

Reproductive Health, Gender and Human Rights: A Dialogue



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***Reproductive Health, Gender and Human Rights:
A Dialogue***

Coordinated by the Women's Reproductive Health Initiative,
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Reproductive Health, Gender and Human Rights: A Dialogue

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Introduction

The late Jonathan Mann, among his many contributions to the world, led the way in linking public health to human rights. His emphasis on integrating human rights into public health is well placed: not only is it the right thing to do but an increasing body of evidence suggests that it also is the most effective thing to do. Human rights violations in the area of sexuality, for example, lead to adverse public health outcomes, such as higher rates of unintended pregnancies, maternal and neonatal mortality, unsafe abortions and sexually transmitted infections (STIs), including HIV/AIDS. Lack of enforcement of basic human rights also inhibits women's social mobility, limiting their access to contraception, maternal and child care and treatment of STIs.

Clearly a dialogue is needed between those working primarily in public health and those working primarily in human rights, since both fields have much to offer each other. It is also clear that although there are many shared goals, there are also differences in perspectives and that there is little collaboration between the two communities. As a consequence, PATH's Women's Reproductive Health Initiative (WRHI) joined nine other NGOs, universities and multilateral organizations to plan a day-long dialogue on reproductive health, gender and human rights. The gathering took place at the World Bank on December 8, 1999. Its purpose was to provide useful information to public health policymakers and implementing agencies on the relevance of human rights issues to public health—and of public health issues to human rights—with particular reference to reproductive health and gender inequity. The ultimate goal of the gathering was to encourage public health agencies to address human rights and gender issues more fully in reproductive health programs.

We are grateful to the following cosponsoring organizations, which variously contributed speakers, discussants, question-and-answer facilitators, note-takers, photographers, materials, travel expenses and a great deal of thoughtful planning: the Center for Health and Gender Equity (CHANGE), the Center for Reproductive Law and Policy (CRLP), Columbia University School of Public Health, The Futures Group International (TFGI), George Washington University School of Public Health, the Global Health Council, Human Rights Watch, the Pan American Health Organization (PAHO) and The World Bank. In addition, the U.S. Agency for International Development (USAID), the International Center for Research on Women (ICRW), the Society of Women and AIDS in Africa (SWAA), and EngenderHealth provided excellent speakers. All the speakers willingly took time to update their presentations, which now constitute the chapters of this publication. We also thank the discussion facilitators during the day of dialogue: Norine Jewell of TFGI, Anu Kumar of the MacArthur Foundation, Rosalia Rodriguez-Garcia of George Washington

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University and Martine de Schutter of PAHO. Finally, we acknowledge our PATH colleagues Helen Cornman, Susie Bloodworth and Manisha Tharaney, who worked tirelessly, and with unfailing graciousness, to organize the conference.

While a major gathering can serve as a catalyst, it is seldom enough to guarantee action. Action requires a sustained interest in the issues, which can be fostered by regular meetings with informed and committed people; program models; tools for designing, monitoring and evaluating programs responsive to gender and human rights issues; and an ongoing source of reliable information. After the conference, WRHI and many of its partner organizations have worked on developing indicators and program models and have co-sponsored a series of follow-up seminars. These seminars built upon the reproductive health, gender and human rights issues discussed at the December 1999 conference, as related to maternal mortality, family planning and abortion, HIV/AIDS, and violence against women. The seminar series allowed for a larger discussion on related topics such as trafficking, adolescent reproductive health and rights, male involvement, sex work, FGM and gender norms in reproductive health. Some of the seminars also served to educate Congress on these issues in hopes of influencing policies related to reproductive health and human rights. A list of follow-up activities is found in Appendix D.

The articles in this publication—both the “hardcopy” and the “e-version”—are based on the presentations at the conference, but many have been updated and have added references and other resource material. We therefore prefer to think of it not as a proceedings document but as a collection of interesting articles by interesting people reflecting various viewpoints on reproductive health, gender and human rights. We hope that the reader will find these articles compelling and useful commentaries on the fields of human rights and public health.

May 2001

Foreword

The Programme of Action of the 1994 International Conference on Population and Development (ICPD) in Cairo, to which the nations of the world agreed, was firmly grounded in commitments to the protection of human rights and the pursuit of gender equity. In the years since the Cairo meeting, many stakeholders have dedicated themselves to making the ICPD vision a reality. The day-to-day challenges of implementing Cairo have not always allowed stakeholders with various perspectives to share and enrich each other's experiences and evolving definitions of the reproductive health and rights agenda.

For this reason, the Dialogue on Reproductive Health, Gender and Human Rights held at the World Bank in December 1999 was particularly important. It provided over 160 key stakeholders from the public health, human rights, and gender communities and a range of organizations—including NGOs, foundations, and international agencies—a forum for sharing lessons learned and deepening their understanding of how reproductive health, human rights and gender equity are linked. The large number of co-sponsoring and participating organizations provided evidence of these institutions' recognition of the importance of building bridges between the various communities and strengthening their commitments to reproductive health and rights, including gender equity.

Discussions focused on a range of crucial concerns raised in Cairo and in the ICPD+5 consultations held during 1999, addressing the unacceptably high levels of maternal mortality and morbidity suffered by poor women around the world as both a rights and a public health issue and identifying other problems, including unwanted pregnancy and unsafe abortion, HIV/AIDS, violence against women and practices such as female genital mutilation, in similar terms. Country case examples were used to explore how these issues could be addressed in concrete terms through better program design and implementation strategies.

Issues that need further thinking were also raised, including ways to ensure reproductive health and rights in an era of changing macroeconomic policies, including health reform. One of the challenges is getting health systems to work better without neglecting human rights. Recognizing that there is a multi-sectoral realm beyond health and rights, the need for more resources and greater efficiency in resource allocation is clear. We not only need more effective use of existing reproductive health programs, but also structural changes in all sectors; it is this broader approach that will contribute most to sustainable and rights-based reproductive health programs.

The collective wisdom of this dialogue is that public health personnel and economists must both begin to look through the "human rights lens," as various

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Given limited human, financial and political resources, how do we decide what is worth fighting for and where to put our resources? We need guidance from the people who work at the intersection of public health and human rights to know where to put our energy.

human rights conventions/treaties, bills of rights and watch groups keep our “feet to the fire.”

At the same time, the gender and rights dimensions, while crucial, are only part of the story of how to improve reproductive health. There are huge external forces working against our agendas. Political, cultural and financial forces often have a bigger impact on delivery of reproductive health services than what we as public health and human rights professionals can achieve from within the system. In order to accomplish something, we need to be selective and specific in choosing our battles. If we spread the work too thinly, the chances of success are limited.

