on Health”, p.14, and “Why Trade Liberalisation Is Not Gender-Neutral”, pp.16-17).⁷⁵

And as Imrana Qadeer points out, when neo-liberal economic policies are implemented “the family, particularly women within it, acquire the role of shock absorbers in the absence of any other form of social security”.⁷⁶

The result has been a rise in women’s poverty and ill-health. A large proportion of maternal and infant deaths in India, for instance, is attributable not to a lack of contraception, or even little or no access to quality health care services, but to undernutrition, anaemia and communicable diseases stemming from lack of food, poverty and inequity.⁷⁷ Access to the three-monthly injectable contraceptive, Depo-Provera, or an IUD, cannot compensate for this ill-health, and can even exacerbate it.⁷⁸ Women cannot exercise their reproductive rights unless other fundamental rights – to food, work, freedom of movement and education, for instance – are met.⁷⁹

At the end of the 1975-1985 UN Decade for Women, when the impacts of structural adjustment policies were becoming evident, a group of women activists, organisers and researchers concluded that:

“with a few exceptions, women’s relative access to economic resources, incomes and employment has worsened, their burden of work has increased, and their relative and even absolute health, nutritional and educational status has declined.”⁸⁰

A Report of the Commonwealth Expert Group on Women and Structural Adjustment categorically attributed a general decline in women’s nutrition and health in many Southern countries, especially in Sub-Saharan Africa, to IMF/World Bank structural adjustment programmes.⁸¹

Cairo Endorses Neo-Liberal Policies

Yet neither the Cairo Programme of Action nor its institutionalised concept of reproductive rights addressed the forces that were having such

Women are the shock absorbers when neo-liberal economic policies are implemented.

Women cannot exercise their reproductive rights unless other fundamental rights are met.

Trade Encroaching on Health

In the decade since the 1994 Cairo International Conference on Population and Development, many structural adjustment measures have become entrenched within bilateral, regional, multilateral and international trade agreements. While the World Bank may influence health policy and health systems more directly, the World Trade Organisation (WTO), the body governing international trade that came into being in January 1995, has arguably become the international agency having the greatest impact on the underlying conditions required for health.

Today's trade agreements govern not only tariffs and quotas on the export and import of manufactured goods (as they have done for 50 years); they also cover agricultural products, services, intellectual property rights, government procurement and overseas investment.

Many of these agreements

require countries to allow competition in health care, water, education and energy services, opening up the way for privatisation and commercialisation.

The privatisation of drinking water supply has become a key trade issue. Because of their responsibilities in the household, women tend to have a higher dependency on access to sanitation and clean drinking water – and are thus more susceptible to water-borne diseases. Recent outbreaks of cholera in South Africa and Latin America have been linked to the privatisation of the local water supply.

Through intellectual property restrictions, trade agreements can restrict a country's access to medicines or make them more expensive.

Domestic laws and regulations intended to protect health or the environment can be treated as obstacles to trade and have to be weakened or abandoned to comply with trade agreements. Thus

instead of banning a harmful substance or product, or restricting its advertising, a government may be confined to putting a warning label on it.

The WTO's General Agreement on Trade in Services (GATS) empowers a WTO dispute panel to decide whether domestic regulations, such as those governing hospitals, are "necessary" or not. Licensing requirements and professional qualifications, including those of health professionals, also come under its remit.

Sources: Koivusalo, M., "The Impact of WTO Agreements on Health and Development Policies", GASPP Policy Brief No. 3, January 2003, Helsinki, www.gaspp.org/publications/policybrief3.pdf; Corner House Briefing 23, *Trading Health Care Away? GATS, Public Services and Privatisation*, The Corner House, July 2001, www.thecornerhouse.org.uk

a negative impact upon the determinants of health other than to endorse them.

The Programme of Action did recognise the devastating impact that SAPs, public sector retrenchment and the transition to market economies had had on health, especially among the poor. And it urged governments to improve structural conditions that have an impact on health, such as housing, water, sanitation, and workplace and neighbourhood environments. Yet, as with its health service recommendations, to implement all these goals, the Programme opted for the very neo-liberal market-oriented policies that had widened income, mortality and morbidity gaps between and within countries in the first place. It did not calculate how much funding would be needed for primary health care, emergency services, education, sanitation, water or housing – yet did cost out family planning.

The Programme of Action defined "reproductive rights" as the right of women "to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so". Yet it did not explain, as US political scientist and activist Rosalind Petchesky points out, how a woman can:

"avail herself of this right if she lacks the financial resources to pay for reproductive health services or the transport to get to them; if she is illiterate or given no information in a language she understands; if her workplace is contaminated with pollutants that have an adverse effect on pregnancy; or if she is harassed by parents, a husband or in-laws who will abuse or beat her if they find out she uses birth control."⁸²

Moreover, in its advocacy of the education of women and girls and of gender sensitive health services, the Programme ignored “the deep-lying imbalances of power and the social structures and practices of subordination that characterize relations between women and men in most societies.”⁸³ As health and reproductive rights activist Jael Silliman points out, women’s rights and reproductive rights were promoted only “within the context of the dominant neoliberal agenda, which negatively affects women’s health and aspirations for empowerment.”⁸⁴

The upshot, according to Petchesky, was that the Programme of Action, despite its “groundbreaking advances”, was “fragile and contradictory” because it failed “to address macroeconomic inequities and the inability of prevailing neoliberal, market-oriented approaches to deliver reproductive and sexual health for the vast majority.” These fault lines “continue to block any real progress in transforming the reproductive and sexual health/rights agenda from noble rhetoric into actual policies and services.”⁸⁵

Indeed, putting reproductive health and rights at the centre of population policies has encouraged policymakers to continue to think of women only as wombs to the neglect of their wider economic and social roles, and of the conditions that could advance health for women. Indian public health specialist Imrana Qadeer believes that the ICPD “converted women’s health into issues of ‘safe abortion’ and ‘reproductive rights’” and “marginalised the issue of comprehensive primary health care, social security and investment in building infrastructural facilities”.⁸⁶ She argues that policymakers (and many reproductive rights activists):

“never really examined either the epidemiological basis of reproductive health or the reasons behind some women’s silence vis-à-vis reproductive health problems. Had they done so, the immensity of women’s health problems and social constraints on women’s lives would have revealed the inadequacy of their isolated strategy in the context of the expressed needs of women for land rights, freedom from atrocities, food, security systems, minimum wages and communal harmony”.⁸⁷

Indian public health activist and academic Mohan Rao goes further to argue that “under the rhetoric of reproductive rights, the rights of the vast majority of women to access to resources, the most basic determinant of health, are being denied.” When reproductive rights are divested of rights to food, employment, water, health care or security of children’s lives and taken out of the contexts of women’s and men’s lives, they “fit in well with the neo-liberal agenda of the day”.⁸⁸

What is needed instead, Women’s Global Network for Reproductive Rights (WGNRR) and DAWN among others have long contended, is a framework firmly linking reproductive and sexual health issues to both human rights and macroeconomic policies. Access to contraceptive information, safe and legal abortion, services to prevent and treat sexually transmitted diseases and reproductive cancers, prenatal care and mental health services needs to be combined with “access to housing, education, employment, property rights and legal equality in all spheres” as well as “freedom from physical abuse, harassment, genital mutilation and all forms of gender-based violence”.⁸⁹ In the run-up to the Cairo ICPD, Loes Keyzers from WGNRR stressed that:

“reproductive health and justice . . . has to do with contraceptive services, with eradication of hunger, with education, with health, with income, with clean water, etc. All of which can be achieved only in a completely overhauled system.”⁹⁰

The Cairo conference embedded women’s rights within a neo-liberal agenda to the detriment of women’s aspirations for justice and empowerment.

Reproductive rights lobbyists did not pay enough attention to the contexts in which rights were to be realised.

Why Trade Liberalisation

"Nowhere at the policy level is the disjuncture between the reproductive and the productive spheres more apparent than in the area of international trade. Most often, international trade is seen as a technical, class-and-gender-neutral process . . . Yet, none of this can occur without the involvement of women's and men's labor. None of this can occur without the active involvement of the reproductive sector in producing food for domestic consumption, in producing and nurturing labor, and in caring for the environment."

Mariama Williams
International Gender and
Trade Network
August 2003

Agriculture

The World Trade Organisation's Agreement on Agriculture (AoA) has been instrumental in liberalising world agriculture over the past decade. The stated aim of agricultural trade agreements is to facilitate exports in two ways: by improving market access to other countries by removing those countries' quantitative import restrictions and lowering their domestic tariffs on agricultural commodities; and by reducing export subsidies and domestic farm supports considered to be "trade distorting". The AoA, however, allows the European Union and United States to maintain (and increase) their import restrictions, high tariffs and subsidies to their farmers, enabling them to export more to the South, while limiting Southern subsidies and exports.

In many Southern contexts, women farmers realise little or no benefit from increased production of cash crops for export, since they are primarily involved in agriculture for household consumption or local sale. Approximately half

the world's food is grown by women who are primarily responsible for feeding their families. In Africa in 1995, women contributed up to 80 per cent of total food production, yet received less than 10 per cent of the credit granted to small farmers. A decade ago, moreover, agriculture accounted for 62 per cent of all female employment in Southern countries. Still in the year 2000, UNIFEM estimated that 60 per cent of the work in agriculture and food production in Asia is done by women.

Because women's access to land and other inputs tends to be limited by traditional land tenure systems, or by legal systems assigning title to agricultural land to the "head of the household", women typically have limited access to credit, extension services and other inputs for cash crops. If they do help out with cash crop production, it is generally as unpaid family labourers. Giving over some of the land they do use for cash crop production, moreover, may further weaken their property rights and threaten their household's food security.

Meanwhile, as domestic agriculture in several Southern countries cannot compete with highly-subsidised imports, millions of poorer farmers, women and men, have been displaced. In many Asian countries, the rice, corn, soyabean and vegetable sectors have been among the worst hit. In the Philippines, for instance, corn imports tripled between 1995 and 2003, forcing many corn farmers to abandon or sell their farms and migrate to the cities or overseas. Women tend to bear the brunt of finding other livelihoods and feeding their families. The majority of the 7.3 million migrants from the Philippines who work overseas are women.

The resulting land concentration and expansion of TNC-controlled commercial crop production has further exacerbated women's lack of access to land, water, seeds and other inputs. Patent rules laid out in the WTO's Agreement on Trade-Related Intellectual Property Right (TRIPS) could restrict still further farmers'

access to seeds, plants and inputs (as well as to medicines and pharmaceutical drugs). Industrialised countries own most of the 900 and more patents that have been granted on the five crops that contribute to three-quarters of the world's food supply.

Despite growing evidence that agricultural trade liberalisation has worsened rural poverty, devastated agriculture and the livelihoods of poorer farmers and rural women, and deepened gender and class inequalities, exporting countries are pushing for further market access in the current renegotiations of the Agreement on Agriculture.

Manufacturing and Investment

Trade liberalisation in Southern countries has undoubtedly increased paid work opportunities for many women. In the year 2000, almost 35 per cent of the manufacturing work force in Latin America were women, 41 per cent in Asia and 28 per cent in Africa. In the export industries of South-East Asia, women account for more than 80 per cent of the work force. Much of this increase is concentrated in export-oriented industries where electrical components are assembled, textiles are processed, and garments and shoes produced.

But there are significant differences in wages and conditions for women and men. Women tend to have less skilled jobs, their wages are rarely above poverty levels, and their working conditions are unsanitary and abusive. Women also predominate in the informal sector.

Many Southern countries have revised their commercial and investment laws as part of bilateral investment agreements to encourage foreign direct investment (FDI). The result has generally been to eliminate rules governing minimum local

Is Not Gender-Neutral

content, trade balancing, access to foreign exchange, and repatriation of dividends.

Import substitution policies, adopted by many countries in South America and Asia in the 1960s and 1970s to encourage domestic production of consumer goods and maintain a balance of payments through barriers on certain imports and foreign exchange restrictions on foreign investors, would now be illegal under WTO agreements.

Women tend to work more in industries in which capital is more mobile, which are more sensitive to foreign competition and which are most affected by economic downturns. They are more likely to be laid off in contexts in which men are perceived as the breadwinners. During such downturns, women's unpaid work within the household increases to compensate for lower overall household incomes, as does their employment within the informal sectors – they in effect bail out creditors while acting as unpaid provisioners of last resort.

The risk of such downturns has been augmented by the increasing ease and speed with which capital can flow into and out of a country.

Although textiles and clothing have just a 6.3 per cent share of world trade, their trade is particularly important to Asian countries, which account for 60 per cent of textile and clothing exports, although the industry is dominated by giant retailers and super-label companies from industrialised countries.

The WTO's Agreement on Textiles and Clothing requires industrialised countries to phase out their quotas and restrictions on imports by 2005, but the research group Women Working Worldwide believe "there is a very real chance that industrialized countries will find ways of introducing new forms of protectionism."

Some countries, such as China, India, Pakistan and South Korea, will gain from implementation of this Agreement, but smaller economies such as Bangladesh are likely to lose out in a quota-free environment, as are those which import fabrics, such as Thailand, Sri Lanka and the Philippines. The

Agreement will enable transnational companies to become even more flexible and mobile in their operations. It is likely to cause a further relocation of garment production from North to South, and within the South itself. Poorer countries could lose their entire textiles and clothing industries altogether.

As researcher Maria Riley concludes, increased trade in textiles and clothing is thus "a mixed blessing or curse from the point of view of women workers" because of the industry's low pay, long hours, seasonal work, job insecurity and unsafe working conditions.

Services

The explosive growth in services in many countries has generated paid employment primarily for women. In Latin America, three-quarters of women paid workers are concentrated in services. Jobs in service industries tend to yield higher incomes and better working conditions than manufacturing jobs – but women are still relegated to certain jobs, receive lower wages and experience more job insecurity than men. When the Asian financial crisis hit the Philippines in 1997, fewer women than men were laid off in the already feminised service sector, and some women took over men's jobs because they accepted lower pay, longer working hours and double shift jobs.

The WTO's General Agreement on Trade in Services (GATS) outlined rules on trade and investment in services for the first time. In practice, it "locks in" service liberalisation. The Agreement may well encompass public sectors, such as education and health, which tend to employ more women than men.

