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# **Reproductive and Sexual Rights: Charting the Course of Transnational Women's NGOs**

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United Nations Research Institute for Social Development

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## Acronyms

|                |  |
|----------------|--|
| <b>AIDS</b>    | acquired immunodeficiency syndrome                                       |
| <b>CBO</b>     | community-based organization   |
| <b>CFFC</b>    | Catholics for a Free Choice  |
| <b>CISMU</b>   | Women's Health Cross-Sectoral Commission (Brazil)                        |
| <b>CLADEM</b>  | Latin American and Caribbean Committee for the Defence of Women's Rights |
| <b>CNDM</b>    | National Council of Women's Rights (Brazil)                              |
| <b>CNPD</b>    | National Commission on Population and Development Brazil)                |
| <b>CRLP</b>    | Center for Reproductive Law and Policy                                   |
| <b>CWPE</b>    | Committee on Women, Population and the Environment                       |
| <b>DALY</b>    | disability-adjusted life years   |
| <b>DAWN</b>    | Development Alternatives with Women for a New Era                        |
| <b>DISH</b>    | Delivery of Improved Services for Health                                 |
| <b>ECOSOC</b>  | United Nations Economic and Social Council                               |
| <b>EU</b>      | European Union   |
| <b>FGM</b>     | female genital mutilation  |
| <b>FPAI</b>    | Family Planning Association of India                                     |
| <b>G-77</b>    | Group of 77  |
| <b>HERA</b>    | Health, Empowerment, Rights and Accountability                           |
| <b>HIV</b>     | human immunodeficiency virus   |
| <b>HSR</b>     | health sector reform   |
| <b>ICESCR</b>  | International Covenant on Economic, Social and Cultural Rights           |
| <b>ICPD</b>    | International Conference on Population and Development                   |
| <b>IFI</b>     | international financial institutions                                     |
| <b>IMF</b>     | International Monetary Fund  |
| <b>IPPF</b>    | International Planned Parenthood Federation                              |
| <b>IRRRAG</b>  | International Reproductive Rights Research Action Group                  |
| <b>IWHC</b>    | International Women's Health Coalition                                   |
| <b>LACWHN</b>  | Latin American and Caribbean Women's Health Network                      |
| <b>NAF</b>     | National Abortion Federation (United States)                             |
| <b>NGO</b>     | non-governmental organization  |
| <b>NPU</b>     | National Population Unit (South Africa)                                  |
| <b>ODA</b>     | official development assistance  |
| <b>PAI</b>     | Population Action International  |
| <b>PAISM</b>   | Comprehensive Women's Health Program (Brazil)                            |
| <b>POA</b>     | Programme of Action  |
| <b>PrepCom</b> | Preparatory Committee  |
| <b>RAINBO</b>  | Research Action Network for Bodily Integrity of Women                    |
| <b>RCH</b>     | reproductive and child health  |
| <b>RTI</b>     | reproductive tract infection   |
| <b>SAP</b>     | structural adjustment programme  |
| <b>STD</b>     | sexually transmitted disease   |
| <b>SUS</b>     | universal health system (Brazil)   |
| <b>TFA</b>     | Target-Free Approach   |
| <b>TNC</b>     | transnational corporation  |
| <b>UDHR</b>    | Universal Declaration of Human Rights                                    |
| <b>UN</b>      | United Nations   |
| <b>UNAIDS</b>  | Joint United Nations Programme on HIV/AIDS                               |

|                |  |
|----------------|--|
| <b>UNCED</b>   | United Nations Conference on Environment and Development         |
| <b>UNDP</b>    | United Nations Development Programme                             |
| <b>UNESCO</b>  | United Nations Educational, Scientific and Cultural Organization |
| <b>UNFPA</b>   | United Nations Population Fund                                   |
| <b>UNICEF</b>  | United Nations Children's Fund                                   |
| <b>UNIFEM</b>  | United Nations Development Fund for Women                        |
| <b>UN/NGLS</b> | United Nations Non-Governmental Liaison Service                  |
| <b>US</b>      | United States  |
| <b>WDR</b>     | World Development Report   |
| <b>WEDO</b>    | Women's Environment and Development Organization                 |
| <b>WGNRR</b>   | Women's Global Network for Reproductive Rights                   |
| <b>WHO</b>     | World Health Organization  |
| <b>WHP</b>     | Women's Health Project (South Africa)                            |
| <b>WHSMF</b>   | Women's Health and Safe Motherhood Project (Philippines)         |
| <b>WSSD</b>    | World Summit for Social Development                              |
| <b>WTO</b>     | World Trade Organization   |

## Summary/Résumé/Resumen

### Summary

This paper critically examines the role that transnational women's NGOs played in the 1990s in the creation and implementation of international agreements related to reproductive and sexual rights. Its focus throughout is twofold. First, it explores the multiple ways in which reproductive and sexual rights intersect with, and are embraced within, a wide range of health, human rights, social and gender justice and human development issues. Second, it uses this inquiry to rethink the complex political dynamics in which transnational women's NGOs find themselves, as they manoeuvre within a globalizing yet deeply divided and grossly inequitable world. These dynamics encompass a double and precarious positioning. On the one hand, feminist groups have had a major impact at both international and national levels in shifting dominant discourses about reproduction, population and sexuality in a direction that puts the ends of women's health and empowerment above that of reducing population growth. This is a major historical achievement and a mark of the power of transnational women's NGOs. On the other hand, the translation of this discursive shift into effective policies and programmes has been seriously limited by global economic processes and religious and cultural forces whose institutional power is far greater than any that feminist groups could possibly attain at this juncture. It has also been limited, however, by internal divisions and strategic short-sightedness among the women's groups themselves.

The paper assesses recent successes and limitations of women's movements as agents of change in the international arena by focusing particularly on the work of organizations and coalitions active in the field of reproductive and sexual health and rights. Building on previous research, it analyses the "fault lines" between reproductive and sexual health/rights and their necessary economic, social and cultural enabling conditions. Groups seeking to implement reproductive and sexual rights for women and young people have long had to confront macroeconomic, fundamentalist and neo-Malthusian agendas that perpetuate gender, race and class inequalities and thus impede concrete implementation of those rights for the vast majority. Recently, however, the project of transforming these conditions has been complicated by several additional trends. These include: (1) ongoing economic crises that simultaneously call into question *and* provide an occasion for reforming structural adjustment policies and public sector cuts imposed by international lenders; (2) health reform plans that stress cost-recovery measures such as user fees; (3) the abdication by national governments of their responsibility to provide social services in basic areas such as health care and education; and (4) the tendency for diverse actors who lack any political accountability—such as fundamentalist religious groups, commercial businesses and non-profit NGOs—to fill the gap.

The body of the paper is organized into four sections. Section I looks at the broad vision of reproductive and sexual health and rights developed by feminists of the North and the South over the past three decades. The discussion here emphasizes the holistic perspective linking three components:



*health, development and human rights*. It also shows how such thinking seriously challenges approaches that dichotomize rights and needs, individuals and communities, by investigating the necessary links, in both ethics and politics, between basic needs and fundamental human rights.

Section II offers an overview of the United Nations conferences of the 1990s in order to assess how and where the women's coalition succeeded in infusing its perspectives on reproductive and sexual rights into the conference documents, and where and why it failed. Focusing mainly on the International Conference on Population and Development (ICPD) in Cairo, the Fourth World Conference on Women in Beijing and the World Summit for Social Development in Copenhagen, the analysis contrasts feminist perspectives and strategies with those of two other major "stakeholders" who have attempted to shape the dominant international discourses and policies around reproductive and sexual health: fundamentalist groups, especially the Vatican, and mainstream population and family planning organizations. The success of these two groups in also influencing the conference documents at strategic points, as well as the weak political process of the United Nations itself, render those documents fragile and contradictory despite their groundbreaking advances.

Section III begins with an overview of globalization, macroeconomic policies affecting social services and recent trends in health sector reform. Within the context of diminished state responsibilities and what I call "the many faces of privatization," the paper looks at the efforts of women's NGOs to hold their governments accountable for international commitments, implement the provisions of the ICPD Programme of Action, and transform reproductive and sexual health/rights into concrete policy. In most cases, economic constraints, gaps in resources and cuts in services—sometimes compounded by the resurgence of fundamentalist movements—form the backdrop to women's activism. In some contexts, however, women's NGOs are making important changes in national policy despite the disabling environment, and occasionally (for example in Brazil) are creating new and promising models of civil society-government co-operation.

Finally, the last section examines recent concerns that NGO activism may become merely another link in the chain of privatization that further weakens state power, and thus state responsibility, in the era of globalization. I conclude that the participation by women's health NGOs in both the United Nations conferences and the national-level implementation processes has on the whole had beneficial outcomes. Both experiences have led to a broader understanding of the necessity for profound structural changes in macroeconomic policies and the system of global governance, if reproductive and sexual rights are to become a reality for all. However, this holistic vision still lacks a commensurate *strategy*—including stronger coalitions with other social movements; measures to counter or regulate the privatization of social services, even when performed by women's groups; and effective mechanisms for civil society organizations to monitor and transform macroeconomic policies and institutions. Such a strategy is indispensable to creating the necessary enabling environment for people-centred health care.

Rosalind Petchesky is Professor of Political Science and Women's Studies at Hunter College, City University of New York, the founder and former international co-ordinator of the International Reproductive Rights Research Action Group (IRRRAG) and a MacArthur Fellow.

## **Résumé**

L'auteur examine d'un oeil critique le rôle que les ONG féminines transnationales ont joué dans les années 90 dans l'élaboration et la mise en oeuvre des accords internationaux relatifs aux droits en matière de reproduction et de sexualité. Elle suit une double piste. Premièrement, elle explore les multiples façons dont ces droits recourent un large éventail de questions touchant à la santé, aux droits de l'homme, à la justice sociale, à l'équité entre hommes et femmes et au développement humain ou s'y inscrivent. Deuxièmement, elle se sert de cette enquête pour repenser les dynamiques politiques complexes dans lesquelles sont engagées les ONG féminines transnationales, qui évoluent dans un monde en voie de mondialisation, certes, mais profondément divisé et d'une iniquité flagrante. Ces dynamiques sont marquées par un double et précaire positionnement. D'une part, les groupes féministes ont été influents aux niveaux tant international que national puisqu'ils ont réussi à faire passer les objectifs de santé et d'autonomisation des femmes avant le ralentissement de la croissance démographique dans les discours dominants sur la reproduction, la population et la sexualité. C'est là un acquis historique majeur et révélateur de la puissance des ONG féminines transnationales. D'autre part, la traduction de ce changement de discours en politiques et programmes efficaces a été sérieusement limitée par la donne économique mondiale et par des forces religieuses et culturelles dont les institutions sont bien plus puissantes que celles de n'importe quel groupe féministe aujourd'hui. Elle a été limitée également par des divisions internes et par la courte vue des groupes féminins eux-mêmes en matière de stratégie.

L'auteur analyse les récents succès remportés par les mouvements féminins comme agents du changement sur la scène internationale et les limites auxquelles ils se sont heurtés, en concentrant particulièrement son attention sur le travail des organisations et des coalitions dont le domaine d'action est celui de la santé et des droits en matière de reproduction et de sexualité. S'appuyant sur des recherches antérieures, elle analyse les "lignes de faille" entre la santé/les droits en matière de reproduction et de sexualité et les conditions économiques, sociales et culturelles qui doivent nécessairement préexister. Les groupes qui cherchent à faire des droits en matière de reproduction et de sexualité une réalité pour les femmes et les jeunes ont dû longtemps s'opposer aux programmes macro-économiques, intégristes et néo-malthusiens qui perpétuent les inégalités entre les sexes, les races et les classes et font donc obstacle à la réalisation concrète de ces droits pour la grande majorité. Récemment, pourtant, plusieurs tendances sont venues compliquer encore le projet de transformation de ces conditions: (1) les crises économiques en cours qui, tout en contestant les politiques d'ajustement structurel et les compressions du secteur public imposées par les créanciers internationaux, fournissent l'occasion de les réformer; (2) les plans de réforme de la santé qui mettent

l'accent sur les mesures de recouvrement des coûts telles que l'introduction de cotisations pour les utilisateurs; (3) la démission des gouvernements nationaux devant la responsabilité qui leur incombe de fournir des services sociaux dans des domaines essentiels tels que les soins de santé et l'éducation; et (4) la tendance de divers acteurs n'ayant aucune obligation politique de rendre des comptes, tels que des groupes religieux intégristes, des entreprises commerciales et des ONG sans but lucratif, à combler le vide.

Le corps de l'étude se divise en plusieurs sections. La première décrit dans les grandes lignes la santé et les droits en matière de reproduction et de sexualité tels qu'ils ont été envisagés par les féministes du Nord et du Sud au cours des 30 années écoulées. Le raisonnement met ici en évidence la perspective globale liant les trois éléments suivants: *la santé, le développement et les droits de l'homme*. Il montre aussi en quoi cette façon de penser remet sérieusement en question les approches qui opposent les droits aux besoins, les individus aux collectivités, en recherchant les liens qu'il doit y avoir, en éthique comme en politique, entre les besoins essentiels et les droits fondamentaux de l'homme.

La section II passe en revue les conférences des Nations Unies des années 90 pour évaluer en quoi et où la coalition féminine a réussi à faire passer son point de vue sur les droits en matière de reproduction et de sexualité dans les documents de ces conférences et où et pourquoi elle n'y a pas réussi. L'analyse, qui porte essentiellement sur la Conférence internationale sur la population et le développement du Caire, sur la Quatrième Conférence mondiale sur les femmes de Beijing et sur le Sommet mondial pour le développement social de Copenhague, confronte les points de vue et stratégies féministes avec ceux de deux autres "parties prenantes" non négligeables, qui ont tenté de modeler les discours internationaux dominants et les politiques sur la santé en matière de reproduction et de sexualité: les groupes intégristes, en particulier le Vatican, et les organisations traditionnelles de planification démographique et familiale. Le succès de ces derniers, qui ont réussi à marquer de leur empreinte les documents des conférences à des points stratégiques, et la faiblesse du processus politique au sein des Nations Unies elles-mêmes rendent ces documents fragiles et contradictoires bien que révolutionnaires à certains égards.

La section III commence par une vue d'ensemble de la mondialisation, des politiques macro-économiques qui ont une incidence sur les services sociaux et des tendances qui se dessinent depuis peu dans la réforme du secteur de la santé. Dans le contexte du recul des responsabilités de l'Etat et de ce que l'auteur appelle "les nombreux visages de la privatisation", l'étude s'intéresse aux efforts déployés par les ONG féminines pour obliger leurs gouvernements à honorer les engagements internationaux, à mettre en oeuvre les dispositions du Programme d'action de la Conférence internationale sur la population et le développement et à transformer les droits/la santé en matière de reproduction et de sexualité en mesures politiques concrètes. Dans la plupart des cas, les femmes militent dans un contexte marqué par les contraintes économiques, le manque de ressources et la suppression de services, circonstances parfois aggravées par la résurgence de mouvements intégristes. Dans certains pays, cependant, les ONG féminines amènent des changements importants de politique malgré un climat peu propice et créent à l'occasion (au Brésil par

exemple) des modèles nouveaux et prometteurs de coopération entre la société civile et le gouvernement.

La dernière section, enfin, examine certaines craintes exprimées récemment, notamment celle que le militantisme des ONG ne devienne qu'un maillon de plus dans la chaîne de la privatisation et n'affaiblisse encore le pouvoir de l'Etat, et de ce fait sa responsabilité, à l'ère de la mondialisation. L'auteur conclut que la participation des ONG féminines de la santé tant aux conférences des Nations Unies qu'aux processus de mise en oeuvre au niveau national a eu, dans l'ensemble, des effets bénéfiques. Ces deux expériences ont aidé à faire comprendre plus largement que la réalisation pour tous des droits en matière de reproduction et de sexualité passait nécessairement par des changements structurels profonds des politiques macro-économiques et du système de gouvernance mondial. Cette vision globale n'a cependant pas encore de *stratégie* à sa mesure—coalitions plus fortes avec d'autres mouvements sociaux, mesures propres à combattre ou à réglementer la privatisation des services sociaux, même lorsqu'ils sont assurés par des organisations féminines; et mécanismes efficaces permettant aux organisations de la société civile d'observer les politiques et institutions macro-économiques et de les modifier. Une telle stratégie est indispensable à la création des conditions propices nécessaires à des soins de santé centrés sur l'être humain.

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## **Resumen**

El presente informe es un estudio crítico de la función que desempeñaron las ONG transnacionales dedicadas a la mujer en la década de los años 90, en lo concerniente a la elaboración y aplicación de acuerdos internacionales relacionados con los derechos reproductivos y sexuales. Se centra en dos aspectos. En primer lugar, se analizan los múltiples modos en que los derechos reproductivos y sexuales están relacionados y vinculados a una gran variedad de cuestiones relativas a la sanidad, los derechos humanos, la justicia social y a la paridad de los sexos y el desarrollo humano. En segundo lugar, este estudio sirve para replantearse la compleja dinámica política en la que se encuentran las ONG transnacionales dedicadas a la mujer, ya que actúan en un mundo en proceso de mundialización, pero profundamente dividido e injusto. Esta dinámica abarca una situación ambigua y precaria. Por una parte, la influencia de los grupos feministas ha sido fundamental, tanto a nivel nacional como internacional, al lograr que los discursos dominantes sobre la reproducción, la población y la sexualidad concedan más importancia a la cuestión de la salud y la habilitación de las mujeres que a la reducción del crecimiento demográfico. Esto constituye un logro histórico importante y un indicio del poder de las ONG dedicadas a la mujer. Por otra parte, la transformación de este cambio discursivo en políticas y programas eficaces se ha visto extensiblemente

limitada por los procesos económicos mundiales y las fuerzas religiosas y culturales, cuyo poder institucional es mucho mayor del que cualquier grupo feminista podría adquirir en la actualidad. Sin embargo, dicha transformación se ha visto limitada igualmente por las divisiones internas y la falta de perspicacia estratégica entre los propios grupos feministas.