Given limited human, financial and political resources, how do we decide what is worth fighting for and where to put our resources? We need guidance from the people who work at the intersection of public health and human rights to know where to put our energy. Although the forces that shape the outcome of maternal and other reproductive health issues may sometimes seem beyond our control, bringing the voices of public health and human rights together is a major step forward. Our collaboration will maximize the likelihood of success in achieving those outcomes both communities seek. Together, we need to keep fighting the fight.

The articles in this volume provide readers who were not able to participate in the meeting with a sense of the exciting dialogue that occurred, and for those who did attend, a chance to revisit the experiences of that very valuable day together.

I. Goal-Setting

This special dialogue is dedicated to the late Jonathan Mann, whose work with the Harvard Institute for Health and Human Rights spearheaded the linking of human rights and public health.

The goals of this dialogue are:

- ◆ To encourage the integration of gender and human rights issues in the field of reproductive health,
- ◆ To provide the tools for this integration,
- ◆ To foster dialogue and cooperation between the human rights community and the public health community.

While those of us working in the public health and human rights arenas are in agreement over basic goals such as addressing inequities in health care and improving the quality of life for all people, there are many issues on which we may not agree. For example, consider how you might answer the following questions, as individuals working primarily in either the public health or human rights arena:

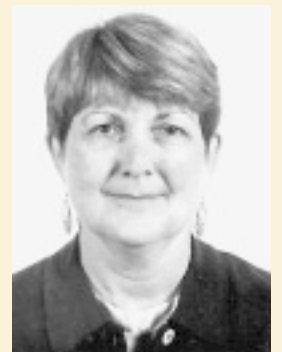
- ◆ With only about 600,000 maternal deaths per year, maternal mortality is low on the Burden of Disease yardstick. Should we devote large sums to prevent it if that means less money for more prevalent causes of death?
- ◆ If research shows that the health consequences of female genital mutilation are not as severe as previously thought, should we abandon our work to eradicate it?
- ◆ Now that we have drugs to reduce mother-to-child transmission of HIV, should we have mandatory testing and treatment for all pregnant mothers?
- ◆ Should sex-workers be required by law to be tested and treated for sexually transmitted infections, including HIV infection? Or would collaborative health education programs with sex workers be as effective and more ethical?
- ◆ Is it justified to promote vigorously long-term and permanent contraception to poor women with many children? Or to offer them generous “travel expenses” to be sterilized?

The contributors to this volume—who engaged in the day-long dialogue—address some of these questions, helping to bridge the gap between the public health and human rights fields.

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2. Reproductive Health, Gender and Human Rights: The Sexuality Connection

The intersection of Reproductive Health, Gender and Human Rights reflects key issues articulated five years ago in Cairo at the International Conference on Population and Development—ICPD. As everyone is now aware, ICPD represented a major turning point in the population field because of its unprecedented emphasis on gender and rights, as well as its call for a broad array of reproductive health services—not just family planning to meet fertility-reduction goals. In the “Cairo” Programme of Action, all of Chapter VII was devoted to explaining the concepts of reproductive health and reproductive rights:

- ◆ Cairo defines reproductive health 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 as well as the capability to have children—and the freedom to decide if, when and how often to do so.
- ◆ This means that women and men have the right to be informed and to have access to effective, affordable contraceptive methods of their choice, as well as to safe abortion, where it is legal.
- ◆ It also means that women have the right to appropriate health-care services to enable them to go safely through pregnancy and childbirth and with the best chance of having a healthy infant.
- ◆ Cairo also states that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights agreements and other consensus documents.
- ◆ To respond to the above rights, reproductive health services must be in the business of both preventing and solving reproductive health problems, as well as promoting sexual health.

In the six years since Cairo, governments, donors and health agencies have faced the challenge of defining and implementing “reproductive health services.” This has not been easy. However, the recent five-year assessment exercises on the Cairo agenda (ICPD+5) have documented that progress is being made in integrating family planning with services to meet clients’ other reproductive health needs, such as antenatal care, HIV prevention, and diagnosis and treatment of reproductive tract infections and sexually transmitted infections (STIs).

Far more difficult to define and to implement are the ICPD provisions that list rights to “sexual health” and “a satisfying sex life.” The fact that five years after Cairo, delegates to the ICPD+5 Preparatory Committee Meeting could not reach consensus on sex education in the schools and on sexual/reproductive health information and services for adolescents is indicative of this difficulty. While

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Human sexuality is seldom incorporated into reproductive health programs. And yet, the majority of threats to reproductive health are not attributable to pathogens, lack of medicines and poor health services alone. They are equally rooted in sexual relationships that are negatively influenced by gender-biased societal norms.

human beings are clearly sexual beings, the area of human sexuality is often misunderstood and reduced to being synonymous with sexual intercourse. Human sexuality is, therefore, seldom discussed among reproductive health professionals, let alone incorporated into reproductive health programs. And yet, the majority of threats to reproductive health are not attributable to pathogens, lack of medicines and poor health services alone. They are equally rooted in sexual relationships that are negatively influenced by gender-biased societal norms.

Six Dimensions of Sexuality

Consider briefly these dimensions of sexuality—and how they can either enhance life or be a source of human misery, including reproductive health problems:

- ◆ **Sensuality**—physical feelings about our own and other people’s bodies, especially the body of a sexual partner. It includes sexual attraction, sexual desire and sexual pleasure. The feelings are strong and can be the impetus for both healthy and unhealthy sexual experiences.
- ◆ **Intimacy**—the ability and need to be emotionally close to another human being, to give and receive love or affection, to experience mutual trust—to be connected to another in an ongoing relationship. This basic human need can be as strong as physical desire. It can lead to forming a mutually satisfying relationship or to entering into or staying in an abusive relationship. When intimacy is threatened, it can be the basis for murderous jealousy.
- ◆ **Sexual health and reproduction**—the reproductive system and all of its functions related to sex, conception, pregnancy and delivery, as well as all actions aimed at keeping it functioning optimally and free from diseases and harmful traditional practices. After ICPD, many family planning programs that earlier focused on preventing pregnancy have become “reproductive health programs” by adding other related services. However, information and counseling still focus on “the facts” and seldom include sexuality and gender issues.
- ◆ **Sexual identity** includes three interlocking pieces that affect how a person sees himself or herself—the individual’s sex, gender roles and sexual orientation. The sex of an individual is determined biologically as male or female, while his or her gender role is culturally derived. Society assigns certain roles, rules of behavior, entitlements and relative value to males and others to females—and there are sanctions if people deviate from these assignments. Almost everywhere, gender norms favor males and discriminate against females. As a

result, too few women have control over when to have sex and whether to use protection against pregnancy or STIs. Very few women even know that they are entitled to certain basic rights such as bodily integrity. Similarly, gender bias adversely affects those whose sexual orientation deviates from the norm.