Eliminating restrictions on financial services, which has been promoted under the WTO, has generally failed to increase women's access to credit, or expand their opportunities to use domestic savings.

Women have less access than men to formal financial services, such as bank loans, because they

generally require smaller amounts of money or have fewer assets to serve as collateral. In some countries, they cannot obtain bank loans without their husband's approval.

Women thus continue to rely more on the informal financial sector – specialised moneylenders, pawnbrokers, savings and credit associations – which is characterised by a lack of regulation and supervision, and is dominated by providers offering loans at very high interest rates.

Although GATS supposedly levels the playing field, local providers will be hard pressed to compete with powerful transnationals, particularly in the telecommunications and banking fields.

Health and Safety

The WTO's requirement that health and safety legislation must not restrict trade could affect women disproportionately by undermining regulations governing pesticides. Women agricultural workers and partners of men using pesticides have increased incidence of miscarriages, still births, delayed pregnancy and birth defects. Women are disproportionately at risk from pesticide residues in food because they have higher levels of body fat where pesticide residues concentrate.

Sources: International Gender and Trade Network website: www.genderandtrade.net; Development Alternatives with Women for a New Era (DAWN) website: www.dawn.org.fi; Gammage, S., Jorgensen, H., McGill, E. and White, M., *Framework for Gender Assessments for Trade and Investment Agreements*, Women's EDGE, Washington, DC, 2002, www.womensedge.org.

Economic fundamentalism has enabled religious and ethnic fundamentalisms to gain ground.

Today's intertwined market and religious fundamentalisms are dismantling women's rights.

Many more women's groups now work more extensively on macro-economic and trade issues, but even in the early 1990s, several groups were stressing that they had to be addressed.⁹¹

Women's groups have also tended to focus on single-issues such as reproductive and sexual health, violence against women, or women's labour and economic conditions, and not to interact sufficiently with those outside their focus. But as New Zealand lawyer Jane Kelsey concludes:

“Those who focus on narrow sectoral concerns and ignore the pervasive economic agenda will lose their own battles and weaken the collective ability to resist”.⁹²

Backlash and Fundamentalisms

Many women's rights activists lobbying a decade ago for reproductive and sexual rights did not, in short, pay sufficient attention to the structural and macroeconomic conditions for those rights. One reason was that, in the early 1990s, both feminists and the population establishment were diverting “disproportionate energy towards combating . . . fundamentalist and traditionalist attacks” on women's rights.⁹³

Yet the impacts of “economic fundamentalism”, particularly the insecurities and exclusions created by neo-liberalism, have enabled religious or ethnic fundamentalist movements and groups:

“to gain more of a hold in both the North and South. In the South these forces feed on insecurities created by the loss of livelihoods in urban and rural areas evoking explicitly anti-women sentiments as a way to provide cultural identity . . . In the North, people's sense of economic insecurity and the loss of self in the mire of consumerism has led to a rise in fundamentalist right-wing groups that are sexist as well as racist and xenophobic.”⁹⁴

“At ground level,” Brazilian reproductive rights researcher and activist Sonia Corrêa says, the growth and violence of traditional fundamentalisms “are directly related to the outcomes of market-oriented globalization.” In global arenas such as official policy circles, meanwhile, their virulence “can be interpreted as a response to ‘our agency’”.⁹⁵

In what can be seen as a backlash against the Cairo framework and its human rights approach, for instance, the United Nations, in consultation with the IMF, World Bank and OECD (but not “civil society”), ignored the Programme of Action's goal of reproductive health services being accessible to all women who need them by the year 2015 when it drew up its eight Millennium Development Goals in September 2001.⁹⁶ Even sections of the women's health movement that had supported feminist population policies expressed disillusionment. As the journal, *Reproductive Health Matters*, commented, “Thus does 25 years of international work for women's health vanish into thin air not with a bang but a whisper.”⁹⁷

In the United States, meanwhile, as a result of far-right pressure, President George W. Bush's first official presidential act in 2001 was to reimpose a measure known informally as the “global gag rule”. This prohibits any NGO overseas from receiving US government aid if it provides or makes referrals for abortions, actively promotes abortion, or lobbies for reform of its country's abortion laws.⁹⁸ In 2002, the US administration refused to pay its approved \$34 million contribution to UNFPA. The US has now called for all language referring to

reproductive health services, reproductive rights and sexual health in the Programme of Action to be removed. DAWN contends that “since the Bush administration took over in the US, every negotiation [such as those at UN conferences on AIDS, children, and sustainable development] that relates to women’s human rights has been the scene of enormous struggle”.⁹⁹

Limits to Reproductive Rights in New Zealand

In the 1990s in New Zealand, a highly-developed national health service was commercialised. The government continued to fund health, but began to purchase services from either publicly-owned or private providers, both competing with each other for tenders. No effective quality control or safety checks were built into the contracts – such measures increase cost, decrease profits and interfere with market signals.

Laboratories were among the first parts of the health service to be privatised outright. They were supposed to be accredited, a process that cost the laboratories money, but no one in government was made responsible for checking that they were.

In 1991, as the health service was being restructured, persistent pressure from the organised women’s health movement resulted in a free nationwide programme to screen for cervical cancer being set up. If detected and treated in time, cervical cancer can be prevented. The programme received enthusiastic support from women, especially in communities such as Gisbourne, the world’s easternmost city, where Maori women had an especially high death rate from the disease.

This public health programme, however, was at odds with the emerging health care structure, which encouraged private care and individual responsibility. The local government in Gisbourne contracted out the actual screening of the smear tests to a private laboratory, which had not been accredited. Then, in the mid-1990s, the Ministry of Health disbanded its training programme for cytology screeners. Its contracts no longer required labs to use

trained screeners, enabling laboratory companies to employ cheaper, untrained labour.

At the same time, the Gisbourne public hospital began to shift its budget away from the cervical screening programme to deal with a flood of drug and mental health issues overwhelming the community, partly as a result of cutbacks in health services.

As a result of all these changes, some smear tests were outsourced to unqualified screeners, some of whom read them on an antiquated microscope on a kitchen table. The price was right – but more than 80 per cent of invasive cancers were not identified accurately.

When a gynaecologist at the public hospital tried to find out why the cervical cancer rate was staying so high in Gisbourne despite the screening programme, she was professionally isolated and ignored. In a fragmented, commercialised health system concentrating on a narrow range of tasks defined by contracts, she had no remit to ask such questions, nor did the relevant health authority provide her with any information.

The failure of the cervical screening programme, the most tangible achievement of the country’s organised women’s health movement, suggests advances in reproductive health will be limited in a public system re-structured to fit the precepts of the global marketplace. The New Zealand programme did not serve women’s interests but those of emerging lab companies that needed to win contracts away from public hospital labs in order to make profits.

Individual versus Social Rights

Even legal recognition of reproductive and sexual rights may not count for much when comprehensive material support

for women’s lives has drained away because of an economic restructuring that created huge inequalities and undermined public services. In New Zealand, contraception and abortion are legal and free in some cases. Maternity services and healthcare for all pre-school children are free. Parental leave and benefits are relatively generous. But many people have lost access to key health services that would make those rights a reality in practice.

By the same token, New Zealand has the highest representation of women in public life anywhere in the world. Yet it is also experiencing new levels of poverty associated with unprecedented levels of unemployment and job losses unmitigated by any welfare. Most families were worse off in real terms in 2000 than they had been in 1984 when economic restructuring began. For the one-third of women and children who now live in poverty, this is having a growing impact on their bodies.

The New Zealand experience illustrates that individual legal rights cannot promote freedom unless those rights are realised through political action and guaranteed by society. Women’s health campaigners who have used the language of individual rights often simply assumed the continued existence of social welfare and a public health system. In doing so, they echoed the economists’ language of the individual right to sovereignty in the marketplace, which was aimed at reducing the role of the state in providing health services.

This is an edited extract from Bunkle, P., “The Limits to Sexual and Reproductive Health Rights in a Corporatized Global Economy”, *Development* (special issue on Globalization, Reproductive Health and Rights), Vol. 46, No. 2, June 2003, pp.27-32.

The Women's International Coalition for Economic Justice link the attempted dismantling of the reproductive rights agenda to today's intertwined fundamentalisms – the fundamentalism of the market, and ethnic and religious fundamentalism.¹⁰⁰ Both can cause women to lose not only their livelihoods, economic security and much of what

Public Good or Private Profit?

The Cairo Programme of Action exhorts governments to work more closely with the private commercial sector to provide reproductive health care services.

But does the commercial sector want to? And if it does, what are its terms and conditions for doing so?

In theory, the interests of population controllers and commercial contraceptive manufacturers should coincide. The "populations" that are of most interest to the commercial sector are the very "populations" regarded as most problematic by neo-Malthusians: countries with large numbers of people, and countries with high urban densities.

"Population size is key to commercial interest. To remain viable, businesses . . . must have a potential market large enough to generate sufficient revenue to cover their costs. Developing countries with larger populations [Egypt, Mexico, Brazil and Indonesia] thus tend to attract more interest from commercial firms."

Remote or sparsely populated areas are, meanwhile, of little interest as "expected sales volume is not high enough to cover the costs of promotion and distribution".

Yet, as a report from US-based Population Action International on "reproductive health commodities" shows, it isn't so easy to "slow population growth" by providing contraception within a market economy. One problem is that:

"Contraceptive manufacturers earn just 20 per cent of their revenues from sales in developing countries, even though two-thirds of the world's contraceptive users live in the developing world.

'In many poorer countries,' observes one pharmaceutical company executive, 'people just don't have the wherewithal to pay market prices for reproductive health products.'"

Only 12 per cent of all family planning users in the South (50 million women) obtain contraception from commercial sources, and less than one per cent in China, which has one of the largest population programmes in the world.

A second problem is that population controllers have historically favoured long-acting or permanent methods, such as five-year implants or sterilisation. Yet there is far less money to be made from such methods than from short-acting, frequently-consumed contraceptives such as the Pill. As the report notes:

"Almost half of women using temporary methods that require regular resupply of commodities – for example, oral contraceptives – obtain their method from a commercial source. However, the for-profit sector serves fewer than 10 per cent of women using longer-acting methods such as sterilisation and IUDs."

Thus as a result:

"oral contraceptives account for fully two-thirds of the revenues generated by world-wide contraceptive sales – with 90 per cent of revenues from oral contraceptive sales coming from *developed* countries . . . [M]arkets – and potential for profits – for other contraceptive methods remain relatively small".

To get commercial enterprises more involved in reproductive health services, the report recommends five strategies.

i) Target Public Programmes at the Poor

First, public programmes should be concentrated in "low income communities and rural areas" – not because they are the most needy but because they "are least likely to attract commercial interest." The report thus hands over to a public sector already hampered by lack of funding or regulatory power the responsibility to pick up the pieces that the commercial sector leaves behind.

By the same token, the report continues, the public sector should stay away from middle- and upper-class urban "consumers" lest it inhibit the development of commercial markets. In Nigeria, for instance, a country frequently described as the most populous in Africa, free contraceptives supplied by international donors and distributed by the public sector undermined the "commercial sector business strategies" of multinational drug companies.

ii) Lower Legal and Regulatory Barriers

Second, the report cautions, it is unwise to promulgate laws and regulations that "limit the provision of family planning and reproductive health care on a profit-making basis" – bans on certain products or services; requirements that products, such as hormonal contraceptives, be dispensed by physicians only; and restrictions on where and by whom products can be sold.

Of injectable hormonal contraceptives, the report states that:

"the need to assure high quality care through careful training of health workers in proper counselling and delivery of services will further slow commercial growth".

Other "inhibiting factors" include delays in product registration; tax policies and import duties; restrictions on brand name advertising and promotion; and price controls.

remaining control they have over their lives and bodies. They are also:

“dismantling women’s hard-won rights to define a sexual rights and reproductive health agenda, to express their sexual and reproductive rights, and to have access to resources that assure life choices leading to reproductive health and well-being.”¹⁰¹

In Egypt and Jordan, for instance, government controls on the price of oral contraceptives discouraged commercial sector interest.

iii) Create Demand for Reproductive Health Care

Third, the report states, governments and donors must “increase demand for reproductive health products and services” since low levels of demand for reproductive health care may inhibit “the interest of commercial enterprises”.

Although “reproductive health care is a multibillion dollar worldwide industry, with sales of contraceptives alone generating some \$3 billion in revenues each year”, such products “typically account for a small proportion” of the estimated \$300 billion generated in annual pharmaceutical sales worldwide. (The transnational companies that dominate the manufacture, distribution and retail sales of contraceptives are Wyeth-Ayerst, Ortho, Schering, Organon, Pharmacia & Upjohn.) Only the public sector, the report claims:

“can afford to engage in broad-based demand creation activities; although the commercial sector as a whole many benefit from such campaigns, no single company can justify these types of investment”.

Yet it is the very “inadequacy of public funding” to provide reproductive health care services in the first place that is held up as the supposed rationale for bringing in the private sector.

Nor is it clear why it is necessary to “increase demand” when the report itself claims that the number of “women of childbearing age” is increasing by almost 24 million a year, and that there is a substantial “unmet need” for family planning among “more than 100 million married women in developing

countries”, or 250 million couples by the year 2015.

iv) Build Commercial Markets Through Public-Private Partnerships

Fourth, the report advises, the public sector should pay for contraceptives that the commercial sector will deliver through commercial channels

It praises the US Agency for International Development (USAID) for its pioneering efforts in this area:

“The United States, with its largely private for-profit health system, has been the foremost proponent of market solutions to reproductive health problems in developing countries.”

In addition, recognising that Northern donors influence not only the financing but also the direction of many family planning programmes, the report calls upon them to “ensure that their commodity support nurtures rather than undermines healthy commercial markets” and to support:

“research on markets and demand for reproductive health care and [share] this information with governments and the business community.”

Thus while subsidies for middle- and upper-income “consumers” are frowned upon, subsidies for companies are not.

v) Dialogue with Public and Private Sectors

Finally, the report urges governments and international donors to hold “continuing dialogue with private businesses” to ensure that “government actions intended to solve public health problems do not supplant for-profit activities”.

Health and Wealth For Whom?