En el informe se evalúan los logros y las limitaciones recientes de los movimientos feministas, como representantes del cambio a nivel internacional, centrándose en particular en la labor desplegada por las organizaciones y coaliciones activas en el ámbito de la salud y los derechos reproductivos y sexuales. Sobre la base de investigaciones anteriores, se estudian las “líneas defectuosas” entre la salud y los derechos reproductivos y sexuales, y sus condiciones favorables necesarias a nivel social, cultural y económico. Los grupos que luchan por poner en práctica los derechos reproductivos y sexuales de la mujer y de los jóvenes han tenido que enfrentarse durante mucho tiempo a los programas macroeconómicos, fundamentalistas y neomaltusianos (represivos) que imponen constantemente las desigualdades por razón de sexo, raza o clase social, y que impiden, por tanto, la aplicación concreta de estos derechos para la gran mayoría. En los últimos tiempos, sin embargo, el proyecto de transformación de estas condiciones se ha complicado debido a otras tendencias adicionales, entre las que se incluyen: (1) las continuas crisis económicas que al mismo tiempo ponen en duda y ofrecen una oportunidad para reformar las políticas de ajuste estructural y los recortes en el sector público impuestos por los prestamistas internacionales; (2) los planes de reforma del sector sanitario que ponen énfasis en las medidas orientadas a la recuperación de los gastos, como los derechos de usuario; (3) la renuncia de los gobiernos nacionales a asumir la responsabilidad de facilitar servicios sociales en sectores básicos como la atención sanitaria y la educación; y (4) la tendencia de varios actores que carecen de responsabilidad política—como grupos religiosos fundamentalistas, empresas comerciales y ONG sin fines de lucro— a facilitar una continuidad.

La parte central del informe se divide en varias secciones. En la Sección I se ofrece una visión general de la salud y los derechos reproductivos y sexuales defendidos por los grupos feministas del Norte y del Sur en las tres últimas décadas. El discurso se centra en la perspectiva global que asocia tres componentes: *salud, desarrollo y derechos humanos*. También se expone el modo en que esta filosofía desafía gravemente los criterios que distinguen los derechos de las necesidades, y las personas de las comunidades, al investigar los vínculos necesarios, tanto en el ámbito de la ética como de la política, entre las necesidades básicas y los derechos humanos fundamentales.

En la Sección II se facilita una visión de conjunto de las conferencias de las Naciones Unidas en la década de 1990, a fin de evaluar el modo y los ámbitos en que los grupos feministas lograron infundir sus puntos de vista sobre los derechos reproductivos y sexuales en los documentos de las conferencias, y los sectores y motivos por los que fracasaron. Al centrarse principalmente en la Conferencia Internacional sobre la Población y el Desarrollo (El Cairo), la Cuarta Conferencia Mundial sobre la Mujer (Beijing), y la Cumbre Mundial para el Desarrollo Social (Copenhague), comparan en este estudio las perspectivas y estrategias feministas con las de otros “participantes” importantes que han intentado que los discursos y políticas internacionales dominantes giren en

torno a la salud reproductiva y sexual: grupos fundamentalistas, en particular el Vaticano, y organizaciones principales de planificación demográfica y familiar. El éxito de estos últimos grupos al influir igualmente en los documentos de las conferencias, y el débil proceso político de las propias Naciones Unidas, refleja la inconsistencia y contradicción de los mismos, a pesar de sus progresos revolucionarios.

La Sección III comienza con una visión general de la mundialización y las políticas macroeconómicas que influyen en los servicios sociales y en las últimas tendencias en lo que concierne a la reforma del sector sanitario. Considerando la disminución de las responsabilidades estatales y lo que llamo “los diferentes aspectos de la privatización”, se estudia la labor desplegada por las ONG dedicadas a la mujer para que los gobiernos asuman la responsabilidad de los compromisos internacionales, apliquen las disposiciones del Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo, y transformen la salud/derechos reproductivos y sexuales en una política concreta. En la mayoría de los casos, los condicionamientos económicos, la falta de recursos y la reducción de los servicios—a menudo acompañados del resurgimiento de los movimientos fundamentalistas—constituyen el telón de fondo de la movilización feminista. En algunos ámbitos, sin embargo, las ONG dedicadas a la mujer están introduciendo cambios importantes en la política nacional, pese al entorno desfavorable y, en algunos casos (por ejemplo, en Brasil) están elaborando programas nuevos y prometedores de cooperación entre la sociedad civil y el gobierno.

Finalmente, en la última sección del informe se estudia la preocupación reciente de que la movilización de las ONG pueda convertirse en un simple eslabón más de la cadena de la privatización que debilite más aún el poder estatal, y, en consecuencia, la responsabilidad estatal, en la era de la mundialización. Llego a la conclusión de que la participación de las ONG dedicadas a la salud de la mujer, tanto en las conferencias de las Naciones Unidas como en los procesos de puesta en práctica a nivel nacional, por lo general ha conducido a resultados positivos. Ambas experiencias han facilitado una comprensión más amplia de la necesidad de efectuar cambios estructurales profundos en las políticas macroeconómicas y el sistema de gobierno general, si se desea que los derechos sexuales sean una realidad para todos. Sin embargo, esta visión global aún carece de una *estrategia* adecuada, incluyendo coaliciones más sólidas con otros movimientos sociales, medidas para contrarrestar o regular la privatización de los servicios sociales—aun cuando sean realizados por los grupos feministas—y sistemas eficaces para que las organizaciones de la sociedad civil controlen y transformen las políticas e instituciones macroeconómicas. Esta estrategia es indispensable para crear el ambiente favorable necesario para la atención sanitaria centrada en las personas.

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## Introduction

A chorus of testimonies affirms the mutually transforming impact of women's movement non-governmental organizations (NGOs) working transnationally and the series of United Nations conferences held in the 1990s. The commitments and expertise of women's groups shaped much of the discourse of the conferences in Rio, Vienna, Cairo, Copenhagen and Beijing and "helped change the way UN conferences are planned and conducted" (Chen, 1996:152). At the same time, the conferences themselves, and the UN system, provided a vital forum and a framework through which a transnational women's movement coalesced. In this process women's groups were able to (1) create effective strategies for influencing international norms and infusing them with feminist perspectives, (2) learn important lessons about manoeuvring within the world of international diplomats and bureaucrats, and (3) experience their own power.

Yet, as the decade and century came to a close, economic crises and market-driven policies in ascendance everywhere cast a shadow over these achievements. Although women's NGOs and coalitions have shown their collective ability to win recognition of gender perspectives and human rights in international rhetoric and policy, they have also come up against harsh limits on their power in a *disabling* environment not of their making. This harsher reality has been evident both in the anti-feminist, anti-NGO backlash occurring within UN meeting halls since 1995, and in the larger context where economic, social and cultural conservatism block effective implementation of hard-won rights.

This paper will assess recent successes and limitations of women's movements as agents of change in the international arena by focusing particularly on the work of organizations and coalitions active in the field of reproductive and sexual health and rights. Its main purpose is to re-examine this work by casting it in the light of macro-level pressures, such as globalization, privatization and shifting power dynamics within both international organizations and the world of NGOs. The proliferation of transnational NGO activity in recent years, however productive, has a sobering underside. It is one mined with numerous hazards such as bureaucratism, elitism and donor dependence; transformative visions deferred to short-range projects and tactics; and unpaid technical assistance and service provision for national governments and international institutions. Transnational women's groups have not escaped such minefields.

## I. Transnational Women's Health Coalitions: Origins and Conceptual Frameworks

Women's health NGOs and transnational coalitions have been the central authors, advocates and implementers of a politics of reproductive health and

rights, and to a somewhat lesser degree, of sexual health and rights.<sup>1</sup> Since, during the 1990s, these concepts became “mainstreamed” as part of an international population and development vocabulary, it is useful to ask what is distinct about women’s movement perspectives, what ethical and social visions lie at their core. How, moreover, have the meanings of reproductive and sexual rights shifted as women’s groups from the South increasingly become their advocates?

A language and politics of “reproductive rights” had their historical origins in Northern-based women’s health movements, particularly in the United States, during the 1970s and early 1980s. These movements were galvanized by conservative attacks on women’s access to abortion as well as a feminist political framework privileging women’s right to have “control over their bodies” in matters of reproduction and sexuality. In the mid- to late-1980s, when women’s movements in the South began to mobilize in their own ways and out of their own situations around reproductive health and rights issues, a framework firmly linking these issues to both development issues and human rights emerged (Corrêa, 1994; M. Fried, 1990; Garcia-Moreno and Claro, 1994; Chen, 1996; G. Sen, 1994a; Silliman 1997).

But to reject the concepts of reproductive and sexual health/rights as being a “Western” import makes little sense, unless we are ready to repudiate “democracy,” “freedom,” “national sovereignty” and “development” for the same reason. Ideas are not the property of any one nation or culture; they “travel,” take on new meanings in diverse circumstances, and indeed may be used creatively to oppose the very (colonial or post-colonial) powers that once bred those ideas (Ram, 1999; Bhasin and Khan, 1986). Garcia-Moreno and

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<sup>1</sup> NGOs encompass a broad-ranging spectrum, from (1) grassroots or community-based organizations, to (2) service or advocacy organizations dependent largely on private or government donors, to (3) giant non-profits that are funded mainly through public resources and sometimes have budgets larger than those of some poor countries—e.g., the International Red Cross or CARE International (Weiss and Gordenker, 1996). Transnational women’s NGOs primarily belong to the second category, although they often grow out of women’s movements whose real strength is in the first, and sometimes they form working alliances with mega-organizations that fit the third.

*Reproductive health* is defined in the 1994 International Conference on Population and Development Programme of Action (ICPD POA) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility. . . and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (Para. 7.2).

*Reproductive rights*, as defined in the same document (Para. 7.3), “embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence. . .”. For a definition of *sexual rights*, see below.



Claro, who document the diverse trajectories of women's health movements around the world, make this argument persuasively: "While Western ideas have played a role, women in Southern countries have generated their own analyses, organizations and movements, with and without exposure to the West, and there has been considerable cross-fertilization of ideas—across many countries and continents" (1994:48). During the 1980s and 1990s, especially in the period of the UN conferences, this cross-fertilization contributed to the growing breadth and political sophistication of transnational women's health movements. Women from the South not only embraced the concept of reproductive rights during this period but insisted that it must encompass all of women's reproductive health needs, not only those related to fertility control, and be integrated with a broader development agenda (Corrêa, 1994; Silliman, 1997).

In its earlier years, the transnational women's health movement tended to focus its energies on specific campaigns. These campaigns were primarily defences of women's right to make their own decisions about childbearing, contraception and sexuality and were aimed at both pro-natalist religious and fundamentalist forces, and anti-natalist population control and medical interests. Thus women activists have attempted to secure access to safe, legal and affordable abortion and contraception at the same time as they have opposed such abusive family planning practices as targets and "incentives" for female sterilization and medical technologies considered harmful or inadequately tested in clinical trials (e.g., long-acting hormonal implants and injections). While such focused campaigns continue (recently securing policies that ban the chemical sterilization method, quinacrine, in India and Chile), three major influences have stimulated the movement to develop a more comprehensive and affirmative agenda. The first of these is the harsh economic conditions women are suffering, as caregivers and receivers, under structural adjustment programmes (SAPs) and privatization of social services. The second is the fury of fundamentalist movements, whether Islamist or Christian, that aim to resurrect traditional patriarchal values and gender roles, sometimes through direct verbal or physical attacks on women's groups. Finally, the UN conferences in Cairo and Beijing provided a historic purpose and occasion for women's health activists working transnationally to develop a broader vision and put it into the language of international documents.

Despite political differences and disparities in access to power and resources (both within and among countries and regions), I would argue that activists and thinkers from the South assumed intellectual and political leadership in shaping a more holistic and integrative direction for the transnational women's health movement in the 1990s. One group that has been especially forceful in insisting that "women's reproductive health must be placed within a comprehensive human development framework" is DAWN (Development Alternatives with Women for a New Era), a network of women activists from all regions of the South (Corrêa, 1994:64). DAWN's "holistic analysis" of reproductive health and rights links women's health needs—for "access to contraceptive information and methods and legal abortion, . . . STD and cancer prevention, prenatal care and mental health services"—to a wide range of enabling conditions, including "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". Its

vision focuses on universally available “comprehensive health services” that would restore “state responsibility for basic needs” and take priority over “market forces” (Corrêa 1994:58). As the Indian economist Gita Sen, one of DAWN’s international co-ordinators, puts it: “Reproductive health programs are . . . likely to be more efficacious when general health and development are served. A poor female agricultural wage-labourer, ill-nourished and anaemic, is likely to respond better to reproductive health care if her nutritional status and overall health improve at the same time” (1994a:223). Such basic conditions as clean water and decent habitations are surely integral to reproductive and sexual health and well-being—for example, using condoms or barrier methods safely, delivering and rearing healthy babies, or avoiding sexual abuse. Their absence puts women in untenable dilemmas, such as HIV+ pregnant women who must choose between breastfeeding their infants and exposing them to the risk of AIDS, or bottle-feeding them and exposing them to deadly bacterial infection from contaminated drinking water (Berer, 1999).

Contrast these realities with the statement of a delegate from the United States participating in the Third Preparatory Committee Meeting (PrepCom) for Beijing in March 1995. She asserted that the US delegation must oppose a provision of the draft Platform’s chapter on health urging governments to “ensure access to safe drinking water and sanitation and put in place effective public distribution systems by the year 2000”. This, she argued, was an “infrastructural problem,” and such time-based targets were “unrealistic” (Petchesky, 1995a:159).<sup>2</sup> Yet, belying the “pragmatic” tone of the US position, there is a profoundly *ethical* truth. For if “infrastructural” conditions and macroeconomic policies create the indispensable enabling environment for reproductive and sexual rights to become practical realities, then those conditions and policies must be incorporated into our ethical framework and seen not only as “basic needs” but as fundamental human rights. Such social and economic rights are not more nor less important than those more obviously related to reproduction, sexuality and health; rather, together they form a single fabric of rights that are interdependent, indivisible and *all* grounded in basic human needs.<sup>3</sup>

### ***The ethical framework of reproductive and sexual rights***

Women’s movements in different countries and regions often have very different priorities in regard to the aspects of reproductive and sexual health/rights they seek to address. Latin American women’s health organizations emerged as part of the broader movements for democratization, in a political climate emphasizing concepts of citizenship and rights. Their

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<sup>2</sup> In the final Platform for Action, conceding to the US objection, the target date was omitted and replaced by the vague phrase “as soon as possible”; see the Beijing Declaration and Platform for Action, Para. 106(x).

<sup>3</sup> The integrative perspective I am applying, and have also attributed to DAWN, is similar to that espoused by economist Amartya Sen in numerous writings, most recently his **Development as Freedom** (1999).

emphasis has been on access to quality reproductive and sexual health services for women as part of their rights as citizens. South Asian women have been primarily concerned with problems of demographic targeting, coercion and promotion of sterilization and long-acting hormonal contraceptives; for them, reproductive rights resonate in the context of donor-driven policies in which local governments are often collusive. Health activists in Africa, confronting dire poverty and the lack of basic services, have been preoccupied by issues of survival: high maternal and infant mortality rates, “safe motherhood,” and more recently stemming the tide of HIV/AIDS and reproductive tract infections that are killing so many young women and impairing their fertility (Alvarez, 1990; Silliman, 1997; Dixon-Mueller, 1993; Berer and Ravindran, 1999). Nonetheless, the process of working together in networks and coalitions over the past decade and a half has produced common understandings that constitute a shared ethical core. Informing every aspect of this ethical core is a realization drawn from women’s everyday experience: that, particularly for women, all human rights have both personal and social dimensions that are intimately connected.

In an article written in preparation for the Cairo conference, Sonia Corrêa and I delineated four principles of a feminist ethical perspective on reproductive and sexual rights: (1) *bodily integrity*, or the right to dignity and respect in one’s physical body and to be free from abuses and assaults; (2) *personhood*, which is closely associated with bodily integrity and implies the right to self-determination and respect in one’s decisions about reproduction and sexuality; (3) *equality* in access to health services and all social resources; and (4) *diversity*, or the right to be respected in one’s group affinities and cultural differences, insofar as these are freely chosen and women are empowered to speak on their own behalf, not subordinated to group claims in the name of “tradition”. All four aspects of this framework, we argued, depended on basic *enabling conditions* for women’s empowerment and development. In other words, women’s empowerment cannot be achieved without transforming the overall social, economic and cultural systems—including but not limited to family and reproductive systems—in which their subordination is entrenched (Corrêa and Petchesky, 1994; see also Dixon-Mueller, 1993). This means that “differences based on race, power, class and access to resources” (as well as ethnicity and age) must be factored into the calculations of gender differences, including in the gathering of data; and that women must never be “treated as a unitary category . . . in the international policy dialogue” (Silliman, 1997).

The concepts of bodily integrity and personhood, while often seen as the hallmarks of Western liberal philosophy and the value it places on individualism and property ownership, are firmly ensconced in international human rights instruments (Copelon and Petchesky, 1995). The “right to life, liberty and security of person” was first recognized in the 1948 Universal Declaration of Human Rights (UDHR), repeated in the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1967) and various regional human rights conventions, and reaffirmed in the ICPD POA’s Principle 2. It is the foundation for a wide range of reproductive and sexual rights, including fully informed consent and freedom from coercion with regard to family planning methods; freedom from female genital mutilation (FGM), child marriage or other harmful traditional practices; freedom from sexual abuse, gender violence, and sexual trafficking; and the freedom of all persons “to

enjoy and control their sexual and reproductive life, having due regard to the rights of others” (IPPF, 1995:13).<sup>4</sup> This genealogy refutes the claim sometimes made in UN conferences that reproductive and sexual rights are “new inventions”.

Based on such established human rights principles, feminists affirm that women’s health and empowerment must be treated as ends in themselves and not merely as means toward other social goals—for example, reducing population numbers, or producing healthy babies to the neglect of women’s health needs (Fathalla, 1999). Unfortunately, too many population specialists, economists and public health officials have latched onto the mantra of “women’s empowerment” for precisely these instrumentalist reasons. Silliman points out that “Investing in Women” has become the “catch phrase . . . of all the major development organizations” as well as bilateral donor agencies and government ministries, who see women’s education and reproductive health as an efficient means toward their own agendas rather than as fundamental human rights (Silliman, 1997).

Such instrumentalism conflicts sharply with the ways in which women’s movements in the South have embraced the concepts of women’s self-determination and right to control over their bodies and adapted those concepts to local women’s situations. Indeed, the campaign against FGM conducted by women’s groups in the Middle East has taken the idea of bodily integrity as its ethical centrepiece and presents itself unequivocally in national and global arenas as a human rights campaign (see Toubia, 1995; Magdy, 1999; Seif El Dawla, 1999). In a different context, Kalpana Ram charts the “transnationality” of the discourse of “owning our bodies” through the recurrent uses of this slogan by Indian women’s health activists from the 1930s until the 1990s. Her project is to document how “key terms such as choice, autonomy, and freedom are taken up and given different meanings” by women’s groups and the state in different social and cultural settings (Ram, 1999:626). As an example, she cites the Indian feminist campaign in the 1980s against prenatal sex selection through amniocentesis, used by middle-class Indian couples to abort female fetuses in the interests of son preference. That campaign, she suggests, did not reject notions of autonomy and women’s right to control their bodies; rather, it recast those concepts in the framework of women’s collective interests and rights to be valued as persons (Ram, 1999; Petchesky, 1995b).