Homophobic societies see homosexuals and transgendered people as males and females who reject their gender “assignment.” Their human rights are routinely violated.

- ◆ **Sexual socialization**—consider the mixed messages young people receive about sexuality. Where and how do they learn about the reproductive system, sexual behavior, sensuality, intimacy and what it means to be a man or a woman? The messages are seldom consistent since they come from different sources with differing values: parents, religious leaders, teachers on one hand; on the other—radio, TV, magazines, observation of adult behavior, and perhaps the most common source, information and norms transmitted by one’s peer group. Girls become sexual beings at puberty and they are both admired and punished for it. They are warned against emotional and physical closeness to boys and men. Boys learn that it is okay to experiment with their sexuality—the more sexual conquests, the more manly they are—but that they must avoid appearing weak or showing emotions. Is it then surprising that globally one-third of women have experienced violence in an intimate relationship?
- ◆ Finally, there is “**sexualization**,” the use of sex to achieve other objectives—such as to control another person, to express anger, or to manifest domination over an ethnic group, as is the case of rape in wartime. Advertising also uses sex to sell products. Its message is “Say yes to this product and you will be sexy.” Sugar daddies—older men who offer money, food and gifts to little girls in exchange for sex—exploit young girls’ poverty status to gain sexual satisfaction or because they think they can avoid AIDS by sleeping with a virgin. Sexualization is only possible due to gender inequity.

Managing Sexuality—Yesterday and Today

In order to address the various dimensions of sexuality and prevent negative outcomes, it is important to also remember how sexuality was managed traditionally and how it is being managed today. Traditionally societies managed sexuality, especially that of their adolescents and particularly girls, as in the following examples:

- ◆ Using shame and guilt to curb sex before marriage (Europe during the Victorian area)
- ◆ Secluding and veiling of girls during adolescence (in the Middle East)
- ◆ Marrying off girls at or just before onset of puberty (most parts of the world)
- ◆ Rites of passage ceremonies or programs that provide adolescents with fundamental life skills including how to manage one’s sexuality (parts of Africa)

...most reproductive health programs concentrate on “the plumbing,” teaching clients a little about the reproductive system, contraception, pregnancy and STIs—and the services and products to deal with them. Seldom do the topics of sexuality, gender and human rights or the skills to negotiate sex and gender norms arise for adolescents or even adults.

These mechanisms of managing sexuality have either already disappeared in some places or are rapidly changing due to education, urbanization, media influences and the development of a global culture. Unfortunately, the family is in a noticeable decline, the extended multi-generational family of traditional societies giving way to nuclear families, single-parent households and the no-parent groups of street children¹. In response to these dramatic changes, many sex education programs are designed to instill fear of disease and pregnancy; many offer “abstinence only” approaches to sexuality.

As mentioned, most reproductive health programs concentrate on “the plumbing,” teaching clients a little about the reproductive system, contraception, pregnancy and STIs—and the services and products to deal with them. Seldom do the topics of sexuality, gender and human rights or the skills to negotiate sex and gender norms arise for adolescents or even adults. Comprehensive sexuality education programs are often mired in controversy as adults try to censor content and eliminate the most critical components. This is often due to a variety of factors:

- ◆ Disagreements about whether sexuality education programs should focus on prevention of unwanted consequences of sex (as in Western Europe) or focus on the prevention of sex itself (as in many other countries).
- ◆ Lack of knowledge about the goals and outcomes of comprehensive sexuality education programs (even though a growing body of research shows that sex education does not promote promiscuity but leads to delayed initiation of first sex, reduction in number of partners and use of contraception among the already sexually active).
- ◆ Many adults are uncomfortable discussing sexuality issues with adolescents or with their spouses, even though lack of discussion may endanger their lives.

Successful Interventions

And it must be asked: where are the programs that address gender issues and reproductive rights directly? There are very few. The good news is that things are slowly beginning to change. Let us discuss a few examples from PATH’s work in

¹ Fuglesang, Minou. Lessons for Life—Past and Present Modes of Sexuality Education in Tanzanian Society. *Soc. Sci. Med.* 44 (8), 1997: 1245-1254.

Kenya and Ghana and the work of colleagues in Senegal:

- ◆ In Kenya, participatory community education on cultural empowerment and reproductive health and rights, including the right to bodily integrity, led to the community's mobilizing its members for change. The community replaced traditional coming-of-age ceremonies, which included female genital mutilation, with what we call Alternative Rites of Passage. In the alternative rite, modern sexuality education is added but all the relevant aspects of traditional sexuality education and the celebration, honor and feasting are retained. Only the cutting is eliminated.
- ◆ In Ghana, our baseline assessment revealed that rape and coercive sex occur quite commonly among adolescents. However, in training health workers and leaders of youth-serving organizations, we found that they themselves often placed blame on girls in cases of rape and coerced sex. Most of them agreed that if a young woman who was dressed provocatively or was in a place she was not supposed to be was raped, she deserved to be raped: "She was asking for it." After the group had analyzed the provisions of several human rights instruments including the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) as well as relevant Ghanaian laws, there was a complete reversal in attitude. The participants said that the young woman might have been showing off her body, looking for admiring glances and comments to boost her self-esteem, possibly looking for a new boyfriend—but she was *not* looking for rape and did not deserve to be raped. They all acknowledged her rights to choose, to free association and to sexual and reproductive health, among other rights.
- ◆ In Senegal, a colleague organization called TOSTAN provided basic literacy, problem-solving and health and human rights education to village women. After receiving training on women's health and human rights education, the women were able to connect several problems that they were earlier oblivious to: "*When we circumcise our daughters, we violate their rights; when we send them to Dakar as domestic help, we violate their rights.*" The women also realized that use of family planning for birthspacing is good for their own and children's health and well-being. The women resolved to stop circumcising their daughters and sending them to Dakar to become domestic servants. Their declaration affected many other villagers who adopted their stance. Ultimately, it encouraged the Senegalese Government to pass a law against the practice of female circumcision or FGM.

In many African communities...education on universal human rights and on national legal rights has been found to be empowering on its own. People are forever changed by exposure to such concepts.