In sum, while the report claims that:

“in an increasingly integrated or globalized world economy, new opportunities exist for the handful of transnational companies involved in the manufacture and distribution of reproductive health products to tap into markets in the developing world,”

it also insists that “fundamental changes are needed in policies relating to the role and responsibilities of governments in paying for and providing reproductive health care” if the commercial sector is to become more involved.

It is governments and aid donors that must create corporate markets and opportunities with public money and regulatory changes. The primary responsibility of governments is not to ensure that all those who need access to health care have it, but:

“to lay the groundwork for a viable commercial market and create a positive business climate for the provision of reproductive health care”.

Taking issue with this strategy will be not just those concerned with “health for all”, but also those who advocate slowing population growth by channelling family planning to the poor.

Source: Rosen, J.E. and Conly, S.R., “Getting Down to Business: Expanding the Private Commercial Sector’s Role in Meeting Reproductive Health Needs”, Population Action International, Washington DC, 1999, www.populationaction.org.

Neo-Malthusian Thinking

Neo-Malthusian or populationist thinking in population and development programmes and institutions also restricts women's ability to exercise their reproductive and sexual rights. Such thinking views women's

Paying for Population Programmes

The Cairo Programme of Action estimated the annual costs of meeting basic reproductive health needs in developing countries and countries in transition (such as those of the former Soviet Union) at US\$17 billion by the year 2000 and US\$21.7 billion by 2015. For 2000, it suggested that one-third (\$5.7 billion) should come from the international community, and the remaining two-thirds (\$11.4 billion) from countries themselves. (In contrast, an estimated US\$5 billion was spent on family planning in the Third World in 1995: US\$3 billion by Third World governments; more than US\$1 billion by developed countries, multilateral institutions and private Western population agencies; and the rest by individual contraceptive users.)

Despite its rhetorical advocacy of a broader reproductive and primary health agenda, ICPD recommended that more than 60 per cent of the funds should be allocated to family planning.

By June/July 1999, however, \$10.9 billion of the US\$17 billion estimate for the year 2000 had been committed, \$2.6 billion by the international donor community (less than one-quarter of the total expenditure and less than half their commitment) and \$8.3 billion by developing countries, particularly China, India and Indonesia (about three-quarters of their commitment).

Of the \$2.6 billion from donors, \$1.6 billion was bilateral assistance, with the US contributing the largest proportion (43 per cent). Development banks accounted for \$600 million in loans, the majority of which came from the World Bank. (In 1999, in contrast, the Bank gave loans of \$12.8 billion to private sector development, mainly in finance, transportation and manufacturing.) Private foundations and NGOs contributed

some \$260 million. The top private funders have been the Bill and Melinda Gates Foundation, the Ford Foundation, the David and Lucile Packard Foundation, the John D. and Catherine T. MacArthur Foundation and the Rockefeller Foundation.

For the past decade, about half of all aid for population programmes has been channelled through NGOs, such as the International Planned Parenthood Federation (IPPF) and the Population Council, and a quarter through bilateral and multilateral programmes. As a result, many NGOs have become more accountable to foreign donors than to the people they are meant to serve. Some have become the conduits through which donor programmes establish themselves outside the realm of government control.

In 2000, sub-Saharan Africa was the largest recipient of population assistance (43 per cent), followed by Asia and the Pacific (31 per cent). Other regions received much less: Latin America and the Caribbean (13 per cent); Western Asia and North Africa (9 per cent) and Eastern and Southern Europe (3.5 per cent). Some 33 per cent went to global and inter-regional activities.

In contrast, grants from OECD countries in 1998 for "basic health", including support for infectious disease control and primary health clinics, for the 619 million people in the Least Developed Countries totalled US\$209 million. Half of this stayed in the donor countries (US\$21 million was tied aid and US\$88 million allocated for technical assistance), leaving US\$78 million for basic health services.

To put all these figures in perspective, in 1999, companies in the US, the world's biggest arms dealer, sold some \$11.8 billion worth of weapons, \$8.1 billion of which went to Southern countries, the arms industry's fastest growing market, assisted by US aid. From

1972 to 1982, Southern countries' military expenditures (not targeted by SAPs) rose from \$7 billion to over \$100 billion while spending on health and education fell. By 1986, the 43 countries with the highest infant mortality rates spent three times as much on defence as on health. By 1988, military spending in the South totalled \$145 billion – sufficient, according to UNICEF, to satisfy needs for food, clean water, health care and education for all. One nuclear warhead in India, it is estimated, costs more than annual expenditure on primary health centres in every rural and urban settlement in the country. Armed violence and militarisation has an escalating impact on health and refugees.

In 2003, annual global arms expenditure was estimated at more than US\$850 billion, while an estimated US\$9 billion would provide basic education for all, and US\$11 billion water and sanitation to everyone in the South.

In 2002, meanwhile, the net transfer of financial resources from the South to the North was US\$200 billion.

Sources: UNFPA, State of World Population 2002, www.unfpa.org/publications; *Financial Resource Flows for Population Activities*, www.nidi.nl/resflows/reports.html; Sachs, J., presentation at the "Massive Effort Advocacy Forum", Winterthur, Switzerland, 2000; Hong, E., *Globalisation and the Impact on Health: A Third World View*, Third World Network, Penang, <http://phmovement.org/pubs/issuepapers/hong.html>; Unnikrishnan, P.V., "Wars, Conflicts and Militarisation are Killing the Dream of *Health For All*", in Narayan, R. and Unnikrishnan, P.V., (eds.) *Health For All Now! Revive Alma Ata*, People's Health Movement, Bangalore, November 2003, www.phmovement.org.

education, welfare and programmes of women's empowerment, in which contraceptive provision can be a part, not as ends in themselves but merely as a means to "getting the numbers down".

Progressive organisations, including many women's groups, have not challenged this thinking sufficiently; indeed, they frequently endorse it.¹⁰² And although Cairo's Programme of Action does not contain the phrase "population problem", identify demographic factors as the principal causes of any problem, or seek many demographic changes, a neo-Malthusian subtext still runs through it. The Programme's ultimate goal is "population stabilisation", and it regards women's empowerment and the elimination of "social, cultural, political and economic discrimination against women" mainly as prerequisites for the low fertility that this requires. Conclude Dennis Hodgson and Susan Cotts Watkins, "protecting the individual rights of women is . . . presented as an indispensable means for achieving aggregate neo-Malthusian ends."¹⁰³

Neo-Malthusian thinking is also found in the words and other actions of the World Bank, USAID and UNFPA. Even if such institutions seldom market population policies in "explicitly demographic terms these days",¹⁰⁴ preferring instead the language of reproductive health, they have not necessarily dropped or modified their goals of reducing fertility. The UNFPA, for example, still links poverty and "too many people". Its *State of World Population 2002* contends that "poverty, poor health and fertility remain highest in the least developed countries where population has tripled since 1955 and is expected to nearly triple again over the next 50 years" and concludes that "promoting reproductive health and rights is indispensable for economic growth and poverty reduction".¹⁰⁵

It might seem to make little or no practical difference whether reproductive rights and health are a "means to an end" rather than an "end in themselves". After all, surely access to family planning or jobs or education under a population policy aimed at restricting fertility is better than no access at all.

But thinking of women's empowerment, education or employment as a means rather than an end, as the Programme of Action and the World Bank does (the World Trade Organisation ignores these issues altogether), has disturbing practical consequences. The history of contraceptive development and provision illustrates the point. Whether a contraceptive is provided within a reproductive health policy aimed at enhancing women's self-determination or within a population policy designed to reduce women's fertility makes a difference to the design of the contraceptive itself. Because the research and design of contraceptives has long been guided by the aim of reducing population growth rather than enhancing women's self-determination, "the lion's share of money for contraceptive research is spent on long-acting, provider-controlled surgical, hormonal and immunological methods which promise a bio-medical approach to fertility control."¹⁰⁶ One consequence is that the:

"goal of pregnancy prevention has taken precedence over safety in contraceptive research, leading to a lopsided emphasis on the 'more effective', or high-tech, methods."¹⁰⁷

Hormone-based longer-acting methods, for instance, can be highly effective in preventing pregnancy but are difficult for women to stop using: they have either to wait for the effect of the hormones to run down – three months with the injectable contraceptive Depo-Provera – or, in the case of Norplant (six capsules implanted under the skin in a

Thinking of women's empowerment, education or employment as a means rather than an end has disturbing practical consequences.

Women's empowerment and self-determination need to be separated from an agenda of mass fertility control.

Immigrants, the elderly, the disabled and those needing welfare are now "overpopulation" targets.

woman's upper arm and effective for five years) or Implanon (a single capsule), to find a doctor willing to remove them. If women are not properly screened and monitored for potential adverse effects, health complications may set in.

Longer-lasting and permanent contraceptive methods are more likely to find favour with those aiming to reduce fertility levels. Methods that can be administered on a mass scale or without people's knowledge or consent are attractive to population controllers. Women in several countries have gone to hospital for an abortion, for instance, only to discover later that they had been sterilised at the same time. Also favoured are those methods that rely on medical experts for removal, such as IUDs or implants. Even in countries such as Britain and the United States, women have had difficulties in getting the implant, Norplant, removed before the end of its five-year period of effectiveness.

In contrast, methods such as the condom and diaphragm, are under the user's control, help prevent the spread of sexually transmitted diseases and have no adverse impact on breastfeeding are, but are:

“grossly neglected, both in terms of the allocation of research funds for their improvement and their promotion and distribution in population programs.”¹⁰⁸

In some countries, this situation is now changing to a certain extent because of HIV/AIDS, although some population programmes simply recommend double-contraception: one to prevent pregnancy and one to prevent STDs.¹⁰⁹

For these (and other) reasons, various women's groups and individuals refused ten years ago during the Cairo process to base their demands for reproductive rights within a population framework. The need to separate “the women's agenda of empowerment and self-determination from the population agenda of mass fertility control” is still important today.¹¹⁰

Neo-Malthusian Thinking in Development Policies

Neo-Malthusian thinking also threatens women's reproductive and sexual rights when it acts through institutions that formulate and carry out economic, development and immigration policies. The Programme of Action calls for population concerns to be incorporated “in all relevant national development strategies, plans, policies and actions”.

Thus Western countries proclaim themselves “full up” (even as the number of children being born there drops to below “replacement level”¹¹¹) and unable to admit migrants at the same time as they push economic policies making more and more people “surplus” to economic requirements. They support wars, development projects and climate change that create ever-larger enforced migrations from the South.¹¹² Claims that burgeoning numbers of immigrants steal jobs, are parasites on state welfare, and destroy the environment of countries such as the US, Britain or Australia derive in large part from Malthusian thinking – even though the word “population” itself may seldom be used.

The policies and actions that flow from such beliefs undermine the rights and interests of many more social groups than just women of childbearing age. Immigrants, the elderly, the disabled and those needing welfare have been added to the list of traditional population “targets”, such as women, indigenous peoples, people of colour, and Southern farmers. Neo-Malthusian thinking has not only bolstered public antagonism, racism and fear in many places and fed renewed calls for

population control and harsh measures against migrants, but has also encouraged attacks on women's rights.¹¹³

Moreover, the ultimate objective of Thomas Malthus in writing his theory of population two hundred years ago resonates with many neo-liberal policymakers today. Malthus's concern was not about the numbers of (poor) people in England, Ireland or other English colonies, nor whether they were sufficiently nourished, but was to end society's responsibility for its members' welfare. By arguing that poverty was the "natural" result of the poor's fertility (the number of children produced by the rich didn't seem to have the same effect), rather than of the social or economic system, his theory of population – that the number of people will always outstrip the amount of food produced – absolved the property-owning class of any accountability for poverty.¹¹⁴ Those driving to create "free" markets today by privatising, undermining or abolishing public health and social services and emphasising individual responsibility consistently derive strength from the goals of neo-Malthusianism. As researcher Rachel Simon Kumar points out:

“although neo-Malthusian and neo-liberal discourses are distinct ideological influences (the former emphasising fertility control and the latter economic rationalism), it may be argued that in the context of developing countries the two are intricately intertwined. In India, for instance, the ideology of economic growth is inseparable from an anti-natalist agenda. Neo-Malthusianism becomes a component of the neo-liberal economic ideology of the state.”¹¹⁵

Campaigning for reproductive and sexual rights within a neo-Malthusian framework is likely to prove as fruitless as doing so within a neo-liberal programme. Even if small gains are made along the way, the framework will inherently work against such rights. Demands for reproductive rights and social justice must be made outside of a population framework at the same time as the neo-Malthusian thinking underpinning so many health, welfare, employment, immigration, education, national security¹¹⁶ and privatisation¹¹⁷ policies that impinge upon women's self-determination is itself challenged.

Conclusion

In sum, groups seeking to implement reproductive and sexual rights have to confront macroeconomic, fundamentalist and neo-Malthusian agendas that perpetuate gender, race and class inequalities and impede the vast majority from achieving those rights. In the past decade, it has become much clearer that the struggle for reproductive health and rights is nothing less than the “democratic transformation of societies to abolish gender, class, racial, and ethnic injustice”.¹¹⁸

Many movements, groups and individuals are already engaged in this struggle. As Betsy Hartmann concludes:

“While feminists may find some space within the [Cairo] consensus to negotiate for higher-quality contraceptive, abortion and health services and increased access to economic and educational resources, the real political space will remain outside, in an alliance with progressive development agencies, social justice environmentalists, and anti-racism organisers. In the New World Order not only are reproductive rights at stake, but basic economic survival and political freedoms.”¹¹⁹

Defence of women's reproductive and sexual rights has been most successful not just where NGOs and governments are supportive but

Neo-Malthusian thinking has bolstered racism and fear – and encouraged attacks on women's rights.

Movements affected by neo-Malthusian ideology and practice need to build networks and alliances with each other.

This briefing was written by Sumati Nair and Preeti Kirbat of Women's Global Network for Reproductive Rights (WGNRR) with Sarah Sexton of The Corner House, all of whom thank the commentators of various drafts. It is one in a series of briefings resulting from a joint project between WGNRR and The Corner House exploring issues related to "Women, Population Control, Public Health and Globalisation". The joint project aims to provide analysis and information for those confronted with these issues and challenges, to generate debate, and to bring about change within policy circles, NGO networks and public media.

also where popular movements are strong, as in Brazil, the Philippines, India, South Africa and Peru.