Like the feminist health movement in India, other Southern women’s groups and, following their lead, the transnational women’s health movement as a whole have understood bodily integrity and *individual* rights of the body and person as deeply connected to *social* rights. Without the ability and means to control their fertility and to be self-determined and free from abuse in their

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<sup>4</sup> The ICPD POA comes closest to articulating the principle of bodily integrity when it links “equal relationships between men and women in matters of sexual relations and reproduction” to “full respect for the physical integrity of the human body” (Para. 7.34).

sexual lives, women and girls cannot function as responsible, fully participating members of their families and communities; they cannot exercise citizenship (Corrêa and Petchesky, 1994). Conversely, being self-determined in their sexuality and fertility depends on many other social and economic components of women's health, development and empowerment.

A pivotal concept informing feminist standpoints on reproductive and sexual rights is that of *women's empowerment*. Batliwala (1994) gives the most cogent definition of this concept, which she calls "the process of challenging existing power relations, and of gaining greater control over the sources of power" (p. 130). While the rhetoric of "empowerment" now abounds nearly everywhere among development specialists and was incorporated into the language of the ICPD POA (thanks to feminist initiatives), its meanings in mainstream contexts have usually been diluted to become indistinguishable from "raising women's status" through piecemeal reforms. The discourses of "gender mainstreaming" and "gender sensitivity" likewise imply this mechanistic approach and its assumption that the problem of gender inequality can be fixed by redirecting some resources toward women's and girls' education, skills, access to health services and improving "communication" between women and men. Such an approach ignores the deep imbalances of power and the social structures and practices of subordination that characterize relations between women and men in most societies. As Corrêa puts it, "feminists aimed to make visible the power conflicts lurking under the apparently benign asymmetry of status between men and women. But they also were concerned with the linkage between the reshaping of gender power at the micro level and broader social and economic transformation" (Corrêa, 1997:2). Gender analysis understands power as not only socially constructed but also dynamic, fluid, and always being contested through a wide range of tactics deployed by the "oppressed"—including subversion, subterfuge and sometimes outright resistance.

Finally, feminists have conceptualized empowerment as entailing not only material but also human resources and social, collective interaction. For example, when the International Reproductive Rights Research Action Group (IRRRAG) inquired into the most crucial enabling conditions that allowed some women to resist abusive husbands, disrespectful doctors and religious dictates in making their reproductive and sexual decisions, one of the most salient factors we found was *membership in a community group or union*. Such membership gave women a sense of identity and purpose outside their immediate families (Petchesky and Judd/IRRRAG, 1998; IRRRAG, 1999).

Feminist concepts of empowerment are closely related to their challenges to mainstream views of "sustainable development". These include a strong critique of the neo-Malthusian doctrine attributing not only poverty and social unrest but also, more recently, environmental destruction to uncontrolled population growth. From the standpoint of the feminist ethical framework outlined above, this doctrine is pernicious and often racist because it blames the victims of economic injustices (impoverished and dark-skinned women) for problems whose causes lie far from their villages and shanties. By focusing narrowly on strategies to lower fertility, the concept of "overpopulation" provides one of the most enduring rationales for population control policies that have targeted poor women of colour, too often used coercive methods, and disregarded the human rights and basic health needs of those women and

their children (Bandarage, 1997; De Barbieri, 1994; Hartmann, 1995; G. Sen, 1994b).

In addition to the ethical and social justice arguments, critics of the neo-Malthusian position and its most recent environmentalist incarnation have countered that position on devastating empirical grounds, citing such facts as:

- the highest fertility rates are in countries with the sparsest populations (e.g., sub-Saharan Africa);
- some of the world's most "overcrowded" countries and cities have the highest per-capita income levels and rates of economic growth (e.g., the Netherlands, Hong Kong, and New York City);
- rapid economic growth and fertility decline and high levels of contraceptive use can coexist with enormous income gaps and persistent poverty (e.g., Brazil and the United States);
- some of the most environmentally polluted countries are those with severe population declines (e.g., Russia, Poland and Ukraine); and
- fertility rates have decreased in most countries, while the continued growth of the world's population is due mainly to the simultaneous *decline in mortality*.<sup>5</sup>

Indeed, economic growth itself plays a key role in environmental degradation (Harcourt, 1994). More specifically, both environmentalists and feminists have pointed out that the worst source of global pollution is over-consumption by Northern, developed countries—an analysis accepted by government delegates in Copenhagen in 1995 and repeated many times in the Social Summit Declaration and Programme of Action. In other words, contrary to the old Malthusian logic that "fewer and better" children were the formula for prosperity, it would appear that the dominant path to modernity has meant more and more *things* in place of children; plenitude, not people, is the worst polluter (Amalric, 1994; Mazur, 1994; Mies and Shiva, 1993).

Growth-centred models of sustainable development, particularly insofar as they privilege macroeconomic indicators of output and official employment levels, also contain an inherent gender bias, for they leave out the (often unpaid) labour of women in households, communities and the informal sector. From a feminist standpoint, a key criterion of sustainability must be a policy's or an industry's *social* as well as environmental impacts, particularly including its impact on gender relations. Gita Sen, in reviewing three decades of population and development policies, predicts that "policies targeted at improving macroeconomic management or increasing gross national product growth while ignoring or worsening the incomes and livelihoods of the majority"—for example, through disinvestments in the social sector—are likely to fail. "In the longer term," she says, "improving health and education, along with meeting

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<sup>5</sup> Bandarage, 1997; A. Sen, 1994; CWPE, 1993; CNPD, 1999; Mazur, 1994; UNDP, 1998.

other basic needs, raises the quality of a country's labour force, which is critical in determining the economy's growth potential and competitiveness," besides helping to lower birth rates (1994b:68).<sup>6</sup> But these are also social justice issues. One has to ask, paraphrasing Spivak (1999), sustainability of and for what?

From the standpoint of transnational women's health movements seeking to empower women as reproductive, sexual and political actors, recent economic crises and retrenchments in public health services have indeed brought home that "macroeconomic policies can no longer be left off the table" (WEDO, 1999:20). Feminists have condemned the ways that international financial institutions (IFIs), donor countries, and developing country governments have allowed debt service, military expenditures and free-market priorities to override the desperate need for public investments in health care and other enabling conditions. Along with other groups, they have called for demilitarization, debt forgiveness and international regulation of unsustainable, unhealthy economic practices through such devices as a "Tobin Tax" on speculative capital flows. Women's health activists worldwide have sounded the alarm about the reproductive and other health threats of environmental toxins released by industries. They joined with protestors against the World Trade Organization (WTO) in Seattle in late 1999 to oppose unfair trade practices (for example, unregulated drug prices and patents that prevent people with AIDS in Africa and Asia from receiving life-prolonging but economically unattainable medications). Such links between health and economic development policies, between sustainability and human needs, are now acknowledged by the major international agencies responsible for health funding, especially the World Bank and the World Health Organization (WHO). But we do not hear from international policy makers that such needs are also inalienable and fundamental human rights that must take priority over profits.<sup>7</sup>

### ***Indivisibility of human rights and basic needs***<sup>8</sup>

At the March 1999 PrepCom meeting for the UN General Assembly Special Session's five-year review of the ICPD (ICPD+5), the "pro-family" newspaper **Vivant!** published a feature article, replete with statistical data and graphics, condemning the "flawed human rights-based approach to health". Central to the article's attack was an argument embracing the discourse of "basic needs" as the ethically and socially superior framework to that of human rights. Associating safe water and nutrition with the "needs" approach and

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<sup>6</sup> Sen's arguments here, of course, are prophetic, written five years before the economic crises of the late 1990s and the beginning of soul-searching by the World Bank and International Monetary Fund (IMF) about whether their austerity regimes and SAPs of the previous years had gone too far.

<sup>7</sup> One exception in this regard is UNAIDS, established in 1996 as the joint arm of six UN agencies (WHO, UNICEF, UNDP, UNESCO, UNFPA and the World Bank) in charge of responding to the HIV/AIDS crisis globally. UNAIDS informs its work with a strong human rights perspective; see UNAIDS, 1999.

<sup>8</sup> A longer version of this section was recently published as R. Petchesky, "Rights and needs: Rethinking the connections in debates over reproductive and sexual rights", **Health and Human Rights**, Vol. 4, No. 2, 2000.

reproductive and sexual health with the “rights” approach, it alleged that “indiscriminate funding for the ICPD’s idealistically high standards of reproductive and sexual health *rights*” had caused “under funding and deterioration of more basic, practicable and affordable health *needs* . . .”. And it further insinuated that such “flawed” priorities represent the agendas of the West and its blatant disregard for the genuine needs and priorities of women in the South (Joseph, 1999).<sup>9</sup>

On its face, to assert a *dichotomy* between rights and needs and then a hierarchy subordinating some health and bodily needs (especially those related to reproduction and sexuality) to others, is inherently gender biased. As the Women’s Coalition for ICPD wrote in its response to this attack:

Rights cannot be divorced from needs. Reproductive and sexual health and other basic human needs—education, sanitation, clean water, nutrition—are equally important and interdependent; *all* are human rights. Especially for women, good pre-natal and obstetric care, safe contraception, and other aspects of health are inseparable from such basic amenities as reliable transportation, hygienic conditions and clean water. At the same time, their rights to liberty, security of the person and development are unattainable without comprehensive, accessible and affordable reproductive and sexual health services and the freedom to make decisions about their fertility and sexuality. . . .<sup>10</sup>

Underlying the “rights”/”needs” dichotomy is a basic fallacy. What it ignores is that rights are merely the codification of needs, reformulating them as ethical and legal norms and thus implying a duty on the part of those in power to provide all the means necessary to make sure those needs are met. This duty is affirmative as well as negative; that is, “states have an obligation not only to respect (to not do harm) but also to take positive measures to ensure [the enjoyment of rights]” (Copelon and Petchesky, 1995:358). The terminology of “human” and “universal” simply says that there should be no distinctions of class, gender, race, ethnicity, and so on; the rights belong to all persons and the duties to fulfil them to all authorities. Rights are meaningless, in other words, without needs. But needs also cannot stand on their own as ethical principles, because they lack any intrinsic methods for (1) determining whose and which needs should take precedence, (2) assigning obligations to specific parties for fulfilling those needs, and (3) empowering those whose needs are at stake to speak for themselves. Without some principle of “personhood” or moral agency, which is only available through a human rights framework, there is

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<sup>9</sup> The article prominently displays a photograph of a dark-skinned woman smiling happily as she gathers wheat in a field, with the caption: “Women in developing countries have a far greater need for nutrition, safe water, and other health services than for the ‘reproductive’ products and services treated as a priority by western nations.” **Vivant!** was published daily during the ICPD+5 PrepCom by a group called the NGO Caucus for Stable Families, whose positions were very closely aligned to those of the Holy See (Vatican).

<sup>10</sup> The quote is from a leaflet, titled **Reproductive Health and Rights are Human Rights**, distributed at ICPD. The leaflet can be obtained from the author or from HERA, c/o International Women’s Health Coalition, 24 East 21<sup>st</sup> Street, New York, NY, 10010, USA, or via e-mail (hera@iwhc.org).



nothing to prevent the state, medical experts or religious authorities from deciding what is good for me on the basis of political expediency, aggregate data or fundamentalist interpretations of scripture. Rights-bearers, on the other hand—who may be groups as well as individuals—are by definition those who are authorized to make official claims in defence of their own needs, now codified and formalized as rights.

This may seem to beg the question of whether some needs, and their corresponding rights, are more “basic” or “fundamental” than others; but my point is the logical interconnection between rights and needs and the indivisibility of different forms of rights, so that prioritizing makes no sense. We might visualize the different aspects of reproductive health rights as a series of concentric circles, beginning with the most intimate relations and radiating out to the most societal and even global (see box 1). Their overlaps become apparent when we look concretely at specific reproductive and sexual rights and the ways they cluster together with other rights in women’s everyday lives. For example, how can we imagine the right “to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so” (ICPD POA, Para. 7.3) without jobs, resources or health insurance to pay for services, especially with the contraction of social benefits and increase in user fees? Women with their own jobs and incomes may still be dependent on a husband (if they have one) to get access to health insurance that will cover maternity care, since so many women work in marginal, informal or uninsured sectors (WEDO, 1999). Nor does having adequate information and clinic services for contraception guarantee women freedom from domestic threats that put their well-being (or their marriage) in jeopardy if they dare to use those services.

A substantial literature documents the intersections between violence against women, both domestic and clinic-based, and threats or impairments to their reproductive health (See S. Fried, 1994; Heise, 1995; Heise et al., 1995; Weiss and Rao Gupta, 1998; CRLP/CLADEM, 1999). But the barriers to enjoyment of reproductive and sexual rights or the “highest attainable standard of health” may be more subtle. Studies show that women themselves, such as those active in the local government bodies in India known as *panchayats*, often comply with the hierarchy of priorities that puts road building before preventing reproductive tract infections. Many women tend to see their own health problems as somehow less important “when cost is an issue” or even as “natural” and inevitable, thus “seeking medical care too late or not at all” (Mukhopadhyay and Sivaramayya, 1999:347; WEDO, 1999:11).

But do the very roots of such compliance and self-denial not involve issues that directly affect women’s right to development? How can the right to development—usually classified in the “economic and social” category—be separated from the (social) right to education, the (political) right to participation in women’s NGOs and the cultural changes necessary to nourish women’s empowerment and self-worth? What about the women in Iran who suffer infertility, birth complications or stillbirths because of working since early childhood in the carpet-weaving industry and having underdeveloped pelvises (WEDO, 1999)? If they could bring their case before the human rights treaty bodies, would they cite violations of their health rights, their reproductive rights, their right to education or their right not to be exploited by

child labour practices or involuntary servitude? But of course, all these rights are relevant here, all are interconnected, and all are grounded in basic needs. I would like to think as well that all should be understood as integral to what we mean when we speak not only of fundamental human rights but also of sustainable human development.

### Box 1—The story of Futhi

*The following is an imaginary profile based on fact.*

*Futhi is one of the 18.5 million women worldwide, and one of the nearly 10.5 per cent of pregnant women using urban prenatal clinics in South Africa, who are infected by HIV. The roots of Futhi's infection start with marriage—a husband who works in the mines, is away a good deal, and has unprotected sex with prostitutes. But there was never a question of leaving him, since she is unable to earn enough on her own to support her two children. Thanks to South Africa's progressive reproductive health policy, Futhi has access to a caring reproductive health clinic nearby. Yet, though she learned about condoms from the clinic nurse, she was afraid to suggest them to her husband for fear he would call her promiscuous and beat her. Besides, Zulu culture tells women to accommodate their husbands' desires. Then Futhi discovered she was pregnant and HIV+ and faced the dilemma of what to do. In South Africa abortion is a woman's right for any reason during the first trimester. Nurses at the prenatal clinic have warned her she cannot breastfeed the new baby without great risk of infecting it with HIV, and there is not yet safe drinking water in her township to use for bottle feeding. She has heard there are drugs that can prevent HIV transmission to the foetus, but these drugs—made by US-based pharmaceutical companies—are too expensive for the economically pressed South African government to buy on the world market. Faced with threats of punitive sanctions under existing patent treaties, the government has declined to seek or authorize local manufacture of cheaper versions. But even if the transnational drug companies lower their prices for African countries, the drugs will still probably cost too much for Futhi, and South Africa's inadequate health care system will lack the capacity to distribute them. So advanced drugs cannot protect Futhi's baby or assure her a longer life to care for her children. Apparently, abortion is her only "choice". Luckily, in South Africa at least it is a choice.*

(Sources: Berer, 1999; UNAIDS, 1999; Weiss and Rao Gupta, 1996; "South Africa", in WEDO, 1999; Silverstein, 1999; and McNeil Jr., 2000.)

Feminists working in transnational movements have brought to the United Nations conferences and treaty bodies this synthetic perspective that refuses to separate rights from needs, or to deny the personal, sexual and health aspects of sustainable development. In doing so, they have transformed the discourses of both social needs and human rights and begun to evolve effective strategies for translating those rights/needs into enforceable policies. But there is still a very long way to go and tremendous power structures blocking the way forward.

## II. Assessing the UN Conferences: Gains and “Fault Lines”

Efforts by transnational women’s groups to concretize reproductive and sexual rights into practical policies and programmes have taken place at international, national and local levels. This section reviews the international work the women’s coalitions carried out, and the forms of opposition they met, during the UN conferences of the 1990s. My aim will be to assess both the strengths and the weaknesses of that activity, and the larger obstacles that still prevent women’s movements from realizing their visions.

While the history of women’s organizations lobbying the international community pre-dates the recent UN conferences by at least a century (Rupp, 1997), their effectiveness and influence grew dramatically during the 1990s. Chen finds the roots of this influence in the previous UN Decade for Women conferences that culminated in Nairobi in 1985, with over 14,000 women from some 150 countries attending the NGO Forum. This historic moment—the first international women’s conference held in Africa—marks the foundation of a truly “global women’s movement” whose “leadership shifted perceptibly—although not entirely—from North to South.” (1996:142).<sup>11</sup> Silliman takes a more critical view of this process, aware of the hierarchies and imbalances that still prevail alongside coalition building and diversity. She makes an important distinction between *NGOs* and *social movements*, suggesting that the former tend to be service- and project-oriented within existing systems, while the latter pursue alternative visions to transform those systems (1999:156). I would put it somewhat differently, arguing that the relationship between NGOs and social movements is precisely what is at issue. Insofar as NGOs maintain close ties and accountability to the social movements they usually grew out of, they can contribute significantly to transformative and oppositional projects.

Transnational women’s NGOs working in the field of reproductive and sexual rights were already having a significant impact on international policy making prior to the Cairo conference in 1994. A decade of women’s health movement activism directly or indirectly influenced a number of powerful institutions that set the agenda for international population programmes (for example, the Ford and MacArthur Foundations, the International Planned Parenthood Foundation [IPPF] and the Population Council). These institutions began to apply a gender perspective to their international funding, to incorporate feminist critiques into their research agendas and to hire staff and consultants who are knowledgeable in this perspective.