Recommendations

In the many African communities where PATH has worked, education on universal human rights and on national legal rights has been found to be empowering on its own. People are forever changed by exposure to such concepts. The question we need to ask ourselves is: “Are reproductive health information and services enough”? In fact, they are only part of an essential package for improved reproductive health. Donors and implementing agencies must think “outside the box”—outside the clinic walls—and increase support for the following complementary approaches at the policy, program and community levels:

- ◆ Address sexuality education comprehensively in school programs, reproductive health services and in communities.
- ◆ Incorporate gender socialization issues (for both boys and girls) and human rights and legal literacy into in-school programs, services and community education programs.
- ◆ Improve the understanding of program implementers about their own culture and that of others, in order to promote positive aspects of culture within programs.
- ◆ Re-orient the top-down IEC strategies used by many programs to become supportive behavior-change interventions involving individual and community stakeholders.
- ◆ Link national-level advocacy—monitoring and implementation of human rights conventions (CEDAW, CRC and others)—as well as positive policies and laws, to coalition-building and community-empowerment programs.
- ◆ Scale up successful pilot programs that address linkages among gender, human rights and reproductive health—and do not forget the sexuality connection.

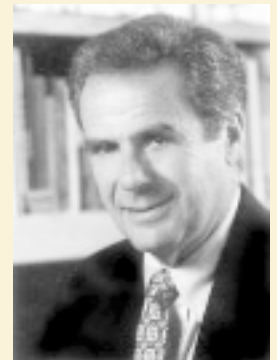
If we invest in strengthening these community-based and rights-focused elements in our existing programs, we will see a rise in healthy behaviors protective of reproductive health and a simultaneous demand for improved services.

3. Maternal Mortality as a Human Rights and Gender Issue

The following are the key health statistics on women’s pregnancy-related mortality and morbidity around the world:

- ◆ An estimated 585,000 women die each year from pregnancy-related causes. For every woman who dies, approximately 10 others suffer a debilitating injury, often with life-long consequences.
- ◆ Maternal morbidity ratios in developing countries are 10-100 times those in developed countries. The maternal mortality ratio in developing countries is 100-1000 per 100,000 live births. In the United States, by comparison, the maternal mortality ratio is 8-12 per 100,000 live births.
- ◆ There are a half-billion women of reproductive age today, and maternal mortality is the leading cause of premature death among women of reproductive age.

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Causes of Maternal Mortality

Causes of maternal deaths and illness have not changed dramatically in recent years. Figure 3-1 lists the major causes of maternal mortality.

Hemorrhage is the leading cause of maternal mortality in many settings, estimated to account for about one-fourth of all deaths. There is a high incidence of maternal mortality during and immediately after deliveries that take place at home. This is especially true in rural communities where a delivery is more often (than in urban areas) attended by a traditional birth attendant (TBA), by a relative, or perhaps by no one at all.

Among those who survive these and other complications of pregnancy, Figure 3-2 (on the next page) lists the most debilitating problems.

In terms of morbidity, there are limited data about the social, economic and emotional impact of the morbidities listed in Figure 3-2. We know that VVF and RVF are devastating conditions that leave women with little or no ability to control leaking urine and feces. Thousands of women in Africa are in need of a surgical repair for these conditions, which render them

Causes of Maternal Mortality
Postpartum hemorrhage
Obstructed labor/Ruptured uterus
Toxemia/eclampsia
Postpartum sepsis
Abortion complications
Infectious diseases: malaria, AIDS, tuberculosis

Figure 3-1

isolated and outcast until the complications are repaired. Waiting lists are extraordinarily long in the small number of facilities that provide them surgical services.

Maternal Morbidity
Vesico-vaginal fistula (VVF)
Recto-vaginal fistula (RVF)
Infection and anemia
Cervical tears
Incontinence
Nerve damage

Figure 3-2

Maternal Mortality: The Three Delays

Maternal mortality is associated with delays in three areas that if addressed could make a major difference:

- ◆ **Delays in recognizing complications.** The seriousness of complications is not recognized or is recognized too late to seek or reach help.
- ◆ **Delays in transporting women to a facility.** Transportation has not been arranged in advance, money for transport has not been set aside, and finding and arranging transport leads to arrival too late for the woman to receive life-saving treatment.
- ◆ **Delays in receiving care at the facility.** Once the facility has been reached, treatment may be delayed by bureaucratic procedures; discriminatory treatment (especially of post-abortion patients); lack of available trained personnel; or lack of appropriate drugs, blood and supplies.

Maternal Mortality Management

Reducing delays and increasing the availability of appropriate emergency obstetrical care (EOC) can greatly reduce maternal deaths. There are a number of important first steps at the community level, consisting of:

- ◆ **Family planning services.** All women should have access to good-quality family planning services and methods of their choice. Family planning reduces maternal deaths by reducing the number of women exposed through unwanted pregnancies and unsafe abortions.
- ◆ **Health education.** Community outreach to inform pregnant women, newlyweds, and family members (including husbands and mothers-in-law) about the risks of pregnancy, and the signs and symptoms of emergency obstetrical complications, can help reduce delay in seeking medical attention.
- ◆ **Training of village workers and TBAs.** Since many births are delivered by informally trained, non-licensed traditional birth attendants, it would save lives if TBAs have and use “clean birth kits” to reduce risk of infection, can recognize and refer for complications and can administer drugs, if feasible. It is essential, however, that referral emergency obstetrical services be available prior to major expenditures on further TBA training.

- ◆ **Arranging for and providing emergency transport.** Awareness-raising within the community about the risks of pregnancy and how to respond to emergencies can lead to such practices as community-designated transportation and a fund to pay for it.

Emergency Obstetrical Care

The main life-saving interventions known as emergency obstetrical care are:

1. Management of hemorrhage (e.g., intravenous fluids and transfusions, and surgical intervention)
2. Antibiotics administered by injection or intravenous infusion
3. Ability to perform safe Cesarean sections
4. Management of abortion complications

Some of the above elements can be administered at a primary health care facility. Cesarean section and management of serious complications of abortion require care at a more medically sophisticated facility. In many parts of the developing world, there are no personnel trained to perform Cesarean sections. General physicians as well as health personnel other than physicians can provide these services if carefully trained.

An estimated 40-50 million abortions occur each per year. Of these, approximately 60,000-110,000 deaths occur due to unsafe abortion, representing about 13 percent of all maternal deaths (and as high as 20 percent in some settings). Most deaths occur to women who do not seek treatment for complications following abortion or delay too long in seeking treatment. While even women who reach the hospital with complications of unsafe abortion may die, treating such complications consumes the largest share of the obstetrical budget of many hospitals. Addressing the intractable contribution of unsafe abortion to maternal mortality and morbidity, particularly in those countries in which it is illegal, is greatly complicated by the highly controversial nature of abortion in society today.