To be effective, such movements need to build networks and alliances with each other. After all, peace, health, environment, women's, indigenous, anti-racist and economic justice movements are confronting many of the same forces and interests that are ranged against them. Moreover, activists working on issues of reproductive rights, immigrant support, genetically-engineered agriculture, anti-racism and disability rights (to name a few) are all affected by neo-Malthusian ideology and practice.

Building such networks and alliances might sound straightforward, but "we operate in an increasingly murky world" where "everyone from Shell Oil to neofascist intellectuals now talk the language of 'empowerment', 'community', 'environment' and 'participation'."¹²⁰ With whom should groups working for social, economic and gender justice make alliances? And how? It is also worth considering which alliances may weaken or divide movements.

There is a difference, moreover, between a single, one-off campaign and wider, longer-term movement building, of which a campaign or specific goal forms only one part. Groups committed to deeper transformation and those in short term campaigns need to consider the wider ramifications of their different approaches. For instance, are the interests behind a short-term campaign of a nature that can sustain a long-term alliance? Is there a shared goal aside from working *against* something? What signals about a movement's politics and priorities are being sent to others by its members and its alliances? What are the effects of compromises that may be made? What is gained and what is lost? What is included and what is left out? Whose voices are heard and whose are silenced in alliance building?

Organisations such as WGNRR now collaborate not just with women's groups but also with a range of social movements striving for health and social justice. Working with the People's Health Movement, for instance, WGNRR highlights general health issues as well as the reproductive and sexual rights aspects of health. By rejecting the population framework, it seeks to avoid losing its critical edge, dulling its tools of analysis, divorcing itself from the women it is supposed to represent and placing too much faith in official rhetoric. It opts instead, together with many others, for a broader politics of social and economic transformation.¹²¹

Feminist activists from different parts of the South and North have made their presence felt at international gatherings such as the World Social Forums in recent years. In doing so, they pave the way for reproductive and sexual rights to be incorporated within the larger agendas of other social movements and of society in general. Numerous encouraging initiatives at local and national levels give hope for new ways of making alliances and working for change.

New Zealand lawyer Jane Kelsey concludes that activists need to "rethink identity and alliances – combine a critical analysis of economic, political, cultural and social models of the past with a forward-thinking vision of what a socially just future might look like".¹²² The vision of women's health groups, anti-racist movements, disability rights groups, grassroots activists and others can be not just of social justice but of "an alliance which can forge a new way ahead".¹²³

Family Planning in India: A Short History

Ever since T.R. Malthus occupied the chair of political economy at the East India Company's college in the 19th century, India's colonial and post-colonial rulers have tended to identify over-population as the cause of the country's poverty.

India was the first country in the world to have an official family planning policy and programme. Established in 1952, it soon became one of the largest.

Indian and international population policy have always had a strong influence on each other. In the 1970s, the "Family Planning Programme" changed its name to "Family Welfare" and began to emphasise maternal and child health services. In 1997, the Programme again changed its name to "Reproductive and Child Health".

1960s and 1970s: Targets

From the outset, family planning services were separated from health care: family planning came under the central Ministry of Health while health services were the responsibility of India's individual state governments. With each successive five-year national development plan, financial allocations for "family planning" grew, as did targeted bilateral and multilateral assistance.

In the mid-1960s, India adopted a system of annual numerical targets for contraceptive users and sterilisations. The central government fixed the targets for each state, which passed them down to district and then community levels. Policymakers believed they would directly reduce fertility, yet they just led to poor and abusive services.

To achieve the targets, financial and other incentives were given to both government field workers and women themselves. In 1961, a government report recommended graded tax penalties from the fourth pregnancy onwards; withdrawal of maternity benefit for women refusing to accept family

planning; provision of government services only to families with three or fewer children; and abortion for socio-economic reasons. As public health activist and academic Mohan Rao comments, the report forebodes the shape of things to come: "the iron hand of coercion beneath the velvet glove of rhetoric".

By the late 1960s and early 1970s, fertility rates had not dropped as much as the government had hoped. The programme shifted its emphasis from intra-uterine devices (IUDs) towards longer-acting and more invasive contraceptives such as hormonal implants.

Between the Emergency years of 1975 and 1977, the government tried to sterilise men, mainly poor men. When not physically forced, the subjects were "persuaded" by offers of blankets, property, radios or money. The programme, however, led to a popular backlash and the ruling party was voted out of office. Since then, family planning efforts have focused on women. In the 1980s, new methods of female sterilisation were introduced: laparoscopy and tubal ligation.

1980s: Population Policy

By the 1980s, certain characteristics of the Indian "family planning" programme were so well established that it could more accurately be described as a "population control" programme:

- Monthly or annual "targets" of numbers of women accepting contraception or being sterilised were given to health personnel. The Sixth Five-Year Plan (1980-1985) set targets of 22 million sterilisations and 7.9 million IUD insertions. The Seventh Five-Year Plan (1985-1990) upped the stakes to 31 million sterilisations and more than 21 million IUD insertions. Reaching the target became more important than meeting a woman's needs and wishes.
- Rural and urban poor, together with tribal and minority women, became the central targets of the programme – they were considered the least likely to protest.

- The testing on women of new chemical contraceptive methods became commonplace.
- Expenditure on family planning increased at the expense of public health services. During the Seventh Five Year Plan, for instance, the national budget for family planning was greater than that for health services.
- Health services for the vast majority remained inadequate or inaccessible, while increasing privatisation encouraged the proliferation of huge high-tech polyclinics in urban areas.

By the 1980s, people's suspicion and mistrust of the public health care system and staff had become deeply rooted in much of the country because of the indiscriminate pushing of family planning. In some states, people avoided primary health centres "for fear of being nabbed for sterilisation". Feminist demographer Malini Karkal describes India as "the only country that promotes population control almost exclusively through a female sterilisation programme." In 1998, female sterilisation still accounted for 71 per cent of contraceptive use. Just over five per cent of couples use reversible modern contraceptive methods. Many women use an IUD until they have had two children and are then sterilised.

1990s: Goals Persist

After the 1994 International Conference on Population and Development, and under both internal and donor pressure, India attempted to move away from its "targets" approach towards one emphasising quality, gender sensitive care responsive to the needs of individual women.

It introduced a target free approach in one or two districts in 1995 and then throughout the country in 1996, although some field workers interpreted the lack of targets as no more work for them. It scrapped incentives

linked to particular contraceptive or sterilisation methods. Although the government changed the title of its "Family Welfare Programme" to "Reproductive and Child Health" in 1997, Amit Sen Gupta concludes:

"nomenclature notwithstanding, the new policy carries within it the basic core of earlier policies that made them unacceptable to large sections of women".

Attitudes among policymakers and service providers have been difficult to change. One physician in a Community Health Centre said:

"The government says that family planning should be left to free choice, but I do not understand why it is wrong to put pressure on women from poor families".

Family planning increasingly became the responsibility of individual states, which continue to "persuade" or coerce people into using contraception or sterilisation in order to reach numerical "goals". States have set up reproductive health centres and programmes, but their focus is still on family planning.

In the states of Uttar Pradesh, Madhya Pradesh, Rajasthan and Maharashtra, anyone married before the legal age is banned from holding a government job; state financial assistance to *panchayats* (local governing bodies) is linked to family planning performance; and medical officers and other health staff are assessed according to their performance in the Reproductive and Child Health programme.

The Madhya Pradesh policy links rural development schemes, income-generating schemes for women, and poverty alleviation programmes as a whole to family planning.

Both Rajasthan and Maharashtra make "adherence to a two-child norm" a service condition for state government employees.

The Andhra Pradesh policy links funding for construction of schools, other public works and other rural development schemes to family planning. Allotment of surplus agricultural land, housing schemes and a variety of social programmes are also tied to acceptance of sterilisation.

Mohan Rao explains the similarities of these new state population policies by noting that several "were drafted with the assistance of a US based private consultancy firm, the Futures Group", whose RAPID project (Resources for Awareness of Population Impact on Development) is funded by USAID. Another Futures Group project, OPTIONS, provides governments in developing countries with advisers to draft population policies.

Meanwhile, the unregulated atmosphere within health care – India has one of the largest, most unregulated, private health care systems in the world that the government has encouraged through subsidies and other schemes – has spilled over into population control. In the late 1990s, it emerged that two doctors, affiliated with US population NGOs and motivated by fears of uncontrolled immigration to the North, were illegally sterilising women with a synthetic anti-malarial drug, quinacrine. This method of sterilisation has never received safety approval anywhere in the world; the World Health Organisation halted clinical trials because of concerns that the substance was carcinogenic.

Although health services are in shambles, the central government is now contemplating bringing back an explicit commitment to targets in population policies and introducing strong disincentives to have more than two children. The Supreme Court has ruled that women wishing to contest *panchayat* elections – in which one-third of seats are reserved for women – cannot have more than two children because of the "torrential increase in population".

There are also moves to bring in injectable contraceptives, which, although they have been available in the private sector since 1994, have been restricted in their use because of need for medical care and follow-up, which is not readily available in the country at large. Trials in India in the 1980s revealed a high drop-out rate after two years, a high contraceptive failure rate (raising concerns about the effects on the foetus) and a high rate of women not becoming fertile again.

Concludes Mohan Rao, "the pull of neo-Malthusian tides seems to be irresistible".

Sex Selection

Population policies have invariably discriminated against women, especially when they introduce contraceptive technologies designed with the sole goal of reducing women's fertility. But other technologies, too, have intersected with population and patriarchal thinking to discriminate against women. The case of ultrasound is illustrative.

Since it was developed in the 1970s, ultrasound scanning spread quickly in India. It has been used not just to monitor pregnancies, but also to detect the sex of a foetus, so that female foetuses can be aborted. According to India's most recent census, the ratio of girls under the age of six per 1,000 boys of the same age declined from 945 in 1991 to 927 in 2001; sex selective abortion and female infanticide are cited as the main causes. In urban areas, the decline was steeper. The most dramatic declines were in Punjab, Haryana and Maharashtra, which are among the richest states in India.

Doctors have marketed ultrasound and other reproductive technologies as a means of expanding reproductive choices for women. They have exploited not only the movement to secure reproductive rights, but also gender bias within Indian society displayed in marriage and kinship patterns, women's work participation, and laws governing inheritance of property. This bias, Rao suggests, is reinforced by state policies influenced by far right Hindu nationalist ideologies.

Population policies seeking to enforce a two-child norm have further reinforced gender bias. Average family size in India has been declining over the past two decades (although not among all classes), in part because of the increased costs of raising children and larger numbers of women entering the paid work force. But the shift to smaller families has not been accompanied by a shift in the social and economic pressures underlying son preference and supporting "the epidemic of gender violence that afflicts women and girls throughout their lifecycle". "If anything", points out Rupsa Malik of the Center for Health and Gender Equity:

"the pressure to have sons has intensified as couples strive simultaneously to reduce family size and ensure the birth of the desired number of sons, leading to increased acceptance of and reliance on the use of sex-selection strategies to achieve these results."

If gender discrimination is not addressed, the trend toward fewer children will not alleviate societal and family pressure on women to abort female foetuses. "Punitive and coercive population policies . . . are an invitation to female sex selective abortion" comments Mohan Rao. The majority of doctors who practise sex-selective abortion cite

overpopulation as the reason for pursuing the practice.

As a result of civil society action, the government passed a law in 1994 to regulate prenatal diagnostic techniques, despite resistance from medical professionals who profit from increased use of ultrasound. In 2000, activists filed public interest litigation in the Supreme Court to ensure effective implementation of the law.

Women activists are now trying to delink women's right to a safe and legal abortion from a sex selective abortion. Safe abortion is increasingly under threat as more women seek late-term sex selective abortions and as the government attempts to curb this practice by making second trimester abortions more restrictive.

Sources: Rao, M., "The Indian Family Planning Programme", *Malthusian Arithmetic: From Population Control to Reproductive Health*, Sage, New Delhi (forthcoming); Imrana Qadeer, "Shrinking spaces", *Seminar*, Issue 511, New Delhi, March 2002, www.india-seminar.com; "Reproductive Rights and Choice: The Role of Abortion in India", International Center for Research On Women, Information Bulletin, November 2001, Washington, DC, www.icrw.org; Malik, R., "A Less Valued Life: Population Policy and Sex Selection in India", CHANGE, Takoma Park, Maryland, October 2002, www.genderhealth.org.

Notes and References

1. UNFPA Executive Director Nafis Sadik, cited in McIntosh, C.A. and Finkle, J.L., "The Cairo Conference on Population and Development: A New Paradigm?", *Population and Development Review*, Vol. 21, No. 2, June 1995, p.224.
2. Presser, H.B. and Sen, G. (eds.) *Women's Empowerment and Demographic Processes: Moving Beyond Cairo*, Oxford University Press, Oxford, 2000, p.3.
3. The United Nations organised the first world population conference in 1954, which focused on demography. The 1965 World Population Conference in Belgrade discussed population as a policy issue for the first time. Both of these meetings were technical and scientific assemblies, however, not gatherings of official government representatives. The issue of population growth was first addressed in an international forum at the 1974 World Population Conference held in Bucharest. Northern countries wanted to implement effective population control policies in the South, an effort that Southern countries vehemently resisted and shifted the debate to development issues. "Development is the best contraceptive," they argued. By the time of the 1984 International Conference on Population in Mexico City, however, there was more consensus among Southern countries, donors and NGOs about the need to limit population growth. Moreover, many Southern economies had deteriorated and their dependence on Western aid had increased, diminishing their political bargaining power. In Mexico City, the US emphasised economic reforms to reduce population growth rather than population policies per se. (At this conference, the US first announced its "global gag rule" prohibiting US government aid going to NGOs supporting abortion.) At the UN's International Conference on Population and Development in Cairo in 1994, Southern countries were even more subdued, even though this conference was the largest and costliest of all UN conferences on population and was marked by the unprecedented involvement of NGOs (Koivusalo, M. and Ollila, E., *Making a*

Health World: Agencies, Actors and Policies in International Health, Zed Books, London, 1997).

UNFPA was established in 1969 as the United Nations Fund for Population Activities. In 1987, the UN's Economic and Social Council renamed it the United Nations Population Fund, but retained the original acronym.