Precedents for the gains and shortcomings of the women’s coalition in Cairo and Beijing were also set in the work of women’s groups at the United Nations Conference on Environment and Development (UNCED) in Rio de Janeiro (1992) and the World Conference on Human Rights in Vienna (1993).

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<sup>11</sup> It was at the Nairobi conference, for example, that the DAWN network and UNIFEM (the United Nations Development Fund for Women) were formed.

Women's groups participating in those meetings created a strategic process and methodology that would be applied in all the subsequent conferences: global, regional and national campaigns and international coalition-building meetings leading up to the conferences; mobilization of a Women's Caucus to draft alternative language and lobby government delegations; and liaison activity between the official conferences and PrepComs and the parallel NGO forums. Utilizing this strategy and their historic document, Women's Action Agenda 21, women's groups in Rio were able for the first time to put women's issues and concerns on the official agenda. Through their influence, the official Agenda 21 took some steps toward reframing the concept of sustainable development as one encompassing not only environmental protection but also the right to health, gender equality, reduction of military expenditures, alleviation of poverty and the concerns of women in all these areas (Chen, 1996).

The idea that "women's rights are human rights" and that violence against women violates universal norms that supersede either "tradition" or national sovereignty was firmly established as a result of transnational women's organizing prior to and during the Vienna Human Rights conference (Bunch and Reilly, 1994; Center for Women's Global Leadership, 1995; Chen, 1996). The Vienna Declaration and Programme of Action and the Declaration on the Elimination of Violence against Women (adopted by the United Nations General Assembly the same year) express the consensus of governments that "gender-based violence and all forms of sexual harassment and exploitation" constitute violations of human rights. Their focus on women as subjects of human rights and women's bodies as the objects of human rights violations was a vital step toward legitimating the discourses of reproductive and sexual rights developed in Cairo and Beijing. Vienna also provided the foundation for the international codification of crimes against women. Building on women's insistence that the International Criminal Tribunals for the Former Yugoslavia and Rwanda prosecute sexual violence, the Women's Caucus for Gender Justice won recognition of rape, sexual slavery, forced pregnancy, forced sterilization, trafficking, and other sexual violence as crimes against humanity—and in some cases as war crimes or genocide—in the International Criminal Court treaty (see United Nations, 1998, Arts. 6, 7 and 8, 1998; Women's Caucus for Gender Justice, 2000; Copelon, 2000).

The Women's Caucus model worked successfully to influence the outcomes of all the 1990s UN conferences for two main reasons. First, it was well organized and had focused, knowledgeable leadership that provided strategic guidance and lobbying skills to women less familiar with the UN process.<sup>12</sup> Second, women's NGOs have something the official delegations need and often lack:

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<sup>12</sup> In Rio, organizational leadership was provided by the Women's Environment and Development Organization (WEDO) and its president, the late Bella Abzug. In Vienna, the Center for Women's Global Leadership (Rutgers University, United States) played a central role. In Cairo and Beijing, while WEDO continued to convene the large, public Women's Caucus, the International Women's Health Coalition (IWHC) mobilized a strategic network of lobbyists, NGO delegates and text-drafters who worked both behind the scenes and in the Women's Caucus.

extensive knowledge and experience of the issues under debate. Nowhere is this truer than in the field of human rights, despite the political sensitivity of human rights issues. As Gaer demonstrates, “human rights NGOs [have been] the engine for virtually every advance made by the UN in the field of human rights since its founding” (1996:51). Women’s human rights groups in particular have been instrumental in supplying the human rights treaty bodies and international tribunals with cases, background information and clarification of norms and concepts, especially in regard to issues of violence against women. Likewise, population and development organizations, as well as government delegates, have depended on women’s NGOs to explain such concepts as “gender” and “reproductive health”. The prominence of women’s human rights and gender perspectives throughout the Cairo, Copenhagen and Beijing documents is a direct legacy of the work done by women’s caucuses in Rio and Vienna.

### **Reassessing Cairo and Beijing**

Shortly after the ICPD in Cairo, both its achievements and its limits from a women’s health perspective were evident. Clearly the transnational women’s coalition had succeeded in winning a real paradigm shift embodied in three aspects of the POA. First, the Cairo document moves firmly from an approach based on demographic targets and narrow family planning methods to a comprehensive reproductive health approach. Second, it integrates the principles of gender equality, equity and women’s empowerment into population and development strategies. Third, it explicitly recognizes reproductive rights, very broadly defined and linked to primary health care, as fundamental human rights (Germain and Kyte, 1995). At the same time, however, the fault lines in the Cairo Programme threatened to block any real progress in transforming the noble rhetoric into actual policies and services. In addition to the weakness of sexual rights in the document and the continued absence of recognition for women’s right to safe, legal abortion, these fault lines consisted of the ICPD’s failure to address macroeconomic inequities and the inability of prevailing neoliberal, market-oriented approaches to deliver reproductive and sexual health for the vast majority (Petchesky, 1995a). To understand how these contradictions occurred in Cairo and persisted in Beijing and the ICPD+5 review process, it is necessary to analyse the opposing political forces that transnational women’s groups confronted there.

### **Fundamentalist perspectives**

Foremost in the field of players contesting reproductive and sexual rights is the cluster of ideological positions and their advocates I will call, for want of a more accurate term, “fundamentalist”. Following a number of recent commentators, I take contemporary fundamentalisms to be political movements that cut across all major religions and geographical regions, although they typically use religious language and symbols as rhetorical tools. While their methods are pragmatic and political, their objectives are mainly conservative, in the sense of trying to restore a real or imagined past against the encroachments of a perceived external enemy (e.g., imperialism, “Western decadence,” “Satanism”). Central to this project is the restoration of a patriarchal form of family and authority, including the subordination of women to men and their confinement to traditional social roles, dress codes and norms of sexual behaviour.

During the Cairo PrepComs and conference in 1994 (and again in Beijing and during ICPD+5), a number of delegations representing Christian or Islamist varieties of fundamentalism joined together to oppose elements of the draft POA they claimed were offensive to their own traditions or laws. Often led by the Vatican (identified as the Holy See for UN purposes), this constituency took particular objection to any language in the document they interpreted to: (1) legitimate or facilitate abortion; (2) give women or adolescents the possibility of making reproductive and sexual decisions independently of men or parents; (3) condone “diverse forms of the family” (other than the patriarchal, heterosexual kind); and (4) extend the concepts of reproductive and sexual health, reproductive rights or sexual rights to unmarried adolescents or gays and lesbians. As Freedman observes, the central problem sparking the opposition by fundamentalists to the ICPD POA “was not fertility regulation itself” but rather “the challenge to ‘traditional’ patriarchal social structures posed by the commitment to women’s empowerment” (1996:66).

Freedman’s point, although it neglects the homophobic dimension of fundamentalist views, is very important in clarifying that we are not in fact looking at “the historical pro-natalist versus anti-natalist controversy” here (DAWN, 1999:8). To be sure, many fundamentalist groups oppose modern methods of contraception, especially for unmarried or childless married women. But some—for example, the Iranian government—actively promote such methods. The deeper object of their common hostility is what they would call a “Western feminist” or “individualist” philosophy of sexual and family relations, and most especially women’s authority over sexual and reproductive decisions. Vatican spokesmen frame this position in the rhetoric of “parental rights and responsibilities” and adherence to “family values”. Nonetheless, although women’s groups failed to gain explicit reference in the Cairo and Beijing documents to freedom of sexual orientation or sexual expression—or the actual term “sexual rights”—the ICPD POA embodies a sexual rights discourse. Thus “reproductive health” includes the ability “to have a satisfying and safe sex life,” and “sexual health” involves “the enhancement of life and personal relations, and not merely [disease prevention]” (Para. 7.2). Nowhere does the POA restrict these principles to heterosexual married adults. Rather, it acknowledges the need “to enable [adolescents] to deal in a positive and responsible way with their sexuality” and urges governments to provide adolescents with appropriate services and counselling with regard to reproductive health, “responsible sexual behaviour”, contraception and prevention of HIV/AIDS and other STDs (Paras. 7.3 and 7.47). And the Beijing Platform goes even further toward defining a concept of sexual rights, when in Para. 96 it says: “*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*”.

On the highly contentious issue of abortion, the transnational women’s movements gained some significant advances when one looks at the ICPD

Programme and the Beijing Platform together. The greatly compromised Para. 8.25 of the ICPD POA, on one hand, acknowledges that “unsafe abortion [is] a major public health concern” and, on the other, refuses to see abortion “as a method of family planning”.<sup>13</sup> Yet, even within its limitations, Para. 8.25 urges governments to make all abortions safe where they are “not against the law” and to provide “access to quality services for the management of complications arising from [unsafe] abortion” in any circumstances. Such provisions have opened a wedge enabling women’s health activists in countries with restrictive abortion laws to win an expansion of safe, legal services (e.g., in Brazil and Bolivia). Moreover, the Beijing Platform goes beyond Cairo in providing that governments should “consider reviewing laws containing punitive measures against women who have undergone illegal abortions” (Para. 106k). Slowly and incrementally, women’s determination in all eras, countries and cultures to seek abortions, even at great risk to their lives and health, in order to gain some control over their fertility and bodies is starting to make an impact on international human rights standards (Petchesky, 1990).

### **Populationist perspectives**

While less vocal than the fundamentalist contingents (whom they regard as enemies), population control organizations—whose principal aim is to disseminate contraceptives and reduce numbers among the world’s poor—were very much present in Cairo. These groups seemed content to let the women’s coalition do the work of directly confronting the fundamentalist opposition and crafting a “consensus” document that would resonate with new language, new ideas and (they hoped) renewed funding. But it would be a mistake to see mainstream population and family planning groups as in some way passive or outside the debates in Cairo. Their lingering (though, I would argue, waning) influence and unreconstructed ideology are evident in the contradictions within the Cairo document between the rhetoric of reproductive and sexual health/rights and an approach to resources still focused on subsidized family planning and reliance on the market for everything else.

On its face the Cairo Programme appears to abandon the old neo-Malthusian numerical projections and panic about “population explosions”. The document’s text is refreshingly free of direct causal links between population growth and either poverty, migration or environmental deterioration, adopting instead a complex, interactive approach to population issues. In regard to the enabling conditions for reproductive and sexual rights, the ICPD POA makes a significant advance beyond previous population conferences by directing governments to provide reproductive health services “through the primary health-care system” and to make these accessible “to all individuals of appropriate ages . . . no later than the year 2015.” (Para. 7.6) It urges that reproductive health services be “integrated” so that maternal health and prenatal care, gynecological health, child health, family planning, programmes

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<sup>13</sup> See Berer, 1993, who points out the absurdity of this position, since preventing an unwanted birth (induced abortion) and preventing an unwanted pregnancy (contraception) obviously have the same end in view.

to improve women's and children's nutritional status, and programmes to prevent HIV infection and other STDs are fully co-ordinated (Paras. 8.8 and 8.17). Above all, the text of the document, especially in Chapters 7 and 8, abandons any notion of family planning, much less population control, as an end in itself. Instead it makes fertility simply one element within a broad framework governed by the principles of "informed free choice" and "equitable access to basic health care for all," repudiating demographic targets, incentives and disincentives.<sup>14</sup> And in the context of equalizing life expectancy across countries and reducing infant, child and maternal mortality, Chapter 8 urges governments to ensure improvements in structural conditions (e.g., housing, clean water, workplace safety and so on) that have an impact on health, especially that of vulnerable groups.

The Beijing Platform's chapter on "Women and Health" improves upon the ICPD Programme in a number of respects. First, it embeds reproductive and sexual health/rights in the general principle of equality and non-discrimination and, specifically, in women's human right to the highest standard of health (Para. 92). Second, it fully adopts the reproductive health and rights provisions of the Cairo document but incorporates them into an overall health and environmental protection agenda instead of separating these into distinct chapters. Third, it introduces a number of concrete actions absent from the ICPD POA, such as programmes and services for prevention and early detection of breast, cervical and other gynecological cancers, and programmes to ensure household and national food security (Paras. 106–107). The attention both documents give to the larger physical and environmental context of health should be linked to their emphasis (Chapter 4 in the ICPD POA, and throughout the Beijing Platform) on creating gender equality and empowering women in all realms of social life—including education, work, politics, community development, household labour and decisions, and sexuality.

As feminist human rights advocates remind us, human rights are "evolving, not static"; they build on one another cumulatively and need to be seen as a whole (Copelon and Petchesky, 1995:357). This means reading the Cairo, Copenhagen and Beijing documents—including Beijing's improvements in regard to abortion access and sexual rights—as an interwoven fabric. When we do so, it would appear that international policies have moved very far indeed from a normative framework that privileges populationist aims toward one in which gender justice and overall health and sustainable development take priority. But, while this is true with regard to the normative principles and goals of the ICPD POA, when we examine the sections devoted to *resources* and *implementation* a different picture emerges.

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<sup>14</sup> The principle of "basic health care for all" comes from the Alma Ata Declaration adopted by the International Conference on Primary Health Care in 1978.



**Table 1: A feminist report card on the Cairo Programme of Action**

| New achievements  | Remaining gaps and challenges   |
|---|---|
| <ul style="list-style-type: none"> <li>• Shift from population control to “reproductive rights and reproductive health” paradigm; comprehensive definition of reproductive health including sexual health, integrated with primary health services for all (Ch. 7; Paras. 7.2, 8.8).</li> </ul>   | <ul style="list-style-type: none"> <li>• Access to safe, legal abortion not recognized as part of reproductive health and rights; deference to national laws; where illegal, requirement of treatment for complications only (Para. 8.25).</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Definition of “reproductive rights” as part of “already recognized international human rights”; includes “the right to attain the highest standard of reproductive and sexual health,” “the <i>means</i> to do so,” “informed choice” and freedom from “discrimination, coercion and violence” (end to targets and incentives— Paras. 7.3, 7.12, 7.22).</li> </ul> | <ul style="list-style-type: none"> <li>• Reliance on private market mechanisms (cost-recovery schemes, user fees, health reform to assure “cost-effectiveness”), increased involvement of private sector and deregulation, rather than measures for global macroeconomic restructuring, to generate resources and assure accountability (Paras. 8.8, 13.22, 15.15, 15.18).</li> </ul> |
| <ul style="list-style-type: none"> <li>• Recognition of adolescent rights to all reproductive and sexual health services, including “sexual education” and full protection against unwanted pregnancy, HIV/AIDS and other STDs (Paras. 7.2, 7.37, 7.45, 7.47).</li> </ul>   | <ul style="list-style-type: none"> <li>• Ambiguous language about “the rights, duties and responsibilities of parents” could compromise right to confidentiality; inadequate resource allocations; absence of multisectoral integration (e.g., health and education sectors).</li> </ul>  |
| <ul style="list-style-type: none"> <li>• ‘Gender Equality, Equity and Empowerment of Women’ as a separate chapter; recognition of “the empowerment and autonomy of women and the improvement of their political, social, economic and health status” as “a highly important end in itself” (Para. 4.1).</li> </ul>  | <ul style="list-style-type: none"> <li>• No resource allocations or specified amounts for any aspect of sustainable development, primary health care, women’s empowerment and improved status, poverty alleviation or environment (Ch. 13).</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Recognition of all forms of violence against women, including FGM, and measures to end them as integral to reproductive health (Paras. 4.4, 4.9, 4.22, 4.23, 7.3, 7.6, 7.17).</li> </ul>   | <ul style="list-style-type: none"> <li>• Treatment of “women” as a unitary category; failure to recognize racial, ethnic and class divisions in access to resources and services and health risks (except HIV/AIDS).</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Shared male responsibility for childcare, housework and reproductive and sexual health as essential to gender equality (Ch. 4-C).</li> </ul>   | <ul style="list-style-type: none"> <li>• No concrete strategies for implementation, no resource allocations.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Encouragement of governments to expand and strengthen “grassroots, community-based and activist groups for women” (Para. 4.12).</li> </ul>   | <ul style="list-style-type: none"> <li>• No resource allocations or specified targets.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Recognition of the “diversity of family forms,” including female-headed households, and the need for government policies to benefit all, especially the most vulnerable (Paras. 5.1, 5.2).</li> </ul>  | <ul style="list-style-type: none"> <li>• Failure to expressly recognize affirmative sexual rights along with reproductive rights, including right to diversity of sexual expression and orientation.</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Definition of reproductive health services as integrating not only family planning but also prenatal and obstetric care, infertility treatment, prevention and treatment of HIV/AIDS, STDs and gynecological cancers (Paras. 7.6, 8.8).</li> </ul>   | <ul style="list-style-type: none"> <li>• Specification of precise money target (\$17 billion) but <i>imbalance</i> in resource allocations: twice as much specified for “family planning component” as for all of “reproductive health component” put together (Paras. 13.14–13.15).</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Target date of 2015 for reproductive health services, increasing life expectancy, reducing infant and child mortality, and reducing maternal mortality (Paras. 7.6, 7.16, 8.5, 8.16, 8.21).</li> </ul>   | <ul style="list-style-type: none"> <li>• Inadequate allocation of resources to reproductive health component; no resources directed to necessary infrastructure, poverty alleviation and enabling conditions.</li> </ul>  |

In spite of all the language relegating family planning to a broader reproductive and primary health agenda, when it comes to actual allocations of resources the “family planning component” (i.e., distribution of contraceptives) still receives the lion’s share (see table 1). Indeed, family planning is projected as costing nearly twice as much in 2015 as all of reproductive health, maternal and child health, gynecological health, prevention and treatment of HIV/AIDS and other STDs, and adolescent reproductive and sexual health and education combined (Paras. 13.14–13.15). Admittedly, the ICPD POA is the only conference document that sets a precise money target (\$17 billion in 2000 and increasing amounts in subsequent years)—a positive step in principle. But the fact that this is the only area in which the financial calculations of “experts” are accepted seems more a victory for the population establishment than for women’s health movements. As for primary health care, emergency services, education, sanitation, water, housing, and all the other aspects of the “development” side of ICPD—much less any programmes for women’s empowerment—these are dismissed with the gratuitous comment that “additional resources will be needed” (Paras. 13.17–13.18).