Other Important Issues in Addressing Maternal Mortality

There are several other issues to consider in addressing maternal mortality, some of which may be surprising:

- ◆ **Training and roles for TBAs.** What level of care can TBAs deliver? How much emphasis should be put on training TBAs to recognize and treat complications as opposed to investing in other aspects of the health care system? While much effort has been devoted in the last 30 years to training TBAs to perform safe deliveries, the unpredictability of complications and shortage of facilities to treat them has meant that this effort has had minimal, if any, impact on

It is not possible to predict accurately which women will suffer serious obstetrical complications. Because of the large number of women classified as being at low risk, a majority of the complications leading to death are seen among low-risk women.

maternal mortality.

◆ **Risk screening is not the way to go.** Although prenatal care is important, it is not possible to predict accurately which women will suffer serious obstetrical complications. In fact, simply because of the large number of women classified as being at low risk, a majority of the complications leading to death are seen among low-risk women. Therefore, since most complications cannot be predicted or prevented, it is necessary to provide services universally for women who have complications.

◆ **Morbidity vs. mortality.** For each maternal death, the number of women who are disabled, often permanently, is estimated at as much as ten times higher. Since the physical processes leading to mortality and morbidity are the same, approaches to decrease mortality will also help to reduce morbidity.

◆ **Measurement of maternal mortality.** It is difficult to measure accurately the number of maternal deaths. Vital statistics in most poor countries are inadequate, and deaths may be attributed to other, non-pregnancy-related causes or go unreported altogether.

Reporting is especially problematic for deaths occurring among unmarried women or due to unsafe abortion. On the other hand, if measurement has improved somewhat due to increased attention to the issue, deaths due to maternal causes will appear to be higher relative to the past, leading to an artificial plateau in death rates, despite a decade of efforts to promote safe motherhood.

Highlights of the Safe Motherhood Initiative

Initiatives to achieve safe motherhood have been underway for more than a decade. Nearly 20 years ago, new studies documented the extent of the problem of maternal mortality. In 1985 the World Health Organization sponsored a conference on maternal mortality. Referring to maternal and child health (MCH) services in developing countries, the question “Where is the M in MCH?” became an impetus for the development of the Safe Motherhood Initiative in 1987. A decade-long effort to reduce maternal mortality culminated in the 1997 Safe Motherhood conference in Sri Lanka. While much progress had been made in understanding the root causes of maternal mortality, experts noted that little progress had been made in reducing it.

The Averting Maternal Death and Disability Project

On this premise, the Averting Maternal Death and Disability (AMDD) Project of Columbia University’s Mailman School of Public Health was initiated

in 1999, with a sizeable five-year grant from the Bill and Melinda Gates Foundation. The goal of AMDD is to assure that all women have access to emergency obstetrical services. To augment its small staff, experts from collaborating organizations serve as consultants. In addition, AMDD works through partner agencies, including affiliates of UNICEF, UNFPA, WHO, the World Bank, CARE, Save the Children, and the Regional Prevention of Maternal Mortality Program (RPMM) in Africa. AMDD collaborators are PATH, FHI, JHPIEGO, EngenderHealth and The Population Council. AMDD is working to provide EOC in India, Bangladesh, Pakistan, Nepal, Bhutan, Peru, Morocco and Mozambique. A number of African countries are involved through an alliance with RPMM.

Maternal Mortality—A Human Rights Approach

High rates of maternal mortality—avoidable death in pregnancy and childbirth—constitute a violation of human rights and demand prompt attention and action. The technical solutions to reduce maternal mortality are not enough. As a basic human right, women should be able to have a child safely and with good quality of care. The human rights “system”—laws, policies, and conventions—must be used to hold states accountable for obligations undertaken pursuant to treaties. Human rights principles should be used to reshape health policies and programs and to guide the delivery of health services.

A human rights approach enforces the concept that **the provision of appropriate health services is a right that people are entitled to demand from their government and a duty that a government owes its people**. Presently there are two international treaties most relevant to the reduction of maternal mortality: The International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination Against Women.

A human rights approach addresses specific issues such as:

- ◆ Maternal mortality in the context of the complex social, economic and cultural conditions that keep it high
- ◆ Discrimination against women and against the poor and minorities
- ◆ Gross inequality between developed and developing countries

Human Rights in the Context of the Three Delays

The Three Delays result from the human rights violations, especially the undervalued position of women in society:

1. Discrimination against women in the home and family prevents women from seeking and receiving health information and care.
2. Discrimination in access to health services on the basis of gender, class or

residence puts care out of reach for many women due to geographic and/or economic reasons. Adequate care is especially lacking in rural areas.

3. Discrimination against women in provider-patient relationships as well as the macroeconomic forces currently devastating health systems contribute to the likelihood that decent care will be non-existent or fatally delayed at the facility level.

We must acknowledge that we are not opening new territories. For example, UNICEF is committed to the human rights approach and is poised to use “rights-based” programming. However the challenge is to put human rights *principles* and health *programming* together. In order to reduce maternal mortality, health programs must perform adequate emergency obstetrical care. Without investments in programs, human rights principles remain unenforceable.

How Can Progress in Reducing Maternal Mortality Be Assessed?

In 1997, WHO, UNICEF and UNFPA issued *Guidelines for Monitoring of the Availability and Use of Obstetric Services*. The guidelines are a tool for documenting, monitoring and advocating for EOC at the local, national and international levels. They provide program managers and policymakers with indicators and minimum acceptable standards to help them monitor progress in increasing access to and use of EOC services. The UN Guidelines assess the EOC environment by asking these basic questions:

- ◆ Are enough health facilities providing EOC?
- ◆ Are the facilities equitably distributed across the population?
- ◆ Are pregnant women in general and those with obstetric complications using the facilities?
- ◆ Are the facilities providing enough life-saving services to meet needs?
- ◆ Is the quality of these services adequate?

The *Guidelines* offer an alternative to maternal mortality rates and ratios in terms of measuring progress in reducing maternal deaths. They are less expensive to use, can show changes in a relatively short period of time, and can be used to monitor compliance with international human rights laws to end discrimination against women. Actual measurement of maternal mortality ratios in poor countries is grossly underreported and the costs of “fixing” the vital registration system is far too high, given the importance of using limited funds to provide emergency services.

As a postscript, one could note that the human rights approach is relevant in developed countries too: in the United States the lack of health insurance for many pregnant women and others is equally a violation of human rights.

4. Women's Reproductive Health: The Public Health Perspective

Our objective in public health is, of course, to make the world a better place, and it is not an easy task. For starters, there are some huge global reproductive health problems:

- ◆ Unwanted/mistimed pregnancies—75 million per year
- ◆ Unsafe abortions—20 million per year
- ◆ “Unmet need” for family planning—100 million per year
- ◆ Pregnancy-related deaths—585,000 women per year
- ◆ Pregnancy-related morbidity—15 million per year
- ◆ Anemia and other nutritional deficiencies—500 million cases per year.