4. For a history of population institutions and thinking, see Ross, E., *The Malthus Factor: Poverty, Politics and Population in Capitalist Development*, Zed Books, London and New York, 1998; Corner House Briefing 20, July 2000, www.thecornerhouse.org.uk/briefing/20malth.html.

Much (but not all) of the debate about population growth seems influenced by a fear of being outnumbered – "those who talk about a population problem are often talking about the numbers of a people other than themselves". Concludes sociologist Frank Furedi, "The ability of the ideology of population control routinely to shed one explanation in favour of another suggests that its apprehensions are independent of actual population trends" (Furedi, F., "The Numbers Game", *Population and Development: A Critical Introduction*, Polity Press, Oxford, 1995, pp.52, 28).

5. Population control as a major international development strategy dates back to the 1950s. The World Bank, UNFPA, WHO and UNICEF took their first steps in the area of family planning in the 1960s, a period during which governments of many recipient countries became increasingly tolerant of efforts to create or strengthen international population assistance. USAID became an important funder of population activities by the early 1970s.

The goal of "population control" movements at various times and places has been not just antinatalist (less births) but also pronatalist (more births) or eugenic (more of certain people, fewer of others). The term "population control" is now associated with coercion and force and no longer acceptable

in policy circles. In the mass media, however, such as UK television broadcasts, it is still used uncontroversially and synonymously with family planning or birth control in Southern countries.

Because of coercive family planning programmes and concerns about increasing numbers of people, the word "population" has come to be closely associated with the number of children to whom women give birth. But the study of "population" – demography – also looks at trends in ageing and dying, and where people are living, encompassing rural-urban, regional and international migration.

6. International donors financed many family planning programmes, although some Third World governments, particularly those in Asia, began to provide an increasing proportion of funding themselves. But whereas women in several Asian countries experienced the overzealousness of family planners, those in other countries, such as Latin America, had difficulty in obtaining any modern contraceptives at all because of opposition from the church and state.
7. In theory, population policies should address all attributes of a population – age structure, geographical distribution and total size – but in practice most address its growth and size only, focusing more on births and fertility levels than mortality and migration.
7. Hartmann, B., *Reproductive Rights and Wrongs: The Global Politics of Population Control*, South End Press, Boston, MA, 1995 (second edition), pp.37-38. For distinctions between a population programme and a reproductive health programme, see pp.57-58.
8. Prasad, S. and Nair, S., "Fertility Control and Muslim Women in Hyderabad", *Reproductive Health in India's Primary Health Care*, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, 1998, p.45. It should be noted that women and men in every society have always attempted to influence their fertility with varying degrees of efficacy.
9. See Higer, A.J., "US Population Policy and Feminism: A Working Relationship?"

- Political Environments* no. 2, Summer 1995, <info@cwpe.org>.
10. "Fundamentalism" is a broad term not limited to any one religious grouping or referring to an individual's religious observance. Contemporary fundamentalisms are political movements occurring all over the world that tend to use religious language and symbols in their attempts to win or consolidate their power and extend their social control. They appear in different and changing forms, sometimes as a state project, sometimes in opposition to the state. Central to their agendas is support for patriarchal forms of family and authority through which to control women in various ways. They often view women as embodying the morals and traditional values of the family and the community. Their adherence to "doctrinaire patriarchy" ties together diverse fundamentalist adherents – whether Christian, Islamic, Jewish, Hindu or other. For more information, see *Women Against Fundamentalism*, www.waf.gn.apc.org.
 11. Heim, S. and Schaz, U., *Population Explosion, The Making of a Vision*, FINNRAE, Hamburg, December 1993.
 12. Personal communication with Joan Dunlop, November 1986, quoted in Hartmann, B., *Reproductive Rights and Wrongs; The Global Politics of Population Control and Contraceptive Choice*, (first edition) Harper & Row, New York, 1987, p.295.
 13. "Common ground" was the phrase for the combined reproductive rights/neo-Malthusian agenda that appeared several years before Cairo. For instance, the report of a meeting between women's health advocates and scientists organised by IWHC and the World Health Organisation in 1991 was entitled "Creating common ground". The phrase was also evident at the 1992 United Nations "Earth Summit" Conference on the Environment and Development (UNCED) held in Rio de Janeiro. (Hodgson, D. and Cotts Watkins, S., "Feminists and Neo-Malthusians: Past and Present Alliances", *Population and Development Review*, 1997, 23(3) p.515; Foskey, D., *Changing the World or Reacting to a Changed World? The Global Politics of Population and Reproduction After the International Conference on Population and Development*, unpublished Ph.D. thesis, 2003)
 14. See, for example, Dixon-Mueller, R., *Population Policy and Women's Rights: Transforming Reproductive Choice*, Praeger, Westport, CT, 1993.
 15. An estimated 20 million women have abortions each year in countries where abortion is restricted or prohibited by law. Because unsafe abortion accounts for an estimated 13 per cent or more of maternal mortality globally, many policymakers and activists regard access to safe and legal abortion as a fundamental safeguard for women's health, even if they do not think of it as a right. Abortion was made illegal in many countries only in the 19th century.
 16. To stress the voluntary nature of the actions sought, and in contrast to the implied force associated with phrases such as "population control" or "population reduction", experts have begun to use terms such as "stemming", "stabilising" or "slowing" population growth. See "Journalist's Notebook: What's in a Word?", December 1998, (handout distributed at a conference prior to the UN's Cairo+5 meeting in 1999), quoted in Hartmann, B., "The Changing Faces of Population Control" in Silliman, J. and Bhattacharjee, A., *Policing the National Body: Race, Gender, and Criminalization*, South End Press, Cambridge, MA, 2002, p.259.
 17. The Population Crisis Committee, set up in 1965, subsequently changed its name to Population Action International in the 1990s. The IWHC's funding sources shifted from the Population Crisis Committee to the Hewlett, Mellon, Ford and MacArthur Foundations. (Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.497).
 18. "Women's Voices '94—A Declaration on Population Policies", *Population and Development Review*, No. 19, No. 3, September 1993, pp.637-640. Although the IWHC took the lead in formulating a position that made an alliance with neo-Malthusians possible, "its ideological frames, tactics, and influence owe much to previous developments in feminism as a social movement" (Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.497).
 19. Antrobus, P., et al, "History and Process of Some Initiatives", unpublished manuscript, Buzios, Brazil, August 1993.
The Declaration does not challenge the need for population policies, but calls "for a fundamental revision in [their] design, structure and implementation . . . to foster the empowerment and well being of all women." It lists seven "fundamental ethical principles" that population policies should adhere to at national and international levels; minimum programme requirements; and necessary conditions for implementation.
 20. McIntosh, C.A. and Finkle, J.L., op. cit. 1, p.239.
 21. The initiators of the Women's Declaration did acknowledge that "building the Alliance . . . requires respecting differences among members in order to achieve solidarity on specific issues and strategies." The IWHC organised a meeting in January 1994 in Rio de Janeiro to forge a more unified Cairo strategy among women activists from around the world. Despite several statements at this meeting declaring "unanimous opposition to designing fertility control measures of population policies specifically targeted at Southern countries", participants finally agreed to attend the ICPD "with a united voice and to work to effect change within the limits of conference procedures" (Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.500). Mohan Rao describes the lead organisations driving this "consensus" as "multinational feminisms – as opposed to women's movements with an internationalist perspective" (Rao, M., "Introduction", *Malthusian Arithmetic: From Population Control to Reproductive Health*, Sage, New Delhi (forthcoming)).
In 1995, seven Indian women's organisations criticised Northern women's groups in the Cairo process. "[T]he agendas of the G-7 group were pushed through and issues concerning Third World women were left unaddressed . . . The representatives of millions of Third World women in Cairo hoped, while supporting the struggles of Western women for their right to abortion, at least some attention would be paid to their experience. Instead they did not get the support of women representing the First World" (*Towards Beijing: Crucial Issues of Concern*, 1995, reprinted in *Lokayan Bulletin*, Vol. 12, Nos. 1-2, 1995, quoted in Rao, M., "Reifying Reproduction", *ibid.*).
Others have pointed out that mainstream US groups, perhaps "blinded by the bright lights of power", focused their attention overseas and ignored the increasing violence, reproductive rights violations and withdrawal of welfare to which poorer women of colour, in particular in the US, were subject. Comments women's activist and critical US academic Betsy Hartmann, "especially for white middle-class groups, it is much easier to sound progressive on the international stage than to do the hard work of multiracial network building at home" (Hartmann, B., op. cit. 16; Bhattacharjee, A., *Whose Safety? Women of Color and the Violence of Law Enforcement*, American Friends Service Committee/ Committee on Women, Population and the Environment, 2001, www.afsc.org; www.cwpe.org).
 22. Since official international population assistance began in the mid-1960s, the United States has been the acknowledged leader in the field. It has consistently been the largest donor, has provided much of the intellectual leadership linking fertility reduction with economic development, and has been the pillar of multilateral efforts through the UN system, the World Bank and organisations such as the International Planned Parenthood Federation (IPPF).
The US Agency for International Development (USAID) established an office of population in 1964, began funding direct family planning activities in 1967, and has continuously emphasised the role of the private sector and social marketing in population programmes. One analysis of USAID funding for population activities in 114 countries over 20 years concluded that adopting a population policy increased the likelihood of a country receiving international aid and the amount received (Barret, D. and Tsui, A.O., "Policy as symbolic statement: international response to national population policies", *Social Forces*, 78 (1), 1999, pp.213-234).
 23. McIntosh, C.A. and Finkle, J.L., op. cit. 1, p.239.
 24. Sociologist Frank Furedi notes that "the issue of women's position in society has provided the population lobby with a considerable degree of legitimacy to pursue its objective" since the 1970s, and that "even those normally hostile to egalitarian causes have integrated women's issues into their arguments", even if they adopt an explicitly instrumentalist approach (Furedi, F., op. cit. 4, p.126).
Another sociologist, Dennis Hodgson, pointed out that "the failure of . . . family planning to substantially lower fertility . . . had led to some questioning it as a method of population control . . . [S]ome of the disenchanted argued for more coercive forms of population control, while others called for redirecting developing benefits to the impoverished to hasten their adoption of small family ideals" (quoted in Rao, M., "The Writing on the Wall: Structural Adjustment Programme and the World Development Report 1993—Implications for Family Planning in India", *Social Scientist*, Vol. 22, Nos. 9-12, Sept-Dec. 1994, p.77, ref. 23).
 25. Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.496-77.
 26. Petchesky, R.P., *Global Prescriptions: Gendering Health and Human Rights*, Zed Books, London, 2003, p. 50. See also Silliman, J., "Expanding Civil Society, Shrinking Political Spaces: The Case of Women's Nongovernmental Organizations", in Silliman, J. and King, Y. (eds.) *Dangerous Intersections: Feminist Perspectives on Population, Environment and Development*, South End Press, Cambridge, MA, 1999.
In the 1980s, population organisations had