Even more troubling is the ICPD’s overall approach to implementation and enforcement. While the chapter on health recognizes the devastating impact that SAPs, “public-sector retrenchment” and “the transition to market economies” have had on health indicators, especially among the poor, the implementation chapters revert to the market-oriented policies that have actually widened income gaps and mortality and morbidity gaps globally and within countries. In order to improve “cost-effectiveness,” “cost-recovery” and quality of services, governments are urged to reintroduce user fees and social marketing schemes; “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 “review legal, regulatory and import policies . . . that unnecessarily prevent or restrict the greater involvement of the private sector” (Paras. 13.22, 15.15 and 15.18). There is a cautionary word about providing adequate “safety nets”, but no indication of their scope or duration. Nor does the ICPD POA anywhere address the need for multisectoral approaches at the national level, so that health, population and development ministries do not continue to function as separate, competing entities. In sum, “development” in the ICPD framework remains stuck within free-market capitalist priorities.

This prevalence of a market-oriented perspective in the POA occurred by default more than by plan. That perspective is unquestioned dogma among the major donor governments—particularly the US and the European Union (EU)—and the IFIs. Their presence in the ICPD-related meetings may have intimidated any very outspoken opposition among the “Group of 77” (G-77) countries,<sup>15</sup> who are desperately seeking foreign investments and debt relief.

The fundamentalist contingents, despite all their rhetoric about “basic needs”, were too preoccupied with opposing the reproductive and sexual rights

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<sup>15</sup> The G-77 “is an intergovernmental group established in 1964 to represent the interests of developing countries in the United Nations” (UNIFEM, 1995). Today it consists of nearly 150 member states that differ vastly in culture, economic conditions, internal politics, and power position both within the UN and in the global arena.

language to have taken an outspoken position on the macroeconomic issues. As for the Women's Caucus, its position on these questions was also contradictory in practice. On one hand, the Caucus proposed language strongly criticizing SAPs and their adverse impact on women. On the other hand, its members were reluctant to push the US and the EU too hard on the resource questions because it needed those delegations as allies on reproductive and sexual health and rights. Among the civil society participants in Cairo, only the population and family planning groups had an unequivocal interest in accommodating the neoliberal agenda and placating the Northern donors, in hopes of increasing their own funds.

To understand the quiet but critical role of population and family planning groups in abetting this agenda, it needs to be underlined that achieving social equality and the redistribution of wealth has never been their concern. Throughout its history, the international population establishment (aided by academic demographers) has relentlessly pursued the aim it took on from its origins during the Cold War: "to reduce Third World population growth through the diffusion of contraceptive technology" (Freedman, 1996:65; Greenhalgh, 1996; De Barbieri, 1994). Many of these organizations, including the UNFPA, have become much more sophisticated in their methods for achieving this aim, having been persuaded by massive research evidence that coercion and mistreatment too often drive women away from clinics while education and jobs motivate them to have fewer children—hence their embrace of feminist concepts. But while this "feminization" of the populationist rhetoric is sincere, it is also opportunistic. On a purely strategic level, population and family planning organizations needed the expertise, commitment and ideas of the women's coalition throughout the ICPD process to act as a buttress against the fundamentalists; thus they pursued a marriage of convenience. But the primary interest of these groups is to rationalize their own existence and increase their budgets; for if family planning is just one part of reproductive health care, which is part of primary health care, one might ask what is the rationale for separate "population" programmes at all.

Given the right-wing Congressional blocks to US funding for international family planning and population programmes, it would seem the UNFPA and US-based population organizations are reluctant to give up the one card they still believe can justify their activities before the US Congress: popular fears of "overpopulation" and the view that population growth in developing countries is a "security threat" to US interests (Hartmann, 1999). Even as its own population growth projections decline year after year, the UNFPA continues to preface its most recent publications and media statements with figures projecting how many billions will inhabit Earth, especially in developing countries, and correlating these with environmental and social disaster. The UNFPA's commitment to the reproductive health and rights-based approach of Cairo is no doubt real, but it is seen primarily as a *means* "to slow population growth", "to accelerate economic growth" and "to reduce potential environmental damage" rather than a matter of basic human rights (UNFPA,

1997a, 1999). The sacred cows it never wants to challenge are those of economic growth and free markets.<sup>16</sup>

Much more tenacious and doctrinaire in their population control aims are US-based population and environmental groups such as Population Action International (PAI) and the National Audubon Society. In a flier produced for the ICPD+5 review, the Audubon Society falsely defines the “consensus” reached in Cairo in crude neo-Malthusian terms: “. . . the need and the means to slow population growth and eventually stabilize human numbers”. PAI, in a 1997 booklet directly addressed to the World Bank and its post-Cairo funding policies, berates the Bank for having given “limited attention . . . to the problem of rapid population growth in the last few years”, sweeping population issues “narrowly under the health sector”, and redirecting its loans and research efforts toward health and education rather than family planning (Conly and Epp, 1997).

If population interests are accusing the World Bank of abandoning a population control agenda in favour of women’s health and education, then the women’s and development NGOs must have been doing something right in Cairo, Copenhagen and Beijing. Yet the fault lines in the Cairo Programme, its unbalanced resource allocations and its assumption that equitable population policies based on people’s health and social needs are compatible with market-driven economic policies remain extremely troubling. They recall the criticisms by certain feminist groups who attended the ICPD’s NGO Forum but remained distrustful of not only the official conference but the Women’s Caucus. These groups charged that the whole ICPD process was an exercise in co-optation; that it used the language of reproductive health and rights to legitimate old-style population control with a feminist face; and that, given the population establishment’s historical record, any population policy can never be compatible with feminist values and goals.<sup>17</sup>

### **Feminist counterpoints**

While mainstream organizations like PAI and the National Audubon Society fuel these charges, I would respond with three points in defence of the Women’s Caucus in Cairo. First, there is no logical necessity for population policies to be elitist, reductionist or aimed only at reducing numbers (especially among the poor, migrants and people of colour). Demography, after all, is a science dealing not only with fertility and numbers but with how people (populations) are distributed across age cohorts, genders, ethnic groups and geographic areas; their marriage, employment and cohabitation patterns; their deaths and diseases; as well as their access to goods, land and services. Given a different kind of vision, demographers and population planners could just as well apply their tools to identifying and eliminating inequities in these patterns

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<sup>16</sup> A striking exception is the 1997 report titled **The Right to Choose: Reproductive Rights and Reproductive Health**, which is grounded in a strong human rights and gender equality framework (see UNFPA, 1997b).

<sup>17</sup> They included the Women’s Global Network for Reproductive Rights, UBINIG (Bangladesh), ANTIGENA (Switzerland), the Committee on Women, Population and the Environment (United States), and the Third World Network. See Isis International, 1993, for their statements, as well as Hartmann, 1994; WGNRR, 1993; and Silliman, 1999.

of distribution, whether it be in treatment for HIV/AIDS or in access to liveable housing.<sup>18</sup>

Second, women's movements have influenced not only the research methods and concerns of mainstream population organizations but also their allocation of resources and service delivery programmes in countries around the world. An important example is the work of IPPF in its Western Hemisphere (Latin America and the Caribbean) and South Asian regions, where gender perspectives, quality of care, and most recently women's empowerment and development have become the major indices of successful programming. In reproductive health projects run by IPPF's affiliate, the Family Planning Association of India (FPAI), in Maharashtra state, for instance, project personnel say they never speak of "family planning" but rather try to "empower the women in the *mabila mandals* [local women's organizations] to think, express themselves, take decisions and act". Through a variety of skills training programmes, these projects have resulted in a dramatic rise in women's age at marriage and their literacy rates as well as their contraceptive use. Similar projects in Madhya Pradesh report that now "94% of project clients are opting for temporary contraceptive methods (mainly the condom) in an area where the traditional emphasis has been on sterilization" (IPPF, 1999:14).

What makes IPPF, by any criteria a Northern-based, "mainstream" and powerful international family planning organization, different from PAI? To understand how IPPF priorities in some regions began to change, we need to look at the internal dynamics that link significant parts of that organization to women's movements on the outside.<sup>19</sup> In a valuable new case study, Adriana Ortiz-Ortega and Judith Helzner (1999) attribute a decade of change in IPPF policies to the following factors: (1) the momentum of the feminist movement in the mid- to late-1980s; (2) the appointment of in-house feminists in key staff and board positions; and (3) the building of close alliances with women's health networks and movements outside the organization.<sup>20</sup> The experience of IPPF suggests two important conclusions. First, feminists working within mainstream institutions *can* help to change policies and programmes in ways that directly benefit the lives of the most marginalized people—if their work is constantly informed by connections to grassroots and transnational women's movements. Progressive work within institutions and independent movements outside those institutions are *both* crucial to social change and reinforce one another. Second, mainstream population and family planning organizations are no more monolithic than are women's NGOs. Some cling to their neo-Malthusian convictions, while others are responding to feminist ideas and

<sup>18</sup> This argument was first made by Marge Berer in 1990 (see Berer, 1990; 1993).

<sup>19</sup> My argument here is not meant to suggest a "revolution" at the international policy level of IPPF but rather to emphasize the process by which progressive change begins within institutions. Not only did IPPF's international office recently dissolve its Gender Advisory Panel, relegating gender to a lowly "task force." It also has yet to commit general funds to the kinds of empowerment projects I describe here, which still depend largely on outside grants. In other words, a feminist transformation in IPPF's mission is far from having become *institutionalized*. (Many thanks to Judith Helzner for these insights.)

<sup>20</sup> In the Western Hemisphere Region, the principal liaison group was the Latin American and Caribbean Women's Health Network. IPPF in South Asia maintains similar relations with local and national women's groups, which are very strong and well organized in that region.

practices and attempting to incorporate them into their programmes and direct services.

### ***Learning from the fault lines: Women in the Social Summit and ICPD+5***

My final point in defence of the Women's Caucus is best illustrated in the lessons transnational feminist groups have learned about (1) how to work most effectively within the UN system, and (2) the importance of challenging global power arrangements. Feminist critics of lobbying UN conferences argue that, despite many gains achieved, "by choosing the United Nations conferences as a site for NGO organizing, women's NGOs had to operate within the framework set by the United Nations and government representatives" and thus found themselves "straitjacketed" if not muzzled. These critics also question "using limited resources to respond to an agenda set by governments and UN agencies rather than using their resources to work for change outside of these international structures" (Silliman, 1999:151; Keyzers, 1999:17). Certainly, legitimate questions can be raised about the costs as well as benefits (both human and material) of women's NGOs becoming involved in "UN-level diplomacy," just as they can with regard to lobbying and electoral politics at the national or local levels. But women's work for social change has to occur *both* within and outside established institutions, and in global, national and grassroots contexts simultaneously. Far from competing, these different levels and forms of work are, or should be, mutually reinforcing. Rather than "mainstreaming the women's movements and strait-jacketing women's activism," the very process of participating in the conferences sharpened the strategic abilities and broadened the political understanding of many women's groups from North and South.

As this analysis has tried to show, transnational women's movements working within the UN conferences were contending with hostile forces on all sides, in addition to coping with an alien system of rigid rules and procedures. In such a situation, compromises and unholy alliances are hard to avoid. If the Women's Caucus can be accused of anything, it would be to have diverted disproportionate energy toward combating the fundamentalist and nationalist opponents of reproductive and sexual rights and less toward assuring the structural and macroeconomic conditions for those rights. This concentration of energies meant forming alliances with larger, more established NGOs, who "tend to take [fewer] risks or politically costly positions and are more amenable to conciliation and compromise" (Silliman, 1999:149). At the same time, beginning with the Beijing preparatory process women's NGOs began facing a well-organized backlash in the name of national sovereignty and traditional morality, fomented by the Vatican and some of its government allies. This backlash entailed "restrictions on NGO access and accreditation" to the official conferences, "mostly closed-door negotiations" and an overwhelming resort to "brackets" or filibustering tactics to avoid consensus over particularly contentious texts and stall or even sabotage any final document (Chen, 1996:152). In other words, the very success of women's NGOs in inserting feminist ideas into the ICPD POA aroused an intense reaction.

Such a backlash with regard to reproductive and sexual rights had already appeared in Copenhagen in March of 1995. The World Summit for Social

Development (WSSD) Programme of Action in some ways reflects Cairo in reverse. Its holistic framework, integrating sustainable development, poverty eradication, health, education, human rights, gender and racial equality, infuses the entire document instead of being concentrated within certain chapters. The “Principles and Goals” section declares the empowerment of people, “particularly women,” to be “a main objective of development and its principal resource”. It affirms the urgency of women’s full participation in all spheres and levels of social, political and economic life and their “access to all resources needed for the full exercise of their fundamental rights”. Chapter 4 on “Social Integration” elaborates on these principles, linking them to a concept of pluralism and diversity in societies and inclusion of all vulnerable and marginalized groups. And yet the Social Summit document virtually ignores not only sexuality and sexual orientation but also the definition of reproductive and sexual health and choice as fundamental human rights. It incorporates “full access to preventive and curative health care”, especially for women and children, into its programmes for poverty eradication and social integration. But, deferring to the Vatican position, it qualifies every mention of such access with the notion of “parental rights and responsibilities”, avoiding any reference to reproductive or sexual *rights* (Paras. 35-c, 36-h and 74-g).<sup>21</sup> The items listed as necessary “to meet the basic needs of all” are broad and comprehensive. But sexuality is nowhere among them, and the document’s repeated commitment to a human rights approach is strangely silent throughout the section on “basic human needs” (Chapter 2-C).

In part these omissions reflect a practical reality: the stronger presence of Vatican forces in Copenhagen relative to that of women’s reproductive rights groups, who (with infinitely fewer human and financial resources) could not manage travelling to Copenhagen in the few months between Cairo and Beijing. At the same time, behind this reality lurks a set of priorities in which the major funding agencies that support global feminist advocacy (and are located mostly in the North) do not put social development high on their agenda, and many feminist-identified organizations themselves still do not think of social development or macroeconomic issues and “women’s issues” in the same breath. While a central argument of this paper is that such bifurcated thinking among transnational women’s groups is gradually changing, it is not changing rapidly enough—in part because the fundamentalist challenge takes centre stage.

A fundamentalist, anti-feminist backlash was also highly visible during the ICPD+5 negotiations at United Nations headquarters in New York in 1999. Under the leadership of HERA (Health, Empowerment, Rights and Accountability)—a transnational network of women’s health activists who had served as core lobbyists and NGO members of government delegations in Cairo and Beijing—the “Women’s Coalition for ICPD” mobilized over 100 organizations from both the South and the North in a strategic process very similar to that applied at the prior UN meetings. In a scenario that was familiar but intensified relative to the 1994–95 conferences, the coalition had to

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<sup>21</sup> The amendments to the draft Declaration and POA proposed by the Women’s Caucus had inserted strong and consistent language reaffirming Cairo and calling for promotion of women’s sexual and reproductive rights, but these proposals were virtually ignored in the final version of the WSSD document.

contend with two main problems: (1) a Vatican/fundamentalist strategy that was not only highly organized but much more focused on a few key issues; and (2) a decision by the G-77 countries to function throughout these meetings as a bloc with a single spokesperson. This latter tactic not only created a formidable mechanism for delaying the proceedings endlessly (since the G-77 could never agree on anything). It also “straitjacketed” a number of G-77 delegations whose domestic policies are more in the spirit of Cairo than were their positions at the UN. A third problem was that many government delegates were local mission bureaucrats rather than seasoned experts who might be expected to know something about the ICPD and have experience in its implementation. Women’s coalition members soon began to realize they were lobbying among people who had not even been in Cairo, had never read the POA, and did not know the difference between reviewing practical actions to implement a document and redrafting that document all over again. But of course these dynamics were really indications of the low level of governments’ commitment to the review process and their growing resentment of NGO activity at the United Nations. Quite arguably, the work of the Women’s NGO Coalition at these meetings was pivotal to sustaining momentum; without it, no final report would have been produced at all.

And yet a consensus document did finally emerge, one that holds the line on the major reproductive and sexual health/rights provisions of the Cairo POA and, in a few instances, goes beyond them. For example, delegates adopted a new provision advanced by the Women’s Coalition regarding the training of health service providers to ensure that abortion, where legal, “is safe and accessible” (Para. 63-iii). Given the frequent absence of such training and access, even in countries such as the United States where abortion is a legal right, this provision has great practical importance. Moreover, by the end of the ICPD+5 process, it was clear that “sexual rights” had become an official part of the international human rights lexicon, regardless of the absence of the actual words in any document. This achievement at the level of language, the result of persistent efforts by women’s health and human rights NGOs, is more than a symbolic victory. A compilation of the work of the five UN human rights treaty bodies relevant to reproductive and sexual health indicates numerous instances since the Cairo and Beijing conferences in which the human rights committees have cited countries for their failure to prevent sexual and other forms of violence against women; or to provide sex education, sexual and HIV/AIDS counselling for men and women, or more funds for sexual health services (Stanchiere et al., 1999).<sup>22</sup>

Far from being “silenced” in the 1999 meetings, Women’s Coalition members worked in many resourceful ways to make their presence and ideas felt—through press conferences, fliers, hallway demonstrations, and an effective alliance with the newly organized Youth Coalition. In fact, I would argue that by 1999 women’s transnational NGOs had become far more sophisticated than they were in 1994 about the need for effective strategies to address the *structures of power* underlying existing patterns of global governance. One example of such

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<sup>22</sup> The major human rights treaty bodies at the UN are the Committee on Social, Economic and Cultural Rights; the Committee on the Elimination of All Forms of Racial Discrimination; the Committee on the Elimination of All Forms of Discrimination Against Women; the Committee on the Rights of the Child; and the Human Rights Committee.



a strategy is the vigorous international petition campaign (“See Change”) launched by Catholics for a Free Choice (CFFC) during ICPD+5 to challenge the Vatican’s status as a “non-member state permanent observer” at the United Nations (CFFC, 1999). The increasing attention of women’s health activists to the larger structures of power at the global level also extends to the macroeconomic conditions of reproductive and sexual rights—the “fault lines” of Cairo. In the years between Cairo and ICPD+5, transnational women’s NGOs working in the health sector became more committed to repairing those fault lines and to confronting directly the problems of privatization, unregulated global capital flows, inequitable trade patterns and the resulting shrinkage of social resources to meet health needs. In its proposed amendments to the “Key Actions” report, the Women’s Coalition thus recommended insertion of a paragraph addressing these macroeconomic issues and concerns. It further proposed amending the draft document’s existing language in the “Resources” section advocating “selective use of user fees, social marketing, cost-sharing and other forms of cost recovery” to assure “access to services by the poor, especially women”. And in addition to debt cancellation and debt swaps (to which all parties agreed), the Coalition’s proposals included “*additional mechanisms to raise resources such as taxes on financial transactions at the global and national level whose proceeds would be earmarked for human development programmes including sexual and reproductive health*”.