One must also include huge HIV/STI problems in the list:

- ◆ Deaths from HIV/AIDS—2.6 million thus far
- ◆ New HIV infections—5.6 million per year
- ◆ Total HIV-infected—36.1 million
- ◆ New gonorrhea, chlamydia and syphilis infections—50 million per year.

There are also huge global child survival problems:

- ◆ 11.6 million child deaths per year, of which
 - ◆ Acute respiratory infections kill 4.4 million;
 - ◆ Diarrhea claims 2 million; and
 - ◆ Immunizable diseases claim 1.6 million.

Disability-Adjusted Life Years (DALYs) take into account the age at which events occur in estimating the human potential that is lost due to the major causes of death and disabilities. The ten leading causes of DALYs lost for 1998 are listed in Figure 4-1.

This list illustrates the impact of infant and childhood diseases and conditions, as well as the tremendous toll that HIV/AIDS is taking among adolescents and young adults. Attention must also be given to the large numbers affected by chronic diseases. The amount of health-related human misery is *large*, but the resources available to fight them are *puny*. The public health community has always had a scarcity mentality. Because resources are so scarce relative to the problems to be addressed, we are necessarily very frugal. Public health is obsessed with how to accomplish the most with the least amount of funds.

There are three standard ethical principles that public health adheres to:

- ◆ **Beneficence:** the obligation to maximize benefits and minimize harms;
- ◆ **Equity:** distributing the benefits and burdens of actions fairly; and

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Causes of DALYs Lost, 1998		
Rank	Cause	DALYs
1	Lower respiratory conditions	6.0
2	Perinatal conditions	5.8
3	Diarrheal diseases	5.3
4	HIV/AIDs	5.1
5	Unipolar major depression	4.2
6	Ischaemic heart condition	3.8
7	Cerebrovascular disease	3.0
8	Malaria	2.8
9	Motor vehicle accidents	2.8
10	Tuberculosis	2.0

Figure 4-1

◆ **Autonomy:** defending the right of persons to self-determination and protecting those with impaired autonomy.

To a great extent, these three principles explain what we in public health are trying to do. We advocate for the common good, for fairness and justice and for the rights of all persons. The constituency of public health is everybody, including those who do not come for services. An illustrative motto comes from North Carolina: “Public Health is Everywhere, Everyday, Everybody.” There is a tendency in public health to think in terms of numbers; however, we need to remember, as former director of the CDC William Foege put it, *“In everything we do, behind everything we say, as the basis of every program decision, we are willing to see faces.”* Priority should depend on the magnitude of the problem and how good the intervention is. Not all problems

have good solutions. An example is aging. We can age “well,” but we have no good solutions to stop the aging process.

The public health approach looks for the following in determining which problems to address and what interventions to address them with:

- ◆ It is an **important** problem.
- ◆ There is an **effective** intervention.
- ◆ There will be a **broad benefit** from the intervention.
- ◆ The approach considers **selectivity** and **priority**.
- ◆ The approach uses **leverage or synergy** to maximize effectiveness and efficiency.
- ◆ The approach is **strategic**—it has well-thought-out objectives and achievable results.
- ◆ A key priority is **prevention**.
- ◆ The intervention is **feasible** (in terms of resources, politically, and other factors).
- ◆ The intervention is **sustainable**.

An example of selectivity and priority is the case of smallpox immunizations in Bangladesh, as shown in Figure 4-2. In order to be feasible and sustainable, the strategy was to immunize people who lived near known cases of smallpox. In public health we try to adopt an opportunistic approach—in the case of Bangladesh, to immunize during the season when incidence is lowest.

It is important to recognize that women play a pivotal role for health and well-being in the family and community, for the child and for themselves. There is a multiplier effect in dealing with women, since women are the brokers for their children’s health, both before and after birth.

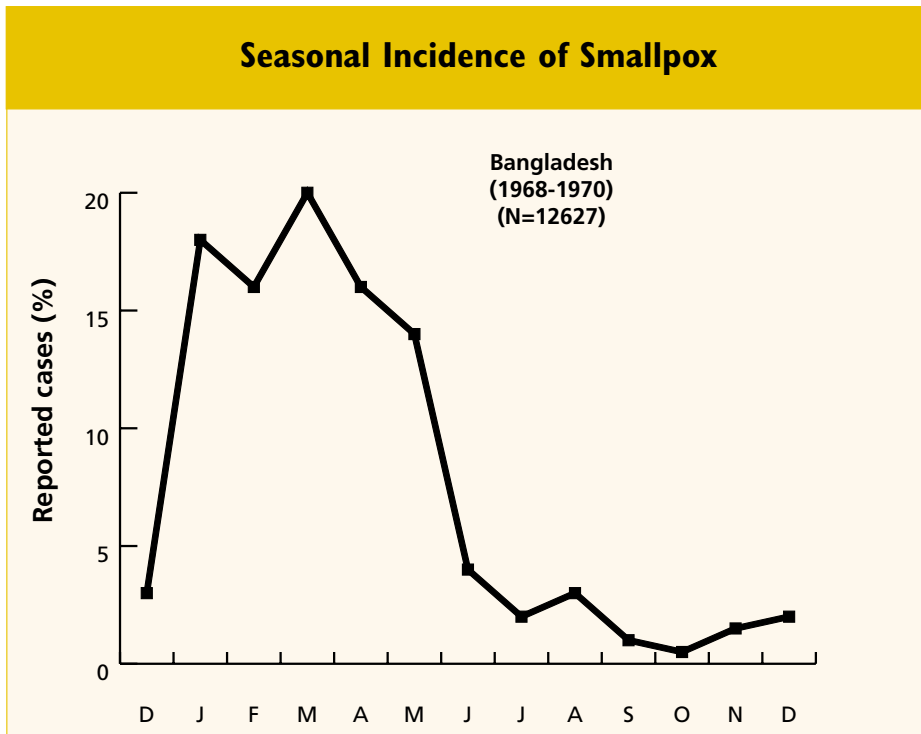


Figure 4-2

These are some examples of public health interventions:

- ◆ Various types of health services and outreach
- ◆ Curative (oral rehydration therapy)
- ◆ Diagnostic (blood pressure checks)
- ◆ Preventive (immunization)
- ◆ Non-clinical (social marketing of condoms)
- ◆ Environmental (clean water, guard rails)
- ◆ Behavior change (smoking cessation)
- ◆ Regulatory (restrictions to protect against second-hand tobacco smoke)
- ◆ Legal (laws against drunk driving)
- ◆ Financial (tax on tobacco and alcohol)
- ◆ Information (labeling of food and drugs)
- ◆ Nutritional (vitamin A-fortification)
- ◆ Economic development (education, more nutritious food)
- ◆ Political/normative/social/human rights (eradication of female genital cutting)

Notice that there is really a very broad range of approaches, and clinical services delivery is not necessarily the most important. To paraphrase a political slogan: “It’s the intervention, smarty!” Intervention is the key in public health. The public health community must do whatever works within ethical boundaries. Let us consider the best public health approach to dealing with sexually transmitted infections (STIs).