- developed close strategic alliances with mainstream environmental organisations. Coming under increasing corporate influence at this time, these environmental groups were more receptive to such an alliance than they might otherwise have been, contends Betsy Hartmann. "Population was a convenient . . . way to divert attention from the lack of strong activism against industrial polluters". The alliance benefited population groups more than environmental ones as the former have not taken on a broader environmental agenda. Population money, however, enabled many of the larger environmental groups to set up and maintain population offices within their organisations. The Pew Charitable Trusts (a private foundation based in Philadelphia and the largest environmental grantmaker in the United States) channelled over \$13 million to environmental groups in advance of the ICPD. This environmental alliance, combined with the alliance between population groups and women's groups, not only "lets Northern governments and elites (and Southern ones too) off the hook for environmental degradation", but also casts them as gender-sensitive conservationists and family planners (Hartmann, B., "Strategic Scarcity: The Origins and Impact of Environmental Conflict Ideas", Ph.D. thesis, Development Studies Institute, London School of Economics and Political Science, 2003).
27. More generally, some have argued that women's organising for the Cairo process not only blunted the critical analysis of the global women's health movement, but also helped to "depoliticise" it and concentrate power in the hands of a few well-funded, mainly US-based organisations (Hartmann, B., op. cit. 16; Swenson, N., "Global Health Movement" in Kramarae, C. and Spender, D., (eds.) *Encyclopedia of Women*, Routledge, New York, 2000).
28. The depth of this commitment varied between organisations, however. Some still maintain a neo-Malthusian approach.
29. Some prominent population-oriented representatives declined the invitation to sign the Declaration: the Centre for Development and Population Activities, Population Action International, and Steven Sinding, Director of Population Sciences at the Rockefeller Foundation (Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.515).
30. Quoted in Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.502.
- Even US population researchers Jason Finkle and Alison McIntosh, who believe that the ICPD Programme of Action "was not . . . a step forward for the population movement, which for many years has given primacy to efforts to limit population growth", concede that "it is a tribute to the organizational capabilities of women's groups, no less than the power of their message, that they were able to enlist and maintain the support of foundations, NGOs and even normally intransigent government delegations" (Finkle, J.L. and McIntosh, A., "Cairo Revisited: Some Thoughts on the Implications of the ICPD", *Health Transition Review*, Vol. 6, No. 1, April 1996, p.110-1).
31. Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.503.
- US private funders were also instrumental in creating, promoting and funding this "common ground" agenda. Notable was the Pew Charitable Trusts (see note 26) environmental grantmaker, but also the Ford, MacArthur, Hewlett, Mellon and Rockefeller foundations. (Hartmann, B., op. cit. 7, pp.120, 148-151)
- Yet the Cairo consensus had little positive impact within the US itself.
32. ICPD Programme of Action, Chapter II "Principles", Principle 4, contained in UNFPA, *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994*, A/CONF.171/13/Rev.1, www.unfpa.org/icpd/icpd_poa.htm.
- The Programme makes no mention, however, of how women are differentiated by race and class.
33. ICPD Programme of Action, Chapter VII, "Reproductive Rights and Reproductive Health: Family Planning", paragraph 7.12, *ibid*.
34. ICPD Programme of Action, Chapter VII, "Reproductive Rights and Reproductive Health", paragraph 7.2, *ibid*.
35. ICPD Programme of Action, Chapter VII, "Reproductive Rights and Reproductive Health", paragraph 7.6, *ibid*.
36. The Programme did not recognise sexual rights nor mention women's access to safe and legal abortion (see footnotes 15 and 37), nor did it give suggestions as to how governments might prioritise women's reproductive health needs and rights in actual policies and services.
- The Programme of Action also set out goals in three other areas besides access to reproductive and sexual health services: reduction of infant and child mortality (para. 8.16); reduction of maternal mortality (para. 8.21); and universal education (para 4.18), but did not include women's education within its proposed expenditures. Like health care services, access to education, especially for girls, is being reduced worldwide because of cut-backs in state spending and commercialisation within education. These goals were refined and amplified in 1999 at an ICPD+5 meeting in The Hague, The Netherlands, and another goal added: reducing HIV infection rates in persons 15-24 years of age by 25 per cent in the most-affected countries by 2005 and by 25 per cent globally by 2010.
37. The Cairo Programme of Action mentioned "sexual health" several times and alluded to "sexual rights" in the context of violence against women and HIV/AIDS, but shied away from defining the term. The statement from the 1995 UN Fourth World Conference on Women, held in Beijing, encapsulated the content of sexual rights, albeit without using the term, largely because so many non-Western governments and organisations, particularly African governments, supported the language:
- "the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences."
- As with the Cairo Programme of Action, the aim of the statement was not to create new rights but to extend international human rights to the area of sexuality. Many African governments accept sexual rights as a means to prevent the spread of HIV/AIDS and to address violence against women, both of which threaten the social and economic functioning of many countries. Women tend to be more vulnerable than men to sexually transmitted diseases (STDs) because of biology and
- because of the interactions between poverty, culture and gender inequality. Women's financial dependence on men, the physical and sexual abuse they receive, and double sexual standards mean that women aged between 15 and 24 in sub-Saharan Africa are more than twice as likely to be HIV infected than men of the same age group.
- European governments, however, understand sexual rights more narrowly to mean freedom from discrimination on the basis of sexual orientation, an interpretation that most African governments (except that of South Africa) would not support.
- Both of these interpretations suggest negative rights (freedom from something) rather than positive rights valuable in and of themselves. The achievement of sexual rights, as with reproductive rights, requires gender equality in cultural, social and economic systems (Klugman, B., "Sexual Rights in Southern Africa: A Beijing Discourse or a Strategic Necessity?", www.wits.ac.za/whp/sexualrights_beijing.pdf).
38. Ojiambo Ochieng, R., "Supporting Women and Girls' Sexual and Reproductive Health and Rights: The Ugandan Experience", *Development*, Vol. 26, No. 2, June 2003, p.40.
39. Shen, Q., "China: Taking Up the Reproductive Health and Rights Agenda", *Development*, Vol. 46, No. 2, June 2003, pp.80-84. Many of the previous Chinese policies are still entrenched, however. See Johnson, K., *Wanting a Daughter, Needing a Son: Abandonment, Adoption and Orphanage Care in China*, Yeong and Yeong Book Company, St.Paul's, Minnesota, 2004.
40. India's national population policy for the year 2000, while calling for a target-free comprehensive approach (encompassing wider issues and health care), still aims for "replacement level fertility rates" by the year 2010 and a "stable population" by 2045. The change in language has not changed the programme's approach substantially (see Box, p.27ff).
41. Luke, N. and Cotts Watkins, S., "Reactions of Developing-Country Elites to International Population Policy", *Population and Development Review*, Vol. 28, No. 4, December 2002, pp.718, 21.
- Interviews conducted in 1997 in Bangladesh, Ghana, Jordan, Malawi and Senegal concluded that "the most common response . . . was to pick and choose among the components of the Cairo agenda. Typically, family planning and maternal health were acceptable, but . . . those closely related to sex and gender [including gender-based violence and services for adolescents], were ignored." Those governments that did not support women's rights relied on the principle of national sovereignty to ignore several sections of the Programme of Action.
- During the Cairo conference, the main issue of contention was abortion. Several countries, including the Roman Catholic Holy See (the Vatican), which is a state and thus represented at the United Nations, objected to any language that legitimated or facilitated abortion; gave women or adolescents the possibility of making reproductive and sexual decisions independently of men or parents; or condoned diverse forms of the family. At issue was the perceived challenge to "traditional" patriarchal social structures rather than fertility regulation itself. Access to abortion and contraception, therefore, was not a pro-natalist versus anti-natalist controversy (Petchesky, R.P., op. cit. 26, p.37).
- Consensus was reached on access to safe abortion, services and education for adoles-

cents, and sexuality by finding language that allowed different interpretations. For instance, the Programme stated that abortion should not be promoted as a method of family planning (Koivusalo, M. and Ollila, E., op. cit. 3, p.202).

The disagreement over abortion illustrated that, although the Conference was “ostensibly about demographic matters”, it provided an opportunity for “a clash of views about values, traditions and acceptable forms of sexual behaviour” (Furedi, F., op. cit. 4, p.30).

42. Hodgson, D. and Cotts Watkins, S., op. cit. 13, pp.508-9. These authors acknowledge, however, that a change of language may simply provide “a more ‘politically correct’ rationale for fertility control.”
43. For example, UNFPA and IPPF now prioritise working with adolescents in their HIV/AIDS and “unwanted pregnancy” programmes, even though adolescent sexuality and abortion remain controversial and funding constrained (Petchesky, R.P., op. cit. 26, pp.48-9).
44. Because of the systematic erosion of primary health care systems in recent years, many governments, with the support of international financial institutions and aid agencies, now rely more on NGOs to deliver reproductive health services. The Programme of Action called for governments to work more closely with NGOs and women’s organisations on population and development programmes. Since the 1990s, more and more multilateral and bilateral development assistance in general has been channelled to NGOs. By the end of 1999, USAID was putting 40 per cent of its resources into NGOs. Today, NGOs deliver more official development assistance than the entire UN system (excluding the World Bank and IMF). Donor agencies now often prefer to fund NGOs rather than governments to provide basic services. Recruited to take up the slack left by cutbacks in public health care services, however, many women’s and other NGOs may have unwittingly helped to enable the privatisation and liberalisation of economies and services and left themselves with less energy for political advocacy. Many NGOs have become more accountable to foreign donors than to the people they are meant to serve. In Egypt, anthropologist and doctor Kamran Asdar Ali states that NGOs have “essentially become the conduits through which the internationally-sponsored family planning programme establishes itself outside the realm of government control.” The process can divide NGOs, as larger, more established organisations receive funding and gain influence while smaller, grassroots groups, particularly those critical of government or donor policies, are marginalised. NGOs can also become less willing to criticise government and donor policies and actions, and can be used to legitimise repressive or regressive social agendas (Silliman, J., op. cit. 26; Asdar Ali, K., “Myths, Lies and Impotence: Structural Adjustment and Male Voice in Egypt”, *American Ethnologist*, 2003; Hartmann, B., op. cit. 16).
45. Health researcher Maureen Mackintosh points out that “there are no decent *free* markets in health care; the only decent markets are strongly socially constrained.” Besides driving up the costs of health care, a market-based approach to health can lead to lack of interest in the factors that make people ill. It promises that medical technology can fix diseased individuals, and that good health can be bought and sold in the marketplace rather

than being something to promote or work for. In many instances, the private health care sector has not provided a higher quality of care, nor been more economically responsible and efficient. For an analysis of the difficulties in turning health care into profitable marketable commodities, and summary of the evidence and experience that health care services are inherently not private goods, see Mackintosh, M., “Health Care Commercialisation and the Embedding of Inequality”, RUIG/Unrisd Health Project Synthesis Paper, September 2003, www.unrisd.org.

46. The constraints on contraceptive availability that the World Bank report identified were “excessively restrictive screening requirements” of women before a method could be dispensed and “unnecessary or duplicative approval procedures” of a method in a country once other countries had approved it. See World Bank, *Investing in Health*, World Bank Washington DC, 1993, p.84.
- The World Bank has been instrumental in promoting the concept of health care services as a “private good” that can be delivered through the market. Only a few aspects of health care, according to this analysis, are “public goods” that benefit others besides the “consumer”. Immunisations are one. Family planning would be a “private good” from an individual woman’s perspective, but a “public good” according to a neo-Malthusian one.
47. A vertical health programme is a way of structuring the planning, management and delivery of a single health care intervention (such as immunisation, control against diarrhoea or tuberculosis, or family planning) that is not integrated with other health activities. Vertical programmes enable funders to control and monitor their investments more easily through quantitative targets, such as the number of children immunised. Vertical programmes can be effective in meeting a narrow, pre-set objective, but tend to fragment and duplicate health systems into self-contained units (LaFond, A., *Sustaining Primary Health Care*, Earthscan, London, 1995).
- Vertical disease programmes disaggregate some diseases from others and from the health care system, thereby undermining attempts to address interlinked and underlying causes. For instance, communicable diseases (such as malaria, tuberculosis and leprosy) are one of the outcomes of malnutrition and causes of reproductive ill health. International attention to some communicable diseases has increased in recent years because of the resurgence and spread in the last two decades of old and new diseases, such as cholera, tuberculosis, malaria, yellow fever, trypanosomiasis, dengue and HIV/AIDS, particularly among poorer people. A contributing factor to the increase, however, has been the disruption of infectious disease control programmes, for instance, in Sub-Saharan Africa and India, because of cutbacks in public expenditure. Before 1960, control of communicable diseases accounted for nearly 30 per cent of India’s public health budget; now it is down to four per cent.
- Most international efforts to tackle communicable diseases now focus on supplying new medicines within vertical, time-limited programmes accompanied by a range of financial and policy conditions (such as implementing international intellectual property rules). They pay little attention to strengthening basic health services or to preventive and public health measures. Besides medication, control of diseases such as HIV/AIDS,

tuberculosis and malaria requires improved living and working conditions, well-functioning health systems, strong coordination between different sectors and community mobilisation.

48. A country’s political, economic and historical context affect the reforms as well: its international bargaining power; governance structure; level of external debt; financial stability; past political structures; and state involvement in health. Reforms have also been influenced by international NGOs, consultants, national and provincial governments, the medical profession, the public health movement and other civil society organisations.
- In Latin America, health sector reforms have focused on dismantling social security systems and directing them towards the for-profit sector, decentralising public health systems, and increasing the role of the private sector, both for-profit and NGO. In Mexico, for instance, the compulsory social security system has been the channel through which health care has been opened to private insurance companies, health maintenance organisations and hospital enterprises, mainly from abroad (Laurell, A.C., “Health Reform in Mexico: The Promotion of Inequality”, *International Journal of Health Services*, Vol. 31, No. 2, 2001, pp.291-321). In sub-Saharan Africa, the focus of reforms has been more on introducing new financing mechanisms. In Asia, well-developed public health systems emphasising primary health care have been eroded rapidly in countries such as China and Malaysia, while inequalities have been further entrenched in countries such as India and the Philippines, where the public health system was less extensive or developed (Sen, K. (ed.), *Restructuring Health Services: Changing Contexts and Comparative Perspectives*, Zed Books, London and New York, 2003).
49. Sen, K., “Health Reforms and Developing Countries—A Critique”, in Qadeer, I., Sen, K., and Nayyar, K.R. (eds.), *Public Health and the Poverty of Reforms: The South Asian Predicament*, Sage, New Delhi, 2001.
- The reforms have aimed not just at reducing public spending and taxation, but also at directing public spending towards the private sector, meaning that some services are publicly financed but privately provided.
50. Petchesky, R.P., “Globalization, Health Sector Reform, Gender and Reproductive Health: The Economic Justice Implications”, in *Globalization, Health Sector Reform, Gender and Reproductive Health*, Ford Foundation, New York, 2003, www.fordfound.org/publications/recent_articles/globalization.cfm. See also Bianco, M., “Cost Benefit and Economic Approach Related to Health Care Services System”, <http://www.un.org/womenwatch/daw/csw/cost.htm>.
51. “Health For All” was the goal of the 1978 Alma Ata Declaration on primary health care, advanced by WHO and UNICEF and signed by 134 states. It affirmed health as a fundamental human right and addressed the underlying social, economic and political causes of illness and disease. The core principles of primary health care are: health is a right; adequate health care services should be accessible and affordable to all; promotive, preventive, curative and rehabilitative services should be provided; different sectors determining health should collaborate; communities should participate in the planning, organising and control of primary health care; it is a government’s responsibility to provide health care services for all; military

expenditure should be reallocated and peace promoted. Primary health care was not seen as the elimination of disease by targeted technological means alone but as a complex of strategies determining people's livelihood and quality of life and thus encompassing the agriculture, food, education, housing, energy and utilities sectors as well as the health sector.

Whereas primary health care incorporates the combined practices of promotive, preventive, curative and rehabilitative services, a commercialised health system separates them out, assigning some to the public sector, some to the private, and also separates diseases and health conditions. As a result, health care services are fragmented and preventive services lost.

In many ways, the Programme of Action contributed to undermining the Alma Ata Declaration, for instance, by making financial allocations for reproductive health only.

52. Health researcher Hilary Standing suggests three reasons why "sexual and reproductive health was almost invisible" in the health sector reform agenda. First, a language and discourse gap between the two agendas: one used a managerial/technocratic language, the other an advocacy language. Their supporters rarely interacted internationally, nationally or locally. Second, health sector reform has focused on supply side interventions such as financing mechanisms and human resources management; sexual and reproductive health advocacy has been concerned with service delivery. Third, health sector reformers regarded sexual and reproductive health services as vertical or "special interest" programmes, which they neglected other than to make them more efficient financially. Sexual and reproductive health advocates did not understand the importance of engaging with reforms (Standing, H., "Gender Impacts of Health Reforms—The Current State of Policy and Implementation", *Women's Health Journal*, 2000 (3-4), July-Dec, pp.10-19).
53. Quoted in Hartmann, B., op. cit. 7, p.138.
54. Social marketing refers to the widespread promotion and over-the-counter sales of contraceptives. This can be problematic with contraceptive methods for which women should be medically screened and monitored. Without medical follow-up, contraceptive users, especially those who are anaemic or malnourished, could experience unpleasant, if not dangerous, side effects, undermining in the longer-term their health and well-being and that of their children (Bandarage, A., *Women, Population and Global Crisis: A Political-Economic Analysis*, Zed Books, London and New York, 1997, p.91).
55. ICPD Programme of Action, Chapter XV, "Partnership with the Non-Governmental Sector: The Private Sector", 15.15(b), op. cit. 32.
56. ICPD Programme of Action, Chapter XV, "Partnership with the Non-Governmental Sector: The Private Sector", 15.18, *ibid*.
57. For-profit health care undermines the public sector in several ways. When public and voluntary health services have to compete with commercial providers for funding, less money flows into the public system. The private sector caters for healthier and wealthier "consumers", leaving the public sector to care for more vulnerable people despite having less funding and resources. Private operators take trained and experienced staff from the public system, select patients whose needs have been identified by public services, offer only the (profitable) services they want to, and set up

private facilities, ranging from laboratory analysis to residential care, which can be rented or contracted out to the public service.