The final document passed by the UN General Assembly adopted none of these suggestions, nor did the G-77 countries seriously consider them. Instead, the “post-Cairo consensus” relies on appeals once again to donor countries and organizations to increase their contributions to official development assistance (ODA) earmarked for health care, education, poverty eradication and women’s empowerment; to enact measures to relieve the debt burden of poor countries; and to build in “adequate social safety net measures to promote access to services” by those who might be excluded (Paras. 95, 100 and 105).<sup>23</sup> In addition, the document calls on the private sector (now universally acknowledged as playing a central role in providing health services and commodities) to “ensure that its services and commodities are of high quality and meet internationally accepted standards; that its activities are conducted in a socially responsible, culturally sensitive, acceptable and cost-effective manner; . . . that it adheres to basic rights recognized by the international community and recalled in the Programme of Action” (Para. 86). Of course, no international mechanisms yet exist to enforce such standards and obligations on the part of the “private sector,” except to rely on the good faith of TNCs and the political will of governments. Nor are the private sector or the international financial institutions in any way a party to the UN conference documents or human rights conventions or subject to their (morally if not legally binding) jurisdiction.

It is interesting to look back in time to the Social Summit in 1995, where various participants came closer than they have in any UN conference before or since to trying to challenge these basic structural gaps in “global governance”. One of the most visionary was the Women’s Caucus, whose far-

<sup>23</sup> The very concept of a “safety net” is problematic because of its vagueness; nowhere does it specify basic minimums that must be met, *as a matter of human rights*, nor by when or for which groups.

reaching amendments for the draft Declaration and POA opposed the prevailing market-driven policies by proposing, among other things, to:

- Replace the document's emphasis on "[*promoting*] dynamic, open, free markets" with an emphasis on "[*regulating*] markets in the public interest with a view to reducing inequality, preventing instability, expanding employment, increasing the security of employment and establishing a socially acceptable minimum wage" (Commitment 1).
- Establish the basis for international trade equity through "effective regulations for the trade and investment activities of transnational corporations" (Commitment 1).
- "Initiate the foundation of a global fund for human security that would serve as a compensation mechanism for the social insecurity that results from the instability of the international market. . . financed by a levy on the commercial exchanges [of] international private financiers" (Commitment 1).
- Require the IFIs and the WTO "to promote universally accepted standards of economic and social rights"; to comply with and further international human rights commitments, . . . specifically commitments to women's equality"; and "to report to the human rights treaty bodies" (Commitment 8 and Ch. 5).
- Generate new financial resources through "new forms of taxation that will promote sustainable social and economic development such as placing taxes on resource use, commodification of common resources, taxes to discourage the production of toxic products, taxes on international financial speculative transactions" [Tobin Tax] (Ch. 5).<sup>24</sup>

Above all, the Women's Caucus amendments to the Social Summit POA contain the design for an elaborate machinery that would make the IMF, the World Bank and the WTO, as well as governments and transnational corporations, accountable to both ECOSOC and the human rights treaty bodies for upholding international standards of human rights, poverty elimination, gender equality and trade equity. In addition, this machinery would include: (1) a new juridical assembly able to hear cases and apply sanctions for non-compliance; (2) regular mechanisms for monitoring and correcting the impact of SAPs on women and poverty levels; and (3) an "elected international assembly of representatives of social groups to meet in conjunction with governments under the existing General Assembly as a component of a new system of global governance"—thereby *institutionalizing* and *democratizing* NGO participation in the UN system. Utopian no doubt, but by 1995 transnational women's coalitions were well aware that the international political and economic system would have to be turned upside down in order to achieve a healthy world.

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<sup>24</sup> Many of these recommendations are similar to ones contained in "The Copenhagen Alternative Declaration" (8 March 1995), a document emanating from the work of the NGO Development Caucus.

Once again, the official document finally accepted by government delegations, reflecting the actual balance of power in the world as it is, ignored most of these recommendations. Instead, despite its many progressive, feminist aims, when it comes to resources, implementation and follow-up the Social Summit Declaration and POA, like the ICPD POA, makes numerous concessions to the prevailing neoliberal, market-oriented doctrine. In Chapter I describing “An Enabling Environment for Social Development,” the approach to markets is primarily one of promoting their openness (“free trade”) rather than regulating their adverse effects. While SAPs are urged to “include social development goals” and “give priority to human resource development,” they should also “establish a more favourable climate for trade and investment” (Commitment 7). Nowhere are any economic principles framed in concepts such as social solidarity or social rights, nor is there a trace of the redistributive language of the Women’s Caucus amendments. As for strategies to increase resources for social development, these rely mainly on the .7 per cent of ODA commitment of donor countries, “20/20” agreements between donor and recipient countries, and debt reduction or cancellation (Ch. 5). But the Social Summit POA depends largely for the enforcement of these strategies on the good will of governments and IFIs. In sharp contrast to the Women’s Caucus and transnational development NGOs, it outlines no new or reformed institutional mechanisms, much less mechanisms that include democratic participation by members of international civil society, to ensure that IFIs, TNCs and governments are held accountable for their policies and practices.

Critics have charged that the UN conferences of the 1990s—which, after all, produced documents that are not only flawed but have no binding legal force—amounted to a tremendous waste of resources and energy. Even if the original documents themselves are worthy statements of principle, the UN system and UN diplomats are poorly equipped to engage in a meaningful process of monitoring and reviewing their implementation at the national level.<sup>25</sup> As O’Neill writes, “States sign these agreements in response to pressure from domestic women’s groups as well as out of concern for their international reputation”. Their compliance through concrete legislation and policy, however, will mostly depend on “women’s strong presence in government” and/or the will and positioning of women’s NGOs to demand, or carry out, the implementation and monitoring process themselves (O’Neill, 1995:62, 69). Silliman goes further, arguing that “changes made at the international conference level are not structural” and, being non-binding, “do not effect changes on a domestic level”. Moreover, she asserts, “working to ‘monitor’ the promises made at UN conferences . . . often deflects NGO energies and sucks them into the orbit of governments and international lending agencies, where their impact is marginal and where too often their politics are compromised” (Silliman, 1999:152).

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<sup>25</sup> Such concerns were publicly expressed in an open letter to Secretary-General Kofi Annan signed by a large and varied group of NGOs who had participated in the ICPD+5 process. Transmitted at the closing of the UN General Assembly Special Session in early July 1999, the letter asked the Secretary-General to “actively reconsider the process by which the implementation of important UN conferences [is] reviewed and appraised”. It complained that, in the case of the ICPD, the review process had been diverted into “a reassessment of the fundamentals” already “agreed and firmly established in Cairo”; that “procedures [had prevailed] over substance”; and that “scarce human and financial resources of the UN, governments and also of civil society” had been “wasted” as a result.

Certainly the outcomes of the Social Summit and the ICPD+5 processes I have just analysed give depressing confirmation that the conferences do not fundamentally challenge global structures of power. The market values and privatization that dominate the thinking of the IFIs, TNCs and major donor countries have also captured that of most Southern governments and seriously compromise the normative principles that the women's caucuses won. Nonetheless, I would argue that participation in the UN conferences has been a critical vehicle for strengthening and broadening transnational women's coalitions. More importantly, it has raised their awareness about the macroeconomic priorities of global institutions and just how much remains to be done in order to change those priorities. The following section will examine the impact of the conference documents at the national level and how the work of monitoring their implementation (indeed, left largely to women) has affected NGOs. Without the documents, however, and the transformative feminist values they contain despite their weaknesses, and because of women's efforts, there would be little to hold governments accountable for.

### III. Implementing International Norms at the National Level: The Many Faces of Privatization

As events during the 1990s United Nations conferences suggest, major shifts and power struggles are taking place in the global politics of health. I would argue that the current centre of gravity in dominant population and development strategies has moved away from the outmoded methods of population controllers to more complex and sophisticated objectives. These objectives are not primarily concerned with reducing numbers or disseminating contraceptives but rather with restructuring systems of financing and delivery, and opening up markets in what used to be the public sector to facilitate private investment, cost-effectiveness and growth. Their main command centres are located among health and development economists at the World Bank rather than demographers at UNFPA or international population organizations like PAI, and their approach to health reform dovetails with what we might call the *revisionist neoliberal approach* to macroeconomic policies: free markets stabilized by moderate (and globally centralized) regulations; and privatization softened by minimal (and locally decentralized) "safety nets" for the very poorest. It is an approach that presents feminist movements with a more complicated scenario than that of populationist and medical abuses of women's bodies and personhood. For, through the agency of international donors, it often seeks to empower women's NGOs both as international actors, and as monitors and service providers within countries, while it may disempower states from providing the services that women's NGOs are attempting to improve and expand or restore.

Health sector reform (see box 2) is the rubric that encapsulates the major international and national policy initiatives that will affect reproductive and sexual rights and health in the next decade, and globalization is the larger context in which health sector reform is taking place. *Privatization* in this scenario has meant the downsizing by the state of its public welfare functions

## Box 2: Health sector reform

*Feminist economist Hilary Standing defines health sector reform (HSR) “. . . as an amalgamation of the economic efficiency and public sector/good governance international agendas. Elements of it, particularly those concerned with controlling health sector expenditure, relate to economic crisis and structural adjustment policies. Other elements, particularly those connected to public sector and institutional reform, are related to governance issues and the role of the state as the overall regulatory body (Standing, 1999:1)*

*During the 1990s HSR, formerly the province of health economists and technocrats, caught the attention of governments and NGOs interested in health policy. Standing emphasizes that national and international efforts to address crises in the financing and delivery of health care have taken different forms in different geographical contexts. Thus, in Latin America, where both state agencies and civil society organizations, particularly women's health groups, are relatively strong, it has emphasized decentralization, reform of social security systems, and a major role for both the private sector and NGOs. In sub-Saharan Africa, where countries are heavily donor-dependent, face “severe crisis in health sector budgets” and have “weak state capacity to manage and regulate the health sector,” the emphasis has been on “financing mechanisms and improvement of human resource management” (1999:16). Despite regional and national variations, several common elements seem to emerge:*

- (1) defining more cost-effective financial schemes (the favourite being basic packages of essential services) and more efficient management techniques;*
- (2) devolving management and service provision (as opposed to overall policy and allocations) to district and local levels, i.e. decentralization;*
- (3) developing new health financing and cost-recovery options, e.g. user fees, community financing schemes, insurance and vouchers;*
- (4) reforming the human resource component, e.g. through reducing personnel and/or monitoring performance; and*
- (5) involving the “private sector”—including non-profit NGOs as well as businesses and private practitioner groups—more fully in service management and delivery (e.g. through sub-contracting) (Standing, 1999:8–10).*

*In theory, there is no reason why the criteria of efficiency and cost-effectiveness should be incompatible with either better health outcomes or the goals of equity and human rights; indeed, inefficient and wasteful health systems can hardly be socially just. Moreover, some HSR advocates surely have distributive justice in mind—for example, challenging governments to finance primary health care rather than tertiary care hospitals. Overall, however, feminist observers have found the most common standard of evaluation in most actual HSR schemes still to be the economic one of cost-effectiveness, and the principal method of implementation that of increased privatization of fees and services (Elson and Evers, 1998; Standing, 1999; DAWN, 1999; WEDO, 1999). This emphasis was signalled in the World Bank's **World Development Report (WDR)** in both 1996 and 1997, which endorsed the goal of “ensuring universal access to basic health services” but saw it as best achieved through privatization measures. Thus, less efficient public resources (e.g., hospitals) should be transferred to “private markets”, and many services previously delivered through public agencies should be sub-contracted to private vendors or paid for through vouchers. In either case, “universal access” is not intended to imply universal rights or universal coverage, since it is assumed that most people—all but the very poorest—will be able to pay for these services in the market, either through insurance plans or user fees: “Most curative health care is a (nearly) pure private good—if government does not foot the bill, all but the poorest will find ways to pay for care themselves” (World Bank, 1997:53). The end result, all too often, is that vast areas of the (formerly) social sector are opened up for private investment and profit, a good part of which comes from public revenues; the market becomes the source of most services*

**Box 2, continued**

*for most people; and those who cannot afford to pay ("the most vulnerable") are left to be protected by (often nonexistent) "safety nets". In other words, health care becomes essentially a two-tier system: a commodity for many ("health consumers") and a form of "public assistance"—or an unattainable luxury—for the rest.*

*It is interesting to go back to the 1978 Alma Ata Declaration's emphasis on "health for all people of the world" and the WHO definition of health as "a state of complete physical, mental and social well-being, and not merely the absence of infirmity," and as "a fundamental human right". Alma Ata's emphasis on social justice, universal access and intersectoral action is in fact repeated in both the Cairo POA and the Beijing Platform. The Copenhagen Declaration's Commitment 6 also invokes Alma Ata. Yet many current proponents of HSR seem to be going in the opposite direction—backward in fact, to "vertical, disease-oriented programs" that prevailed in the 1950s and 1960s; to "limited public expenditures" focused on a narrowly defined "package of services"; and to privatized care, financing and user fees (Koivusalo and Ollila, 1997:113).*

*Current debates about health care reform resolve into a distinction between whether health should be treated as a private commodity or as a public good and a human right. From the latter perspective, social justice in the provision of health care services involves three basic components: access, resources and quality. But in no country in the world where the unfettered free market has overridden principles of universality, public responsibility and social rights have these three components been achieved.\* World Bank loans as incentives to maintain social sector investments, or injections of private and public donor grants targeted at preventable, life-threatening diseases, can help alleviate major health crises, but they cannot finance comprehensive health systems nor guarantee equal access to all. Without a fundamental redistribution of the world's wealth, among and within countries, these remedies will remain at best temporary palliatives and UN documents vague promises. And beyond the resource problem, we would still face the governance problem: creating reliable monitoring mechanisms to enforce universal standards of care, dignity and free choice.*

\* A recent UNICEF report of 27 countries in Eastern Europe and the former Soviet Union found that free markets have an adverse impact on gender equality and leave women and girls "worse off". This is particularly true in regard to rising unemployment and loss of income as well as reduced life expectancy due to "increased smoking, alcohol consumption, drug abuse and unsafe sexual activity" resulting in high rates of HIV/AIDS (Olson, 1999; UNICEF, 1999).

so it can become a conduit for the transnational flow of capital and goods, along with the increasing absorption of those functions by private (often commercial) interests. In turn this typically means *commodification* of health care and other basic services, which then become available only for a fee. Among the well-known adverse effects of these trends, especially (but not exclusively) in developing countries, are the reduction of public sector programmes, on which working people and people in poverty depend; rising unemployment; the inability of the state even to provide "safety nets" any longer, due to the shrinkage of public revenues; and increasing poverty and gaps between rich and poor. Privatization itself directly contributes to poverty: "In India, the increased cost of medical care is the second most common cause of rural indebtedness" (WEDO, 1999:11). And, of course, all this is compounded by huge burdens of national debt.

But the adverse impact of globalization is unevenly distributed. Very often women are those whose care-taking burdens multiply when public health and other social services are cut; because women are more likely than men to be employed in the state sector, they suffer higher unemployment rates due to privatization; they are also most vulnerable to prostitution and sexual

trafficking under these conditions (WEDO, 1999; Beijing Platform, Ch. 2; Eisenstein, 1998). Women pay for the cumulative social deficits of globalization and privatization in another way as well, insofar as these trends undermine the very international instruments that were designed to promote gender equality. O'Neill, referring mainly to the Women's Convention and the ICESCR, points out that these international conventions, with their provisions for "better social protection through social security programs, health and safety regulations, day care centers and accessible health care", were written with the model of a strong, interventionist state in mind, based on principles of solidarity and social rights. One could make the same observation about the UN conference documents of the 1990s, insofar as they continually call upon signatory governments to take positive actions to implement gender equality, women's empowerment, eradication of poverty and access to health care, including comprehensive reproductive and sexual health services. The incompatibility between such provisions and global economic trends contributes to the failure of states to carry out their commitments (O'Neill, 1995:62). With the best will in the world, the privatized state, caught between debt and the global marketplace, may simply shrug its overburdened shoulders and say: Fine, but who is going to pay for these human rights?

Yet globalization also has a positive side that has contributed to the expansion of women's movements for equality, health and empowerment. Globalizing processes—of which the UN conferences have been a kind of microcosm—have provided a medium through which transnational women's movements have come together across their many cultural, regional and class differences to develop common political goals and strategies (Eisenstein, 1998). In the face of shifts in health care policies and practices, women are emerging not only as victims but as important actors, asserting their right to respect, self-determination and access to quality, affordable services.

A more ambiguous consequence of globalization is the tendency for women's organizations to participate in so-called partnerships with governments, IGOs and international donor agencies. In part this reflects a positive gain: women's and other transnational NGOs have consistently demanded that their voices and views be heard, and accordingly all of the 1990s UN conference documents acknowledge that governments and international organizations should strengthen "partnerships with the NGO sector" and integrate civil society groups into the policy-making process. Nonetheless, under existing conditions the concept of "partnership" between NGOs and most governing institutions, whether at the national or the international level, raises many troubling concerns. In the best of scenarios, will NGOs—particularly women's NGOs—find themselves doing public sector work without public sector authority and with inadequate resources? Will they unwittingly help to further the process of privatization, relieving the state of responsibility for providing universally accessible social services and for enforcing private sector compliance with human rights standards? The inequality of power and resources between large institutions and NGOs not only undermines the possibility of real "partnership" but creates a catch-22 in which, to "build capacity" among NGOs so that they can "come to the table" with dignity and respect, the dominant party in the "partnership" must play the role of donor, thus reinforcing its power.

### ***The experience of NGOs as country-level implementers, monitors and “partners”***

Perhaps the most useful outcome of women's health activists' participation in the UN conferences of the 1990s was that it armed them with guidelines and a human rights framework to more rigorously evaluate existing reproductive and sexual health services in their countries and advocate for better quality and access. Cross-country surveys conducted by transnational co-ordinating groups such as DAWN and WEDO reveal that the Cairo POA is alive and well at the country level—thanks largely to the efforts of women's NGOs who have become its *de facto* caretakers and implementers on the ground. But the extent to which these efforts have resulted in any concrete policy changes or improvements in health services and their enabling conditions varies greatly from one country to another. The surveys show that the actual applications of health sector reform, as opposed to technocratic theories, are also highly context-specific; their direction in practice depends as much on the political will and ideology of government agencies, and the skill and commitment of feminist advocates, as on the availability of resources.