If we look at the global incidence of curable STIs, half of the people infected do not have symptoms. We also need to look at public health limitations—i.e., the

systems we have for helping the people affected.

Trichomoniasis is the most common STI, but while clearly a problem, it is not of the same gravity as other STIs. Notice in Figure 4-3 that gonorrhea and chlamydia together equal about 150 million new cases per year. This is a daunting reality. How do we deal with a problem of this magnitude?

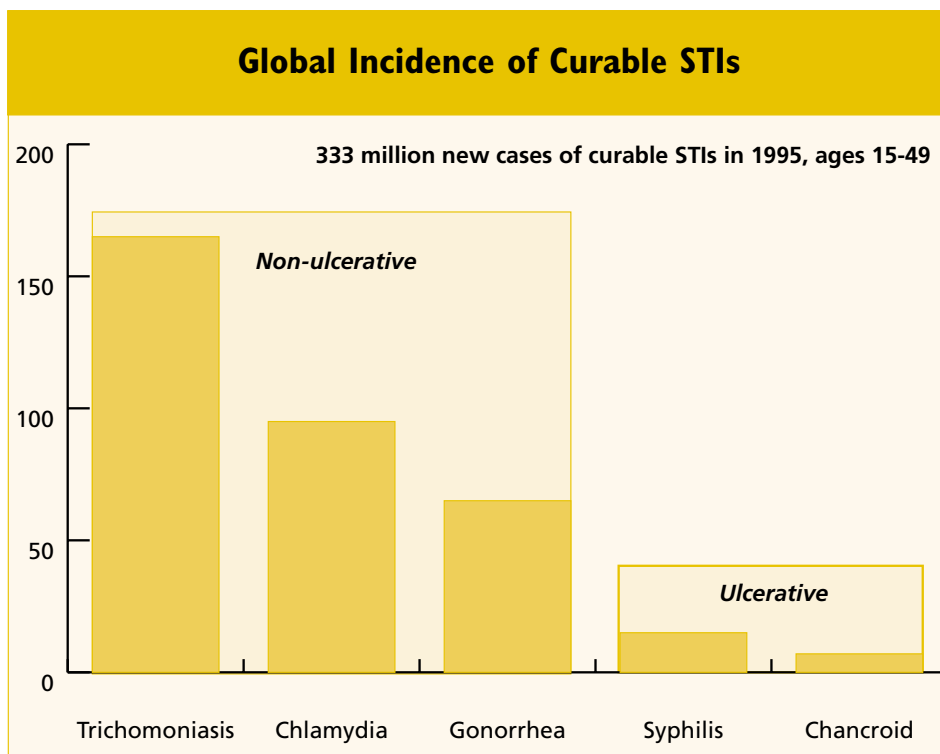


Figure 4-3

Figure 4-4 demonstrates how difficult it is to have a public health impact by using a treatment approach. Each bar represents a critical step in dealing with a case of STI. The proportions are illustrative but instructive. All of the things listed on the bottom—symptoms present, treatment sought, correct diagnosis, correct treatment, treatment completed—are necessary to achieve a cure, but the probability of success is very low. Many people have STIs with no symptoms and many with symptoms do not seek treatment. The last step, partner referral, is especially weak. Thus, it is very difficult to see how a treatment approach to STIs in the broad population can have much of a public health impact.

Figure 4-5 demonstrates the major weakness of using the presence of vaginal discharge to diagnose the presence of an STI for presumptive treatment with an antibiotic. Many women with gonorrhea and chlamydia have no discharge (upper right). The large majority of women with discharge have no gonorrhea or chlamydia. This makes partner referral for a presumed STI very problematic since *most do not have an STI*. Also, this diagnostic approach leads to a large waste of and over-treatment with multiple antibiotics.