58. Nanda, P., "Gender Dimensions of User Fees: Implications for Women's Utilization of Health Care", *Reproductive Health Matters*, 2002:10 (20), pp.127-134. *See also* Nanda, P., *Health Sector Reforms in Zambia: Implications for Reproductive Health and Rights*, Center for Health and Gender Equity, Washington, DC, October 2000.
59. Structural adjustment programmes requiring thousands of nurses and doctors to be made redundant (and the active recruitment of medical personnel by hospitals and care homes in Northern countries) have led to shortages of health workers and thus contributed to higher rates of deaths from disease, and higher rates of infant and maternal mortality and morbidity.
60. Standing, H., "Towards Equitable Financing Strategies for Reproductive Health", IDS Working Paper 153, Institute of Development Studies, Brighton, UK, February 2002.
61. Nanda, P., "Gender Dimensions of User Fees", op. cit. 58.
62. Cited in Standing, H., op. cit. 60.
63. Sadasivam, B., *Risks, Rights and Reform: A 50-Country Survey Assessing Government Actions Five Years After the International Conference on Population and Development*, Women's Environment and Development Organization (WEDO), New York, 1999.
64. Mackintosh, M., op. cit. 45.
65. There is little information available on the role of private providers in reproductive health services, partly because of their heterogeneity, ranging from indigenous practitioners through a variety of NGO providers (missions play a very prominent role in health care in sub-Saharan Africa) to a spectrum of for-profit individual providers and organisations. Public-private arrangements, such as social marketing and various types of partnership, are increasing. In Latin American countries, family planning is much more commonly provided in the private sector (including not-for-profit) – over 60 per cent in some countries – as a consequence of the political influence of the church on governments (Standing, H., op. cit. 60).
According to a 1999 study, the proportion of contracepting women using for-profit sources of family planning is about 46 per cent in the countries of Latin America and the Caribbean, 44 per cent in the Middle East and North Africa, 27 per cent in sub-Saharan Africa and 26 per cent in Asia (excluding China and India). In Nigeria, one study indicated that 60 per cent of 120 women receiving treatment for abortion complications in a large public hospital had the initial procedure performed in a private hospital or clinic (Rosen, J.E. and Conly, S.R., "Getting Down to Business: Expanding the Private Commercial Sector's Role in Meeting Reproductive Health Needs", Population Action International, Washington DC, 1999, www.populationaction.org/resources/publications/gdtb/index.htm).
66. In Tanzania, researcher Lisa Richey points out, the donor-funded National Family Planning Programme, operating in a context of economic decline and the constraints imposed by structural adjustment policies, "translates into local clinics that are mere shells without medicines or basic supplies, but where most of the contraceptives being promoted by the family planning program and supplied by donors can be found". Formal health care needs are outside the scope of donor-funded projects

and even "women's reproductive health" needs under the population rubric are not likely to be met. Clean water, electricity and lighting are invariably poor or absent. "As the Tanzanian state withdraws from the health care sector, the only services and supplies that are available without pay at government clinics are family planning . . . In an ironic twist to the struggle in the 1970s to integrate family planning services into government primary care clinics, in the 1990s there is a failure to integrate any other services into what have become, in effect, family planning clinics" (Richey, L., "Does Economic Policy Conflict with Population Policy? A Case Study of Reproductive Health in Tanzania", CDR Working Paper 01.7, October 2001, http://www.cdr.dk/working_papers/01-7-abs.htm).

67. Sadasivam, B., op. cit. 63, p.10.
68. Development Alternatives with Women for a New Era, *Implementing ICPD: Moving Forward in the Eye of the Storm*, DAWN, Suva, Fiji, 1999, www.dawn.org.fj.
This survey noted that some countries, known for their abusive contraceptive and sterilisation practices such as India, Indonesia and Thailand, had officially abandoned demographic targets in their population policies. (In practice, however, several state governments in India still set numerical targets, merely replacing the word "targets" with "goals".) Others, such as Brazil, Uruguay, Nicaragua, Philippines and Ghana, had started to integrate or coordinate women's health, maternal and child health services with family planning services. Most countries had broadened their definition of reproductive health to encompass the treatment and prevention of sexually transmitted diseases. But the survey found that many population programmes were still "vertical" – focused solely on family planning – and staff were resistant to integrate them into health services more generally. Programmes might have been renamed "reproductive health", but family planning still received most of the resources.
69. ARROW, *Women, Gender Perspectives in Health Policies and Programmes*, Vol.6, No. 3, 2000. The Asia-Pacific Resource and Research Centre for Women (ARROW) is a regional women's NGO based in Malaysia.
According to ARROW's 1996 study of eight South-East Asian countries, other barriers besides global economic policies to implementing the Cairo recommendations were: women's groups and NGOs were not sufficiently involved before or after the ICPD processes; government and family planning NGOs lacked conceptual clarity about and innovative ideas on reproductive health and rights issues and on implementation of the Programme of Action; many government officials did not perceive the relevance or importance of the Programme of Action to government policy. The survey concluded that, even if some countries were now more concerned with other aspects of reproductive health, "population policies remain demographic-centred and target-oriented in terms of quantified goals, and have not shown any shift towards more people-centred development" (ARROW, *Taking Up the Cairo Challenge—Changes in Population Policies and Programmes*, Kuala Lumpur, 1999, www.arrow.org.my/docs/cairoChallenge.html#copy).
70. *See*, for example, *Globalization, Health Sector Reform, Gender and Reproductive Health*, Ford Foundation, 2003, www.fordfound.org/publications/recent_articles/globalization.cfm; *The Implications of Health*

Sector Reform on Reproductive Health and Rights, Center for Health and Gender Equity (CHANGE)/The Population Council, Maryland, 1999, www.genderhealth.org.

71. South Africa has “the most extensive constitutional and legal guarantees of sexual, reproductive and health rights of any country in the world, along with vibrant civil society organisations working for their enforcement”. Yet a 1999 government commission found that the public hospital system is so short of cash that it lacks enough workers, medical equipment, ambulances, linens and medicine to provide proper care to the poor (Petchesky, R.P., op. cit. 50).
72. For a case study description of this process in Tanzania, see Richey, L.A., “Women’s Reproductive Health and Population Policy in the Context of Post-Adjustment Health Care: A Case Study from Tanzania”, *Review of African Political Economy*, Spring 2003, No. 96; “From the Policies to the Clinics: The Reproductive Health Paradox in Post-Adjustment Health Care”, *World Development*, (forthcoming 2004).
73. Alt-WID, “Reaganomics and Women: Structural Adjustment US Style 1980-1992: A Case Study of Women and Poverty in the US”, Washington D.C., undated, p.28, cited in Bandarage, A., op. cit. 54.
74. Several decades of research conclude that women in most societies typically have less access to productive resources and assets, such as land, credit, foreign exchange, occupational training, and other forms of financial, physical and human capital. Women usually work longer total hours in productive and “reproductive” activities (including care of children), have fewer paid employment opportunities, earn lower wages, face greater time constraints and have less leisure time. Women’s and men’s circumstances vary widely across and within countries, however, and are variously affected by class, race and ethnic assumptions and discrimination.
75. All these socio-economic circumstances, and not only access to modern contraception, determine whether and when women have children and how many they give birth to and raise. A study of how Muslim women in Hyderabad viewed their fertility concluded that “women did not see the number of children they had as a problem at all . . . For them their major problems are the lack of money for food, school fees, medicines, the lack of proper facilities like drinking water, drainage and housing and the high cost of health care and the poor services in hospitals” (Prasad, S. and Nair, S., “Fertility Control and Muslim Women in Hyderabad”, *Reproductive Health in India’s Primary Health Care*, Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, 1998, p.45).
- See also Doyal, L., *What Makes Women Sick: Gender and the Political Economy of Health*, Macmillan, London, 1995; Elson, D., *Male Bias in the Development Process*, Manchester University Press, Manchester, 1991; Benería, L. and Feldman, S., *Unequal Burden: Economic Crises, Persistent Poverty and Women’s Work*, Westview Press, Boulder, CO, 1992; Sparr, P., *Mortgaging Women’s Lives: Feminist Critiques of Structural Adjustment*, Zed Book, London, 1994; Bakker, I., *The Strategic Silence: Gender and Economic Policy*, Zed Books, London and New York, 1994; Yong Kim, J., Millen, J.V., Irwin, A. and Gershman, J., *Dying For Growth: Global Inequality and the Health of the Poor*, Common Courage Press,

Monroe, Maine, 2000.

76. Qadeer, I., “Reproductive Health: A Public Health Perspective”, *Economic and Political Weekly*, Vol. XXXIII, No. 41, p.37. See also Sen, K. and Koivusalo, M., “Health Care Reforms and Developing Countries: A Critical Overview”, *International Journal of Health Planning and Management*, 13, 1998, pp.199-215.
77. According to a 1995 WHO and World Bank analysis, 30 per cent of women’s and 12 per cent of men’s overall burden of disease and disability is related to reproductive ill-health. These rough estimates suggest that a large proportion of the health problems of women, men and children are other than those relating to reproductive health (Koivusalo, M. and Ollila, E., op. cit. 3, p.199).
- Diseases that are predominantly infectious cause some two-thirds of women’s deaths in India. Data on women’s mortality in India indicate that the largest proportion of female deaths occur before women had children; nearly 30 per cent of women’s deaths are of girls under the age of 15. Of women of reproductive age, nearly 30 per cent of deaths are caused by major infectious diseases (TB, malaria, cholera, pneumonia, diarrhoea, dysentery and jaundice), while about 12.5 per cent of deaths are due to childbirth and conditions associated with it. The proportion of women who are not pregnant who die because of anaemia is several times higher than the proportion of pregnant anaemic women dying. Mohan Rao argues that “given the overall health situation among women, dominated by communicable diseases, anaemia and under-nutrition, to concentrate on reproductive health is to utterly miss the woods for the trees” (Qadeer, I., op. cit. 76; Rao, M., “Reifying Reproduction”, op. cit. 21).
78. A common effect of Depo-Provera is excessive menstrual-like bleeding, which can cause and exacerbate anaemia.
79. Although access to clean water, sanitation and decent nutrition would reduce maternal and infant deaths, women would still need basic delivery services, and antenatal and postnatal care, to avoid illness and death.
80. Report of a Commonwealth Expert Group on Women and Structural Adjustment, *Engendering Adjustment for the 1990s*, London, Commonwealth Secretariat, 1989, p.83.
81. Bandarage, A., op. cit. 54, p.203.
82. Petchesky, R.P., op. cit. 26, pp.18-19.
83. Ibid., p.11. For a case-study analysis of how state-endorsed family planning practices in Egypt encourage women to think of themselves as individual decision-makers for their immediate families and national interests while other forces bind them to their extended families and religious identities and legislation discriminates against them in marriage, inheritance and work, see Asdar Ali, K., *Planning the Family in Egypt: New Bodies, New Selves*, University of Texas, 2002.
84. Silliman, J., op. cit. 26, p.151.
85. Petchesky, R.P., op. cit. 26, pp.35,36
86. Qadeer, I., “Women and Health”, *Political Environments*, No 6, Fall 1996, www.cwpe.org/pdf/pe6.pdf.
- From a different perspective, sociologist Frank Furedi contends that promoting population policies through the rhetoric of women’s health is a significant innovation that has become central to “the marketing of fertility control”. This medicalization of population issues “is seldom contested, because it appears to be entirely about the non-controversial subject of health”. One result of describing population policies in terms of

reproductive health has been that the “underlying agenda of fertility control becomes inconspicuous to the designated target audience” (Furedi, F., op. cit. 4, p.139).

87. Qadeer, I., “Reproductive Health: A Public Health Perspective”, *WGNRR Newsletter*, No. 68, 1998, p.21.
88. Rao, M., “Reifying Reproduction”, op. cit. 21. See also Richey, L. A., op. cit. 66.
- Another result of neo-liberal economic policies is the privatisation and lack of regulation of family planning services themselves, as corporations, non-governmental organisations and philanthropic bodies become more involved. In Mexico, for instance, many of the predominantly US-owned factories in the export processing *maquiladoras* along the US-Mexico border employ women only if they are not pregnant. Workers and applicants not only have to undergo pregnancy tests but also provide information about their sexual activity and contraceptive use. They tend to be among the poorest and least educated with the least formal work experience. Pregnant women are rendered virtually unemployable. Many women are the primary wage earner for their family (“A Job or Your Rights: Continued Sex Discrimination in Mexico’s Maquiladora Sector”, Human Rights Watch Report, Vol. 10, No 1(B), Human Rights Watch, New York, 1998, www.hrw.org/reports98/women2/Maqui98d.htm).
- Another example is that of the malarial drug, quinacrine, which has been used to sterilise over 100,000 women around the world in more than 20 countries during the past two decades, even though the method has not been approved by a regulatory body anywhere in the world, is considered experimental, has never been tested for its safety or efficacy as a method of sterilisation, and may have potential toxicological, carcinogenic and mutagenic effects. India banned the manufacture, sale, distribution and use of quinacrine pellets in 1998, while Chile has banned its use in sterilisations. Several other countries are taking action to prevent quinacrine sterilisation. Nonetheless, individuals ignore or bypass national drug regulatory processes, and use private funding if public sources are unavailable.
- To sterilise women, pellets of quinacrine hydrochloride are inserted directly into a woman’s uterus with a modified Copper T intrauterine device (IUD) inserter. The pellets dissolve in about 30 minutes, and the liquefied drug flows into the fallopian tubes and causes scarring. Within 6–12 weeks, the scar tissue should block the fallopian tubes. The current expert view, including from the World Health Organisation, is that quinacrine should not be used to sterilise women, even in clinical trials, until toxicological studies and studies of the women who have been sterilised in this way have been conducted.
- Yet since the 1980s, the use of quinacrine in non-surgical sterilisation has been championed by the US Center for Research on Population and Security, headed by Dr. Stephen Mumford, and the International Federation for Family Health, headed by Dr. Elton Kessel. The two organisations have provided financial, technical and material assistance to groups and individuals expressing an interest in the method and distributed quantities of the drug free of charge. The US Food and Drug Administration subsequently ordered Kessel and Mumford to discontinue exporting quinacrine because of safety concerns and because it is not approved for use as a

contraceptive in any country. The FDA also ordered the US organisations to destroy their existing supplies of quinacrine because of concerns about the drug's effect on reproductive-tract cancers, development of abnormal uterine lesions, ectopic pregnancies and foetal anomalies. Yet Mumford and Kessel indicated that they had made arrangements to manufacture and distribute the drug outside the US.