Moreover, when we look more closely at the national setting it would appear that the very concept of “privatization” is too abstract. We need to deconstruct this concept in the light of actual practices to know what we are talking about when we refer to the “private (i.e., non-governmental) sector”: for-profit corporations? non-profit NGOs? religious institutions? grassroots CBOs, religious or secular? or some hybrid arrangement linking two or more of these? Each will have very different purposes and social philosophies; the question is, which are more likely to subscribe to principles of social justice, solidarity, universality and gender, class and racial-ethnic equality? Second, we have to ask the extent to which mechanisms exist to assure *public accountability* to the communities most affected by services or implementation activities, even if the organization in question is “private”. Finally, there are issues of scale and power. Is the NGO in question an international giant like CARE or IPPF, or a locally based and often under-resourced group like SOS-Corpo in Brazil or the Women's Health Project in South Africa? Organizations with the strongest links and accountability to local communities may be those with the least power and resources.

DAWN's survey of post-Cairo implementation efforts involved 23 countries in five geographical regions (DAWN, 1999). With regard to concrete outcomes of implementation, DAWN's assessment is decidedly mixed but with a cautiously optimistic tone overall. Primary among its findings is the “effective impact” the ICPD process—helped very much by the momentum and energy of Beijing—has had “across the South”. This impact is evident in both “a semantic revolution,” incorporating the language of reproductive and sexual health and rights, and a number of positive long-term developments in the realm of policies and services. These include, for example, the official abandonment of demographic targets in some countries (India, Thailand); the integration and cross-sectoral co-ordination of women's health, maternal and child health and family planning services in some countries (Brazil, the Philippines, Ghana); a broader definition of reproductive health to now include components such as interventions against domestic violence (South Africa), breast and cervical cancer treatment and prevention (Brazil, Mexico, Philippines), and HIV/STD



treatment and prevention; and reforms expanding women's access to legal abortion, trained providers and follow-up treatment for post-abortion complications.

On the negative side, however, DAWN found as many disturbing trends in most of the countries surveyed. These include the persistence of verticality and resistance to "integrative efforts" in many health programmes; a continued imbalance in resources, with programmes renamed "reproductive health" but family planning still receiving "much bigger" allocations than other components; narrow versions of "health reform," including the proliferation of privatization and cost-recovery schemes that "keep the poorer populations . . . away from hospitals and health centers"; the persistent inadequacy of financial resources and dependency on international donor assistance.<sup>26</sup> DAWN's analysis observes that not only is there an absolute scarcity of resources at the country level but also that "*quality* of expenditure is as critical as the amount of resources invested". Thus, for example, while "reduction of maternal mortality . . . requires investments in primary health programs to be combined with improvement in referral systems and obstetric assistance, . . . in the current scenario, donors are reluctant to fund infrastructure, and structural adjustment requirements curtail domestic investment" (DAWN, 1999:37). Again, the macroeconomic disabling environment looms large.

The WEDO survey, encompassing 50 countries in all regions, confirms DAWN's findings but with an even more pessimistic set of conclusions. "All respondents to this survey," it notes, "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" (WEDO, 1999:10). Nearly everywhere that cost-recovery mechanisms, especially user fees and privatized services, have been introduced, the results have been disastrous for women as clients. In Zimbabwe, for example, the initiation of user fees for prenatal care has led to a decline in clinic attendance and an increase in maternal mortality rates by a factor of five, according to NGO monitors in that country. Moreover, women who do attend hospitals or other health centres to receive maternal health care must not only pay for their medications but provide their own bandages and bring along candles to provide lighting! The decline in public spending and commodification of health care due to HSR has resulted in hospital closings in Peru and Russia. In Ukraine and Bulgaria it has led to a disproportionate and risky reliance on repeat abortions because women cannot afford contraceptives at market prices (WEDO, 1999).

Respondents to the WEDO survey confirm the negative impact of HSR on women not only as users of services but also as the majority of health workers, many of whom are now laid off due to cutbacks and wage freezes in the public sector. They also note the direct burdens on women as household maintainers, who must now fill the vacuum of diminished social services by spending more time caring for sick and disabled family members and neighbours. In other words, an undetermined proportion of health care gets "privatized" into unpaid household labour—a hidden tax that gender inequities still assign to women

<sup>26</sup> As pointed out earlier, disproportionate financing of family planning over the rest of reproductive health was one of the "fault lines" built into the original Cairo document.

and a “global burden of disease” that nobody computes into DALYs. At the same time, however, some reported developments are more mixed. In certain countries, decentralization of services, a common aspect of health reform, has in fact meant an increase in efficiency and in access for poor and rural women. Yet the devolution of services from the central government to district or local governments—or to NGOs—also frequently entails the transfer of greater authority and responsibility without adequate finances, equipment and staff. Or occasionally (as in India’s “Target-Free Approach”) it seems to bring greater decision-making authority for local providers but not greater empowerment or “choice” for women as clients.

This pattern of unevenness also affects NGO-government “partnerships”. On the one hand, the WEDO survey and case studies by HERA members have uncovered troubling signs that locally based women’s health and other NGOs are being pulled into a global privatization strategy that “empowers” them with too few resources to do too much. Especially in countries that are most dependent on international donor aid and where governments have enacted SAPs, women’s NGOs have filled the vacuum in service provision, replicating the expanded care-taking functions of individual women in households. This is true particularly in some African and Caribbean countries, and most particularly with regard to services for adolescents. On the other hand, where the decentralization of health programmes and services has entailed serious initiatives to involve grassroots women and women’s NGOs in decision-making, what can emerge is a more participatory, democratic model of health care management. This appears to be the case in Brazil, Peru, Bolivia and South Africa (HERA, 1998; WEDO, 1999).

Looking briefly at a few case studies may make these varied patterns more concrete.<sup>27</sup> In India, for example, a target-driven, often coercive population control policy provoked protests by women’s groups throughout the 1980s and calls for reform even by more mainstream voices in the early 1990s. These critiques were reinforced by the Cairo conference and resulted in a government and World Bank-sponsored effort in 1996 to introduce a “Target-Free Approach” (TFA) and a more integrated reproductive and child health (RCH) programme. The major elements projected for this new approach include not only (1) eliminating method-specific demographic targets but also (2) moving to “client-centred program management”, (3) expanding the range of choice, (4) providing an “essential package of reproductive and child health services”, and (5) involving both NGOs and *panchayats* in implementing the new policy. NGOs specifically are supposed to have a complementary role to that of government in the new RCH programme, including involvement in community-level advocacy, counselling, screening, funding, monitoring and deploying innovative projects such as mobile services (Health Watch, 1999; Visaria and Visaria, 1999; Nayyar, 1999; Pachauri, 1999).

Despite the very good intentions of India’s new policy, however, a review by Health Watch—a network of civil society organizations, researchers and activists, many of them from the women’s health movement—confirms that

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<sup>27</sup> In a much longer version of this paper, I document this analysis with country-level case studies based in India, Egypt, Peru, Tajikistan, Iran, Nigeria, Trinidad and Tobago, Brazil, South Africa and the United States.

numerical targets and quantitative methods of evaluating performance are still well in place, only determined at the local rather than the national level. In some of the states reviewed, the reforms seem to empower not clients, but auxiliary nurse-midwives, who “suggest” the method of contraception based on surviving number of children (Health Watch, 1999). In a field study of how the TFA is working in two states, Visaria and Visaria report that in Rajasthan targets for “acceptors” (now locally determined) are still the main focus, although incentive payments have been dropped. Most women are still delivering at home with traditional birth attendants, and the concerns of providers seem weighted far more toward the health of infants than the health and rights of women. Women who seek abortions or complain of RTI or STD symptoms are referred to private doctors, who charge fees they cannot afford. In Tamil Nadu, however, the conditions of maternal and reproductive health care appear considerably better, with much greater emphasis on client agency, encouraging hospital-based deliveries and lowering maternal mortality. Health workers are pleased that now “the pressure is off” (for meeting family planning quotas) and they “are able to inquire about women’s health, their children’s health” and are “better accepted in the community” because people identify them not just “as family planning workers” but as general family care providers. Thus implementation of the programme on the ground depends very much on the local culture of health provision and awareness, which differs between regions and states (Visaria and Visaria, 1999:92, 99).

A somewhat different situation exists in Peru, where the movement for women’s health and rights has also been highly mobilized and effective over the past decade. In the post-Cairo period, Peruvian women’s groups have been involved in a complicated mix of activities: monitoring and protesting government violations of women’s reproductive and sexual rights, providing extensive reproductive health services and simultaneously working in “partnership” with the government to make services more integrated and responsive. In 1996–97 the Latin American and Caribbean Committee for the Defence of Women’s Rights (CLADEM) and other women’s NGOs in Peru helped to document the rampant forced sterilization of poor, rural and indigenous women in some towns, where providers believed that fulfilment of quotas was a condition for job retention and promotion. The coercive tactics these women experienced ranged from promised gifts of food and clothing to intimidation and humiliation. Finally, when three women died from the procedure, Peruvian women’s NGOs called for the resignation of the Minister of Health (CRLP/CLADEM, 1999; WEDO, 1999). Women’s health and rights groups in Peru have also worked to expose other forms of abuse of women in Peruvian hospitals and clinics. In 1998 they brought the particularly horrifying case of Marina, raped by a public health doctor in his private office under the pretext of a gynecological exam, before the Inter-American Human Rights Commission—the first sexual rights case that body has reviewed (CRLP/CLADEM, 1999; Stanchieri et al., 1999).

To assess how skilled and experienced NGOs might perform a bridging function to make government clinicians and staff more sensitive to the real health needs and priorities of poor women, we can look at the work of the organization *Movimiento Manuela Ramos* (Manuela) in its *ReproSalud* project in Peru. Begun in 1995 and funded through a \$22 million grant from USAID, *ReproSalud* is intended to bring innovative approaches to improving the

reproductive health of women in peri-urban and rural areas while also attempting to empower grassroots women to make claims on public health services. Emphasizing preventive and participatory methods, the project aims to “actively [involve] women in identifying, prioritizing and resolving their own reproductive health problems” and to make sure that women’s perspectives are fully incorporated into all levels of public health care design and delivery (Galdos and Feringa, 1998). This example illustrates an undeniable reality: *in many contexts the women’s NGOs who originated the feminist values of the ICPD POA are the organizations best qualified to put those values into practice*. In stark contrast to the record of sterilization abuse and clinic violence in Peru’s public health facilities, ReproSalud’s locally sensitive and empowering methods are sure to be more compatible with the real needs and desires of rural and indigenous women, who tend to avoid public health services because of the indignities they suffer there.

At the same time, such extensive commitment of NGO energies to direct service provision, in close collaboration with both large international donors and the national government, creates dilemmas for previously autonomous NGOs like Manuela. One of the most perplexing of such dilemmas, as Manuela’s members recognize, is the tension inherent in “*the dual role of collaborating and critiquing*” (Galdos and Feringa, 1998:32). This tension arose sharply in relation to the coercive sterilization campaigns described above. There, feminist NGOs found themselves caught between genuine atrocities in the public health services and the eagerness of right-wing, religious forces to use these incidents to repudiate all public sector family planning programmes. Only after an ineffective period of attempting “quiet diplomacy” were they able to speak publicly in opposition to sterilization abuse. In the clinical rape incident, Manuela referred the case to CLADEM “because it did not want to jeopardize its tenuous relationship with the [Ministry of Health] MOH” (1998:29). Not only does Manuela find its oppositional role compromised. Perhaps more problematic is the fact that Manuela, while performing major public health functions through its ReproSalud project, is not part of the public sector and has neither the *authority* nor the *accountability* of a government agency. So it sits tenuously in between the public and the private, while relieving the public sector of responsibility.

Noel-De Bique (1998) articulates some of the more troubling questions raised by NGO involvement in ICPD implementation through both government “partnerships” and direct service provision. First, addressing the disparity in resources, she asks: “To what extent will the work of NGOs be funded by government for the delivery of services? Have resources been committed for the institutional strengthening of such NGOs?” In most of the cases reported in the WEDO, DAWN and HERA surveys, the answer is clearly no. Second, she cites the inherent conflict that NGOs like Manuela are forced to contend with: the “drive to professionalize” and “to compete effectively in a privatized health environment” versus a deep-felt commitment “to provide quality care for all, particularly for those who are unable to afford it”. This is the ambiguous and uncomfortable space—between the hegemonic market and the moribund welfare state—occupied by women’s health NGOs. Finally, Noel-De Bique suggests that there is a kind of reverse inequality whereby government officials responsible for policy formulation and implementation of UN conference agreements “lag behind the work and experience of NGOs”. Yet

“NGO diversity is not reflected in government structures or in the institutions which are mandated to implement or monitor” such agreements. This is not only a problem of ensuring greater *inclusion* of NGOs in government programme planning and review but also one of ensuring the *accountability* of NGOs themselves to a broader grassroots movement. How can NGOs tied into formal government or donor partnerships “continue to see their role as representing the interests of the broadest base of civil society”? (1998:38).

Women’s health NGOs in a few countries have developed creative solutions to these kinds of problems, working toward a model of “partnership” with government that remains organically linked to the larger women’s movement. One such model can be found in the relations between Brazil’s women’s health movement—organized since 1991 into a national network of some 200 organizations and centres (the National Feminist Health and Reproductive Rights Network, or RedeSaúde)—and government agencies responsible for implementing the ICPD POA. These relations have evolved over a decade and a half of measures to embed health policy in the processes of democratization and civil society engagement. As a result, the women’s health movement in Brazil has become *institutionalized* to an unparalleled degree, through representation on a wide array of commissions to oversee government health policies.

As early as 1983, long before the Cairo conference, the Brazilian women’s movement pioneered a Comprehensive Women’s Health Program (PAISM), which was adopted by the Ministry of Health the following year and anticipated the wide range of services encompassed in Cairo’s concept of “reproductive health”. A strong rights perspective has also infused the work of Brazilian women’s health NGOs through their close alliance with the National Council of Women’s Rights (CNDM), which has given high priority to health issues. Moreover, throughout the 1980s and 90s, feminist health activists in Brazil have occupied key roles in some national, state and municipal agencies concerned with health (most notably in the city of São Paulo), as well as participating in a Women’s Health Cross-Sectoral Commission (CISMU) that now functions as a National Health Council advisory board. In the post-Cairo years this feminist constellation has won significant policy and legislative reforms to actualize the sexual and reproductive health goals of PAISM and the ICPD, including defeat of foetal “right to life” proposals in the legislature and expansion of access to safe, legal abortion (Corrêa, 1999; LACWHN, 1998). Brazil’s National Commission on Population and Development (CNDP), set up in 1995 to monitor implementation of the ICPD, is not only headed by a leading figure of the women’s health movement but also includes women’s NGO representatives and integrates 10 different ministries. The CNDP’s positions strongly endorse a politics of redistribution (e.g., minimum income guarantees), solidarity, social accountability and human rights (CNDP, 1999).

What allows this elaborate intersection of state and autonomous mechanisms by women’s health activists is the nature of the Brazilian health system itself. The Brazilian government and society remain firmly committed to a universal health system (SUS) providing free coverage for many basic treatments and services and giving priority to primary care and reproductive and sexual health,

including HIV/AIDS prevention and treatment.<sup>28</sup> Moreover, that system involves increased financing for public sector health care; a high degree of integration (multi-sectoral approaches) as well as decentralization; and “social accountability mechanisms in the form of [citizens’] health councils that operate at all levels (national, state, local)” (Corrêa, 1999:14). To be sure, budgetary constraints and the persistence of vast social, racial and regional inequalities in access to services and the quality of care still plague Brazil’s SUS. Nonetheless, in Corrêa’s view health reform in Brazil has succeeded and substantially improved “women’s quality of life” for two reasons. The first of these is “the inherent characteristics of the SUS: public investment, universality and thorough planning and prioritization of basic health care”. The second is the indispensable role of women’s organizations “in exerting pressure on the health system (convincing managers, sensitizing and training health professionals) and . . . mobilizing public support, creating coalitions, stimulating public debate and systematically monitoring policies” (1999:21).

The partnership model presented in the Brazil scenario is one of (1) strong representation on government/civil society monitoring bodies (CNDP, CISMU, CNDM) by (2) nationally co-ordinated networks of independent women’s NGOs (RedeSaúde), which in turn represent (3) locally based activist groups who are closely tied *both* to grassroots community based organizations *and* to health professionals and managers. These organizations provide the connection and make the necessary translation of Cairo principles at the local and the national levels. It is an organic model that links each level of decision making and interweaves government and civil society.<sup>29</sup> Yet the Brazilian model grows out of very particular historical and political circumstances that may not be easily transferable to other countries. More typically, “partnerships” between NGOs and governments might better be described as partnerships between NGOs and international donor agencies, for whom NGOs become not only the conduits of health reform project funds but in effect the *administrators of a health reform agenda over and above the state*. In cases where NGOs are trying to involve and retrain government health workers and administrators, the result will likely be improved public services for poor women and their children. In other cases, however, will the positioning of NGOs *between* the state and external donors serve to erode even further state responsibility for the quality of health care? Will this in turn lead to a shift in the balance of power, where human development and health are concerned, from state institutions to international donor agencies and civil society organizations? Under what conditions might this form of “NGO privatization” either advance or retard the goals of gender equality, human rights *and* public accountability in health care provision?

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<sup>28</sup> The SUS provides over 70 per cent of outpatient and hospital care, managing a vast network of public units and accredited private services. For approximately 120 million Brazilians (out of a total population of around 160 million), SUS is the sole source of medical care and provides a free, all-inclusive benefits package (Corrêa, 1999). On HIV/AIDS services, see Parker, 2000.

<sup>29</sup> A similar model of effective partnership, in which women’s NGOs maintain both their autonomy and their accountability to broader social movements, exists in South Africa, particularly in the work of the Women’s Health Project (WHP) and its Transformation of Reproductive Health Services Project, which is funded mainly by UNFPA and the United Kingdom’s Department for International Development. I include an analysis of this model in the longer version of this report. See also Klugman et al., 1998; Xaba et al., 1998; and NPU, 1999.

### ***The many faces of privatization***

Recently many commentators have expressed concerns about what I earlier called the underside of NGO empowerment in both transnational and national political processes. Usually these critiques are made from the standpoint of *less* empowered groups (community-based organizations, grassroots organizations) as well as a position of scepticism toward the objectives and motives of powerful international donors. Summarizing this set of arguments, Koivusalo and Ollila ponder whether NGOs are being “used as a vehicle for privatization and social sector restructuring” that meets the needs of donors more than those of poor people in developing countries. They worry that projects elevating NGOs as providers and implementers of social sector reform may promote a “neoliberal, market-based model of social provisioning” and the further shrinkage of the state’s role. Moreover, the increasing professionalization and donor dependency of many NGOs not only risks muting their capacity for effective advocacy and opposition (as in the case of Manuela in Peru). It also tends “to [undermine] grassroots organizations representing poor people” and to divert or disable “oppressed people. . . from demanding that the state agencies deliver the goods” (Koivusalo and Ollila, 1997:100; Silliman, 1999:156; Lang, 1997). Yet NGOs may be no more efficient, qualified or sensitive to community needs than government officials, while lacking the presumed accountability of those officials to local communities

While affirming these concerns to some extent, national-level cases reveal a much more complex picture. First, it is crucial to remember that “NGOs” are not a monolith; they vary tremendously in their size, power and resources, their relations to both donors and national governments, and above all the extent and quality of their connection with grassroots movements. Most women’s NGOs surveyed by DAWN, WEDO and HERA make great efforts both to connect with the voices and needs of grassroots women and to “work with, rather than replace, the functions of the state” (Koivusalo and Ollila, 1997:101). Those involved in direct provision of services are in some cases troubled about the state abdicating its functions and the burden this places on their own workload. In other cases they are finding creative ways to use their gender education and training skills to enhance and expand the role of local and district public health providers, thus bringing the state back in (ReproSalud in Peru and WHIP in South Africa, for example). In most cases, however, women’s NGOs become involved in providing health services to meet an urgent and desperate need that would not be met otherwise. In situations where governments are burdened with debt, corrupt or disinterested, or the state is in chaos or disarray, the idea of popular demands on state agencies seems fanciful, or a luxury in the face of survival.

Second, like NGOs, international donor agencies represent a wide spectrum. Structurally, some are private foundations with a great deal of flexibility and freedom from red tape; some are annexes of government ministries or UN agencies with tremendously onerous bureaucratic requirements they are forced both to impose and to fulfil; some are large and complex international financial institutions, like the World Bank, whose aims and procedures may differ from one sectoral or regional office to another. Donor’s political agendas are just as varied: some may be carrying out neoliberal, market-promoting purposes;

others, humanitarian purposes; others, both at once. In the best (or worst) of circumstances, privatization may be less the cause than the consequence of a lack of capacity on the part of state agencies and the urgent need to “deliver the goods” in whatever way possible. Further, especially given the scarcity of funds everywhere, sometimes it may be necessary to take a hard-nosed attitude toward the motives of international donors. Their interest in evading state bureaucracies or corruption, or in garnering a “popular” constituency by supporting NGOs, may be offset by the importance of projects that advance health and protect human rights: developing HIV/AIDS prevention programmes in Brazil; creating alternative models of contraceptive choice in Peru; setting up integrated, “one-stop” quality health services in Uganda; providing seed money to women’s health groups in urban slums in India to make community improvements as they see fit.<sup>30</sup> Some of these projects are funded by the most powerful and suspect donors—the World Bank in Brazil and India, USAID in Peru and Uganda. Yet these projects also appear to be influenced by feminist goals and attempting to empower the poorest women in the communities where they live. Progressive critics have to deal with this contradiction and figure out what it means in the long run.

The issue of NGOs abetting privatization by functioning as service providers is complicated by another factor: the growing power of religious institutions as not only opponents but “private” *providers* of reproductive health care. A case in point is the United States, where not only have huge for-profit “managed care” institutions (often insurance companies) virtually taken over control of most health care, restricting patients’ access and freedom of choice; but the Catholic Church, with its vast network of hospitals, is rapidly becoming one of the most important health providers in the country.<sup>31</sup> As CFFC’s ongoing survey of the trend toward Catholic/non-Catholic hospital mergers reveals, in some US towns and cities Catholic hospitals are now the only option available. As a result, women who depend on those hospitals are *de facto* deprived of many essential reproductive health services that the church considers immoral (CFFC, 1998; 1999). This ominous trend for women’s reproductive and sexual rights in the United States suggests that women’s NGOs may feel compelled to get involved in both the delivery and the monitoring of health services to counter the rush by private companies and religious organizations to fill the gap left by the state—or, in some cases, to fulfil needs no one else is willing to meet.<sup>32</sup>

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<sup>30</sup> See Gill/World Bank, 1999 for an interesting account of Bank-supported health and community development projects linking local NGOs and poor grassroots women in Hyderabad, India. The Delivery of Improved Services for Health (DISH) project in Uganda (a partnership among two programmes at the Johns Hopkins School of Public Health, one at the University of North Carolina, and the Uganda Ministry of Health), integrates the whole range of reproductive and sexual health services included in the Cairo POA, under the slogan, “Care for Others, Care for Yourself.” See <http://www.jhuccp.org> for more information.

<sup>31</sup> On managed care in the United States, see Rivera et al., 1997 and Annas, 1997; on the exclusion of poor Americans from health insurance coverage, see Pear, 1999. According to the latest figures, 16.3 per cent Americans (44.3 million people) lack any health insurance, an increase of 4.5 million since 1993.

<sup>32</sup> The National Abortion Federation (NAF), a consortium of both non-profit and for-profit free-standing abortion clinics in the United States, has operated by default since 1976; for, although abortion is a constitutional right in the United States, public hospitals and many private physicians refuse to provide abortions because of continued harassment by anti-abortion forces.



Finally states, too, are tremendously varied, and the differences in their political cultures, ideologies and institutional structures—as much as their economic conditions—are an important factor determining the potential impact of NGO activities. It is interesting in this respect to contrast the nature and limits of NGO-government “partnership” in the Philippines and Brazil—two countries that are predominantly Catholic, have undergone recent transformation from dictatorship to democracy, and are characterized by strong and vibrant civil society (including women’s) movements. Indeed, the women’s health movements in Brazil and the Philippines are arguably the strongest, most well co-ordinated and most organically linked to popular grassroots movements of any in the world. Women’s health NGOs in the Philippines—who generally operate in an organized coalition framework—have made important achievements in regard to implementing the principles of the ICPD. In part due to a sympathetic new Minister of Health, but even more to “sustained advocacy by [women’s NGOs] and feminist individuals in the government”, they have managed to turn the country’s population policy in a much more feminist direction (Francisco, 1998:2). The previously narrow and bifurcated family planning programme (administered by the National Population Commission) and maternal health programme (administered by the Department of Health) have now been merged into a much broader Women’s Health and Safe Motherhood Project (WHSMP), one of whose major components is “gender and women’s empowerment”. This shift to a reproductive health approach has involved not only the elimination of targets but new programmes for the diagnosis and treatment of STDs, RTIs and cervical cancer (DAWN, 1999).

Yet other aspects of the Philippines reproductive health policy remain hostile to women’s and young people’s sexual and reproductive rights and seemingly impervious to the efforts of women’s groups to initiate change. Not only does the Philippines continue to have one of the most restrictive abortion policies in the world, but the reproductive health programme provides virtually no adolescent sexual and reproductive health services, no initiatives to promote male responsibility, and little in the way of services to address violence against women. Sexuality education is limited to the “family life” curriculum approved by the church, and even the provision of contraceptives is constrained by both church resistance and dependence on donors for imported supplies. Despite an intensely pro-natalist, pro-motherhood culture, women in the Philippines do not have access to quality prenatal and obstetric care, and seven out of 10 births occur at home (Francisco, 1998; DAWN, 1999). And why is this the case, despite the tireless efforts of a highly vocal and mobilized women’s health movement? One has only to look at two structural features of the Philippines state that democratization has left untouched: the deeply entrenched political power of the Catholic Church in nearly every area of social policy—far greater than the church wields in Brazil; and an economic system that has not only been drained by recent crises and IMF-imposed “fiscal discipline” but is historically and ideologically committed to privatization and commercialism. Even before severe cuts diminished the already meagre health budget from 3.4 per cent to a mere 2.2 per cent of total government spending (compared to Brazil’s 15.5 per cent), the vast majority of health care provision in the country was already privatized and subject to user fees—out of reach for much of the impoverished population (WEDO, 1999).

In the absence of any official recognition of health care, including reproductive and sexual health, as a social and human right, or of state responsibility to meet basic health needs, women's groups in the Philippines struggle on every front: participating actively in the Freedom from Debt Coalition and the Anti-Poverty Coalition; publicly opposing privatization and user fees in the health sector; publicizing the sexual exploitation and abuse of young migrant women who work in the "free enterprise zones"; as well as launching a major campaign for access to safe contraception.<sup>33</sup> Maintaining a separate and sometimes oppositional posture vis-à-vis the state is essential in this context, whereas a quasi-"partnership"—with strong ties to grassroots movements and readiness to be critical when the need arises—seems more feasible in the Brazilian context. A comparison of these two country contexts illustrates that the state does matter; that its effectiveness, investment policies and social philosophy help determine the limits of what civil society organizations will be able to achieve in the realm of health and human development.

Both the Brazilian and the South African scenarios suggest models in which active civil society organizations and socially committed state institutions can interact to create strong systems of accountability even where some services are provided by NGOs or the private sector. We must continue to press for strengthened state functions and the responsibility of the state to protect universal access to the full range of health care as a matter of human right. Yet we also have to address the global inequities behind the incapacity of many states to deliver, with the best of will and adherence to human rights principles. South Africa has the most extensive constitutional and legal guarantees of sexual, reproductive and health rights of any country in the world, along with a vibrant government/civil society "partnership" working for their enforcement. Yet a government commission has just issued a report finding that its 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" (Swarns, 1999).

But even if transnational movements succeeded in winning effective redistributive policies and international enforcement mechanisms to transform the global balance of resources, one has to assume that markets in the foreseeable future are here to stay. It is not a question of states *versus* markets, public *versus* private, but rather of *which kinds* of private entities are going to be involved in providing basic social services, with *what sorts of values and objectives*, and under *what kind of public scrutiny and accountability mechanisms* to assure equality, quality of care and adherence to human rights norms. In the twenty-first century, the provision and monitoring of social rights will increasingly belong to hybrid institutions that cut across old boundaries of public and private and local, national and international.

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<sup>33</sup> This is the current agenda of WomanHealth Philippines, but the activities described are ones in which a broad coalition of women's health groups—Linangan ng Kababaihan, Inc. (LIKHAAN), Gabriela, Women Education Productivity and Research Organization (WEDPRO) and others—participate jointly (Interview with Mercedes Fabros, Director of WomanHealth Philippines, March 1999).

## IV. NGOs, the State and Global Governance: What Can We Learn from the Campaigns for Reproductive and Sexual Rights?

The purpose of this paper has been to examine critically the role that transnational women's NGOs in the 1990s have played in the creation and implementation of international agreements related to reproductive and sexual rights. My focus throughout has been twofold: first, to explore the multiple ways in which reproductive and sexual rights intersect with, and are embraced within, a wide range of health, human rights, social and gender justice and human development issues; and second, to use this inquiry to rethink the complex political dynamics in which transnational women's NGOs find themselves, as they manoeuvre within a globalizing yet deeply divided and grossly inequitable world. As this dual vision might suggest, I believe that feminist groups have had a major impact at both international and national levels in shifting dominant discourses about reproduction, population and sexuality in a direction that puts the ends of women's health and empowerment above that of reducing population growth. This is a major historical achievement and a mark of the power of transnational women's NGOs. At the same time, I also believe that the translation of this discursive shift into effective policies and programmes has been seriously limited by global economic processes, and religious and cultural forces whose institutional power is far greater than any that feminist groups could possibly attain at this juncture. It has also been limited, however, by internal divisions and strategic short-sightedness among the women's groups themselves. Specifically, I would sum up the "lessons learned," from this study as follows:

1. *Need for stronger alliances.* Participation by transnational women's NGOs in the UN conferences of the 1990s was the decisive factor in achieving recognition of a new approach to "population" issues in international documents. This approach (a) recognizes reproductive and sexual rights as fundamental human rights; (b) links those rights firmly to principles of gender equality and the empowerment of women and girls; and (c) relocates family planning within a broad array of reproductive and primary health care needs. Nonetheless, efforts by Women's Caucus participants to link reproductive and sexual rights to social development ("enabling conditions") through mechanisms for generating and redistributing resources and instituting changes in global economic decision-making were too little, too late, and largely unsuccessful. I would attribute this failure to three central causes:

- Preoccupation with the threat of fundamentalist forces and thus reluctance to jeopardize alliances with mainstream population and family planning groups and government delegations (the United States and the European Union) committed to market-oriented macroeconomic policies. This reluctance made it difficult to take a strong, uncompromising position on structural transformations and redistributive policies as the basis for implementing a broad approach to reproductive and sexual health.
- Divisions among transnational women's health NGOs, particularly between those who tend to focus more on implementing

reproductive and sexual health and rights and working to change the policies of intergovernmental and governmental institutions, and those who tend to focus more on opposing population control policies and are suspicious of working within or with those institutions.

- Lack of interest or awareness among many development and environment NGOs concerning the human rights aspects of health, reproduction and sexuality and their linkage to broad economic and social issues.

Such internal divisions, as well as their isolation from other NGOs interested in a social justice agenda, have weakened the international impact of transnational women's health NGOs. In my perception, these divisions are more strategic than political, and every attempt should be made to mend them and re-establish trust in order to build a stronger and more effective transnational movement. In addition, that movement needs to work more closely with transnational development NGOs that are attempting to change global macroeconomic policies and structures. This would serve to educate the latter about the linkages between personal and social rights (especially for women) and to form a counter-alliance that can work independently of *both* fundamentalist and market-oriented forces.

2. *Need for organization, leadership and bridging mechanisms.* The experience of transnational women's NGOs working to implement reproductive and sexual rights, at both the international and the national levels, affirms that "social movements do not sustain themselves without organizations" (Abdulhadi, 1998:669). It is a mistake to dichotomize NGOs and social movements, or activists who work "inside" and those who work "outside" institutions ("lobbying" versus "struggle politics"). The one cannot exist or be effective without the other, and in fact a clear division of labour between those working at different levels, or in different ways, is essential to a movement's long-term viability. In addition, the effectiveness of women's health NGOs both nationally and internationally has depended on strong *leadership*, including effective secretariats or co-ordination centres. In the context of the UN conferences, this usually has meant one or two NGOs with extensive knowledge and a clear vision taking the lead in planning and strategizing on behalf of the Women's Caucus. In national contexts it has more often meant a co-ordinating body that directs a coalition of women's NGOs who have a long history of working together. To maintain their legitimacy and their claim to be representative, on the other hand, NGOs and their leadership require organic ties to grassroots social movements or CBOs. Such ties cannot be taken for granted; they must be consciously nurtured. Country-based efforts to implement women's reproductive and sexual rights (as defined in the Cairo and Beijing documents) have been most successful where NGOs are strongly connected to grassroots social movements (e.g., Brazil, the Philippines, South Africa, Peru). These examples show that NGOs can act as a bridge between social movements and governing institutions and can work effectively for popular participation in local and national health policy making.

3. *Need for strong, responsive systems of national governance.* Surveys conducted by both transnational women's NGOs and United Nations agencies provide

ample evidence that free markets and current patterns of privatization are failing to deliver on the promises of Cairo, Beijing and Copenhagen (WEDO, 1999; DAWN, 1999; UNICEF, 1999). Certainly they are not providing adequate reproductive and sexual health services for all who need them or assuring the realization of reproductive and sexual rights, much less the right to the highest available standard of health care for all. These surveys suggest the need for health reform programmes that strengthen, rather than weaken, *public* health systems, not only through increased investments, but also through reorganization, retraining (e.g., in gender sensitivity) and more effective management. At the same time, corruption, insensitivity and inefficiency in public sector health services have been a constant complaint by not only international donor agencies but also community groups and their constituencies—those who depend on the services most.<sup>34</sup> Given this dubious record in many countries, as well as the prevalence of markets everywhere, it is inevitable that private (for-profit) companies and non-profit charitable, NGO and community-based groups will increasingly function side by side with public agencies to provide services and assess their quality. But in such hybrid (government/non-governmental) systems, *it is essential that the regulation and enforcement of universal standards of access and quality remain a state responsibility.*

Women's NGOs can play an important role both as service providers and as civil society advocates who scrutinize health providers, *both* public and private. In some circumstances they can function as "partners" of the state, providing crucial advice and training of health officials and clinicians. But they should not take over the responsibilities of the state to provide overall regulation and assurance of basic health care for all, nor should they cede their independent, critical role. The most successful models of national-level implementation of sexual and reproductive health programmes exist in countries (e.g., Brazil and South Africa) with strong state institutions that subscribe to principles of social solidarity and justice (across gender, race-ethnic and class divisions), along with strong civil society organizations that push the state forward and call it to account. In those societies, a high level of democracy and popular mobilization makes it possible for women's NGOs *both* to co-operate with *and* to critique, from a stance of independence, government policies and decision-making bodies. Yet these very conditions suggest that such "best practice" models may not be easily transferable to societies where the political conditions are altogether different.

4. *Need for strong institutions of global governance, including enforcement mechanisms for an economic "enabling environment."* Even in those societies where democratic institutions and social solidarity principles prevail, and where women's and other civil society organizations are strong, global economic constraints are making it impossible to carry out the existing social justice agenda (including reproductive and sexual rights and primary health care). International donor institutions, which have the greatest power to deliver resources and secure compliance with international norms, have shown little interest in human rights enforcement and primary concern with cost-effectiveness and securing markets. Recent World Bank policies emphasizing poverty reduction, gender

<sup>34</sup> Regarding the treatment of low-income women by public health services, see IRRRAG studies on Brazil (especially the Northeast), Egypt, Mexico, and the United States, in Petchesky and Judd, 1998.

equality and social sector investments are encouraging, yet that organization remains immune from any external accountability and constrained by the utilitarian values of a lending institution. The human rights treaty bodies, on the other hand, whose concern with reproductive and sexual health rights is greatly expanding, have little enforcement power, and no authority over global finance. Meanwhile, deliberations within the UN system are stymied by the persistent deference to national sovereignty, a lack of political will or commitment to international co-operation on the part of many governments (notably the United States), and grossly insufficient human and financial resources.

Clearly there is a need for radical restructuring of existing global governance institutions that will include both (1) effective mechanisms that assure accountability of the World Bank, the IMF, the WTO, TNCs and major donor countries to uphold international human rights principles; and (2) effective mechanisms of democratic participation for transnational civil society organizations, giving them a genuine place and voice within the UN system. But this kind of transformation is inconceivable without the forceful mobilization of transnational movements worldwide. Toward this end, women's groups committed to a reproductive and sexual rights agenda must begin to ally much more closely with other transnational NGOs that are using human rights strategies—to eliminate poverty, secure a safe environment, end gender violence, challenge racism and militarism, and create alternative models of development and a more just economic order.

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