In addition, US multibillionaire Warren Buffett has donated US\$2 million to Family Health International to carry out laboratory tests on quinacrine in the hope that the method would gain approval from the US Food and Drug Administration. Without this money, quinacrine research would probably not have moved forward (Hartmann, B., "op. cit. 16, p.270).

A recent study in West Bengal, India, revealed that non-surgical quinacrine sterilisation is being practised by informal networks of providers, none of whom are qualified medical doctors, despite India's ban on the practice. The study concludes that quinacrine sterilisation continues because there is no attempt to regulate those who pose as doctors, and there are no significant consequences for those who ignore the ban. For more information, see www.cwpe.org.

89. Corrêa, S., *Population and Reproductive Rights: Feminist Perspectives from the South*, Zed Books, London and New York, 1994, p.58.
90. Keyzers, L., "Commitment for Reproductive Health and Justice", paper presented at plenary panel, "Key Issues for Women Organising for Reproductive Health and Justice, at "Reproductive Health and Justice: International Women's Health Conference for Cairo 94", Rio de Janeiro, January 1994, p.6. See also *Women's Global Network for Reproductive Rights Newsletter*, No. 42, WGNRR, Amsterdam, Jan.-March 1993, pp.28-29.
91. Even these groups, however, were not paying attention to the Uruguay Round of Multilateral Trade Negotiations that was taking place at the same time as the ICPD process. The negotiations started in 1986, were completed in 1994 and led to the formation of the World Trade Organisation in 1995. They entrenched neo-liberal economic policies still further and an approach to health service provision that ignores women's reproductive and other needs.
Moreover, during the 1990s, neo-liberalism was being unquestioningly followed and promoted by the major government donors and international funding organisations of population activities. Developing country governments and the initiators of the Women's Declaration may have been reluctant to disagree openly with the Programme of Action's neo-liberal approach in order to keep these governments and institutions on their side both for their financial support and for their help in minimising the influence of religious fundamentalists. The neo-liberal economic discourse does not acknowledge that "reproduction" involves much more than biological reproduction and encompasses the maintenance and reproduction of families, households and communities.
92. Kelsey, J., *Economic Fundamentalism*, Pluto Press, London, 1995, p.372.
93. See footnote 10.
94. Harcourt, W., "The Reproductive Health and Rights Agenda Under Attack", editorial, *Development*, Vol. 46, No. 2, June 2003, p.4. At Cairo, several Islamic and Christian

interests put aside their centuries-old differences to join in opposing women's rights, denying family planning information and services to adolescents, and imposing a narrow interpretation of "family".

95. Corrêa S., "Quandaries at the Site of Human Rights", *Development*, Vol. 46, No. 2, June 2003, p.22. See also DAWN, *Special Supplement for the World Social Forum, Mumbai on The Many Faces of Fundamentalism*, January 2004, www.dawn.org.fj/publications/DAWNInforms/supplwsfjan04.pdf.
96. The Millennium Development Goals (MDGs), however, do specify discrete targets for and indicators of maternal health, child mortality, contraceptive prevalence, and HIV/AIDS, malaria and other major diseases. UNFPA has linked the ICPD Programme of Action and the MDGs. The health, education and poverty eradication goals identified are narrowly defined and disconnected from each other and wider contexts, but easily measurable and quantifiable. "Gender equality" is identified as a discrete goal, rather than attention being paid to the gender dimensions of other goals such as poverty eradication and combating HIV/AIDS. Yet as Peggy Antrobus of DAWN comments, "no amount of education can protect a woman's exposure to the [HIV] virus if she cannot negotiate safe sex" (Antrobus, P., "MDGs—Most Distracting Gimick", *Dawn Informs*, DAWN, September 2003, pp.6-8, www.dawn.org.fj/publications/DAWNInforms/Dlsep03final.pdf).
97. Berer, M., "Images, Reproductive Health and the Collateral Damage to Women of Fundamentalism and War", *Reproductive Health Matters*, Vol.9, No.18, November 2001, p.6.
98. The rule was first signed by President Ronald Reagan in 1984 after the UN's population conference in Mexico (see footnote 3) but suspended by President Bill Clinton almost a decade later.
99. "DAWN Says No To Negotiations For Beijing + 10 and Cairo + 10", DAWN, Suva, Fiji, 17 March 2003.
Comments Fatou Sow, "the current Bush administration can be considered fundamentalist because of its alliance with right wing fundamentalist groups in the US, and a very conservative and fundamentalist approach to the values of family, sexual and reproductive health and rights" (DAWN, op. cit. 95). Moreover, the United States is now far more concerned about perceived impacts on its "security" from "burgeoning populations" in the South, particularly of young men, than it is about women's well-being.
100. Women's International Coalition for Economic Justice, "Critical Moments, Signs of Resistance and Evolving Strategies", *Development*, Vol. 46, No. 2, June 2003, p.117-120.
101. Harcourt, W., op. cit. 94.
102. See, for example, Evers, B. and Juárez, M., "The Reproductive Health Agenda in the Context of Health Sector Reform", in *Globalization, Health Sector Reform, Gender and Reproductive Health*, op. cit. 70, p.37.
103. Hodgson, D. and Cotts Watkins, S., op. cit. 13, p.470.
104. Furedi, F., op. cit. 4, p. 163.
105. UNFPA, *State of World Population 2002, Summary. People, Poverty and Possibilities: Making Development Work for the Poor*, December 2002.
106. Bandarage, A., op. cit. 54, p.80.

107. Hartmann, B., op. cit. 7, p.38.

108. Ibid. Making population control a goal has an impact not only on contraceptive technologies but also on the delivery of reproductive health services and the relationships between health professionals and women. Family planning programmes designed to reduce birth rates as quickly and cheaply as possible typically do not offer contraceptive choice, adequate counselling, screening and treatment of contraceptive side effects, and the omission of other reproductive health measures. For a description of this process in Tanzania, see Richey, L., op. cit. 72.

109. In some countries, however, particularly where fundamentalist or traditionalist interests hold sway, women have access to neither. In the past decade, it has been HIV/AIDS rather than women's health and self-determination that has increased the interest in some quarters into researching and providing barrier contraceptive methods. Nonetheless, reproductive rights and health analyst Lisa Richey argues that the primary focus of current international population policy on the countries of sub-Saharan Africa that have high fertility rates and the concomitant emphasis on contraceptive delivery is undermining efforts to address AIDS in Africa (Richey, L.A., "Is Overpopulation Still the Problem?: Global Discourse, International Donors and National Policies in Tanzania and Uganda", paper presented to the African Studies Association Annual Meeting, Houston, Texas, November 2001, cited in Hartmann, B., op. cit. 26).

In Tanzania, AIDS and reproductive health programmes are still thought of and implemented through separate channels to the detriment of both. "A population discourse dominated by concern for controlling fertility, whether by women, couples or governments, precludes adequate incorporation of the challenges that AIDS brings to health care policy . . . When HIV/AIDS is at the centre of women's lives – even though it is unspoken – and reproductive health services do not involve meaningful interventions for prevention and treatment, AIDS threatens to render meaningless the other important accomplishments of the reproductive health agenda. In the midst of the AIDS pandemic in many African communities, 'reproductive health' might be best understood as being able to remain healthy long enough to reproduce and raise children . . . AIDS challenges us not just to expand the scope of the old population policies with interventions for tackling the disease, but to rethink the justifications for these policies, their primary actors and their goals" (Richey, L.A., "HIV/AIDS in the Shadows of Reproductive Health Interventions", *Reproductive Health Matters*, 11 (22), 2003, pp.30-35).

110. Keyzers, L., op. cit. 90, p.2.

111. Although the Programme of Action focused on "population stabilisation" in the South, the Report of the European Population Conference for the ICPD explicitly called for tax incentives, low-cost or free child and maternal welfare services and other supports to encourage childbearing and childrearing in Europe (Bandarage, A., op. cit. 54, p.51). The Japanese government, which agreed in 1994 to contribute US\$3 billion for global population and AIDS issues, and is now the leading country aid donor for overseas population activities,

exhorts Japanese women with economic incentives to bear more children so as to avert a domestic population “implosion”.

US economist Nancy Folbre points out that “Multilateral institutions such as the World Bank favor improvements in women’s position in developing countries because these contribute to fertility decline. Yet many of the advanced industrial countries that fund these institutions worry that fertility decline in their own countries has gone too far – to levels below replacement – also because of improvements in women’s position.” Population policymakers might conclude that population stabilisation requires “just enough but not too much” women’s empowerment – “or perhaps the concept of women’s empowerment needs a more encompassing definition” (Folbre, N., “Book Review”, *Population and Development Review*, Vol. 27, No. 2, 2001).

112. See *Listen to the Refugee’s Story: How UK Investment Creates Refugees and Asylum Seekers*, The Corner House/Peace in Kurdistan/ Ilisu Dam Campaign Refugee Project, November 2003, www.thecornerhouse.org.uk/document/refinves.html.
113. Anti-immigration movements in Europe and the US are demanding drastic measures to restrict immigration and curtail benefits to immigrants and refugees. The removal of a clause from the draft Programme of Action on the rights of migrants to family reunification was a victory for the anti-immigration agenda in the North (Bandarage, A., op. cit. 54, p.38).
114. Ross, E., op. cit. 4.

Ever since T.R. Malthus wrote his first treatise in 1798, it has been refuted endlessly by practical instances indicating that any problem attributed to human numbers can just as easily have a different explanation. Anthropologist Eric Ross has documented the various political and economic

interests that have found Malthusianism and its subtle contemporary variants useful over the past two centuries. He stresses that explanations of poverty and environmental degradation as “products of human population pressure on resources” have rationalised or obscured “the aims and contradictions of capitalist development” and given “the cover of legitimacy to Western interests.” In fact, “the proper context . . . for understanding the contemporary circumstances of any developing country . . . is that of global political economy, not local reproductive habits.”

As Australian feminist political ecologist Deb Foskey points out, “Population and reproduction are highly political areas which reflect the broader politics of the international community and provide a vehicle for contests between impassioned deeply-felt values and ideologies” (Foskey, D., op. cit. 13, p.254).

115. Simon Kumar, R., *Marketing Reproduction? Political Rhetoric and Gender Policy in India*, Kali for Women/Zubaan, New Delhi, (forthcoming).
116. National security issues are increasingly invoked to support Cairo’s Programme of Action. For instance, a 2003 report from Population Action International suggests that civil conflict is generated in large part by demographic factors, even though conflict has invariably diverted resources away from women’s access to food, clean water, sanitation and health care, and led to the spread of disease and thus undermined women’s reproductive health and rights significantly. The prevalent nexus of neo-liberalism, fundamentalism and militarism, moreover, threatens women’s health and rights still further. This nexus builds on arguments developed in the 1990s linking conflict with demographic factors and environmental degradation (Cincotta, R.P., Engelman, R. and Anasatasion, D., *The*

Security Demographic: Population and Civil Conflict After the Cold War, Population Action International, Washington DC, 2003, www.populationaction.org/resources/publications/securitydemographic/download.htm; Rehn, E. and Johnson Sirleaf, E., *Women, War and Peace: The Independent Experts’ Assessment on the Impact of Armed Conflict on Women and Women’s Role in Peace-building*, UNIFEM, New York, 2002, http://www.unifem.org/index.php?f_page_pid=149).

- For a critique of these arguments, see Hendrixson, A., “The ‘Youth Bulge’: Defining the Next Generation of Young Men as a Threat to the Future”, *DifferenTakes*, No. 19, Winter 2003, <http://hamp.hampshire.edu/~clpp/popdev.html>; Hendrixson, A., “Superpredator Meets Teenage Mom: Exploding the Myth of the Out-of-Control Youth”, in Silliman, J. and Bhattacharjee, A., op. cit. 16; Hartmann, B., “Population, Environment and Security: A New Trinity” in Silliman, J. and King, Y. (eds.) op. cit. 26.
117. See Hildyard, N., “The Future is Now: Privatisation, Population and the Politics of Tomorrow”, The Corner House, (forthcoming), www.thecornerhouse.org.uk.
118. Corrêa, S. and Petchesky, R., “Reproductive and Sexual Rights: A Feminist Perspective” in Sen, G., Germain, A. and Chen, L.C. (eds.) *Population Policies Reconsidered*, Harvard University Press, Cambridge, MA, 1994.
119. Hartmann, B., op. cit. 7, p.155.
120. Hildyard, N., “Transnational Strategies”, presentation to Forum Against the G-7: Quelles Alternatives à la Globalisation, Lyon, June 1996, www.thecornerhouse.org.uk/document/tncslyon.html.
121. Hartmann, B., op. cit. p.309.
122. Kelsey, J., op. cit. 92, p.372.
123. Ibid.

WGNRR is an autonomous network of individuals, groups and organisations in every continent which aim to support reproductive and sexual self-determination for women.



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The Corner House is a UK-based advocacy, research and solidarity group. It aims to support democratic and community movements for environmental and social justice, and aims to pay constant attention to issues of social, economic and political power and practical strategy. As part of its solidarity work, The Corner House carries out analyses, research and advocacy with the aim of linking issues, of stimulating informed discussion and strategic thought on critical environmental and social concerns, and of encouraging broad alliances to tackle them.

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