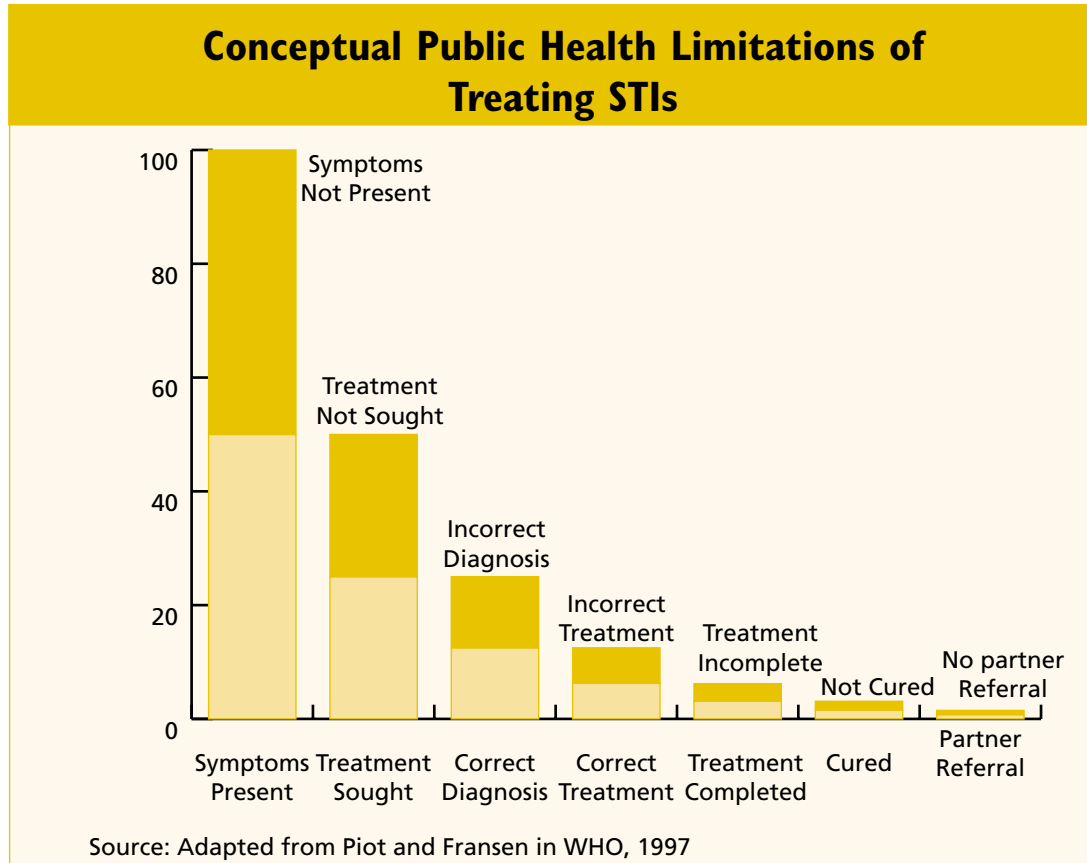


Figure 4-4

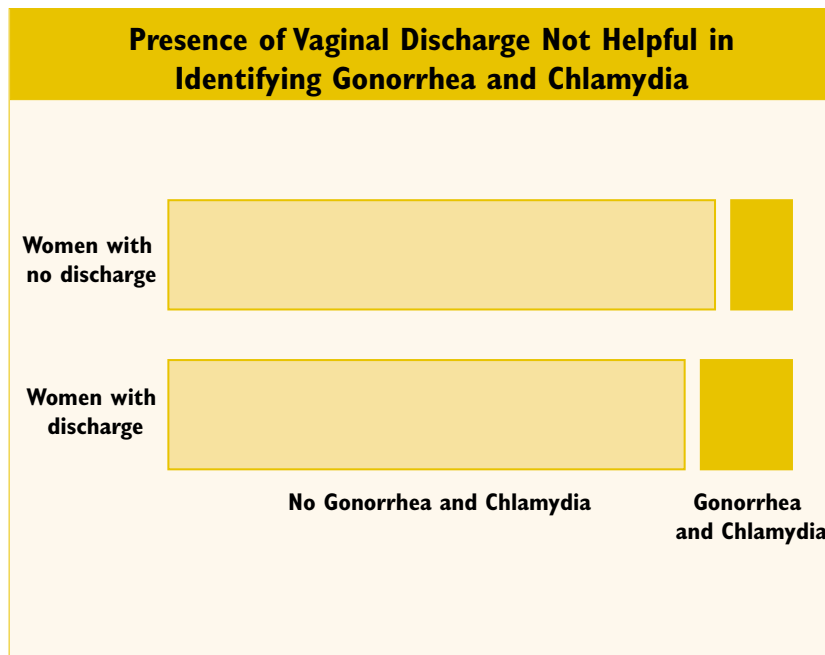


Figure 4.5

We need better strategies, such as targeting the high transmitters. Figure 4-6 demonstrates how important high transmitters are for STI transmission. Based on this modeling of data from Kenya, 500 commercial sex workers (CSWs) with 80 percent HIV prevalence would be expected to infect over 10,000 people. Five hundred of their “clients,” however, would be expected to infect 88 others. Most importantly, the female partners of the male clients would be expected to infect far fewer still. We need to promote prevention. We need to promote humane ways to prevent transmitters from transmitting.

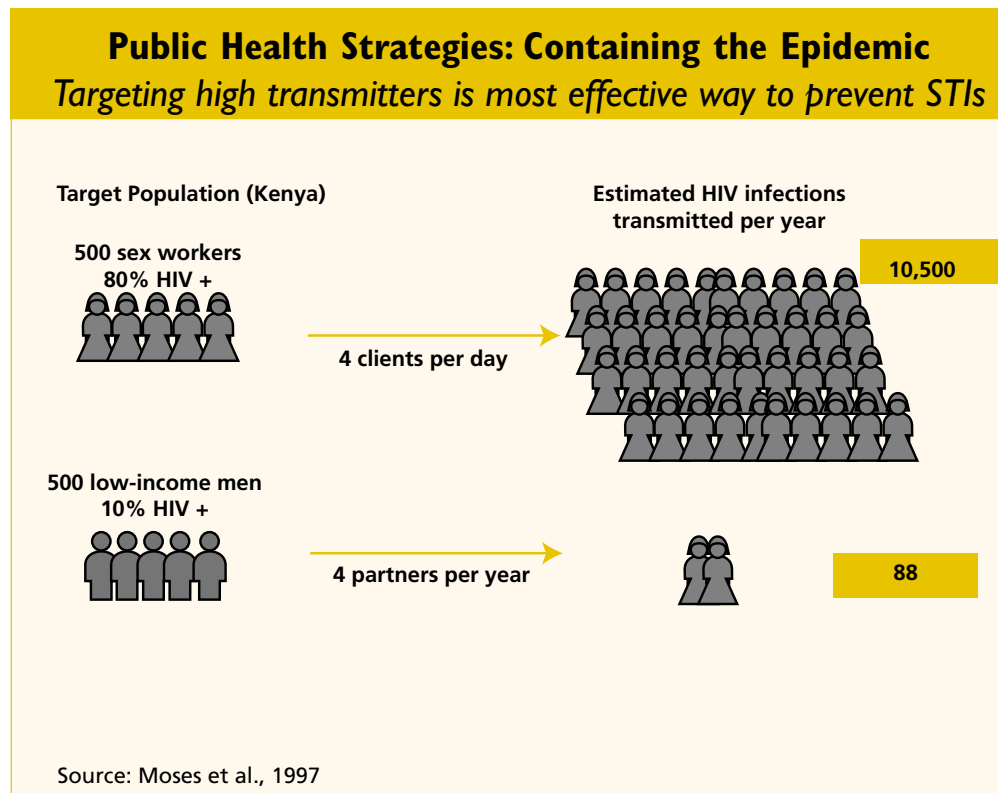


Figure 4-6

USAID’s programmatic technical guidance document *Integration of Family Planning/MCH with HIV/STD Prevention* (December 1998) supports a three-pronged approach stressing prevention. Much of the strategy is to get outside of the “clinic box” with interventions that synergize with family planning programmatic strengths.

Thailand adopted a three-pronged strategy to prevent STIs. They targeted men, high transmitters and the general population. The broad-based strategies were—

- ◆ Aggressive condom promotion
- ◆ Social marketing (condoms and antibiotics)

- ◆ Awareness-raising and education
- ◆ Behavior-change communication
- ◆ Policy and advocacy
- ◆ Research

The “100% Condom Program” was targeted to CSWs in Thailand, and to some extent, their clients (Figure 4-7). This illustrates the power of the prevention approach. It is a classic example that should be in every introductory textbook of public health. *There was an 80 percent decline in all five reportable STIs in men, nationally.* Thus, the prevention approach prevented many thousands of STIs. HIV has since stabilized in Thailand. The 100% condom policy started a major decline in male STIs. It was a successful attempt at making condoms a social norm.

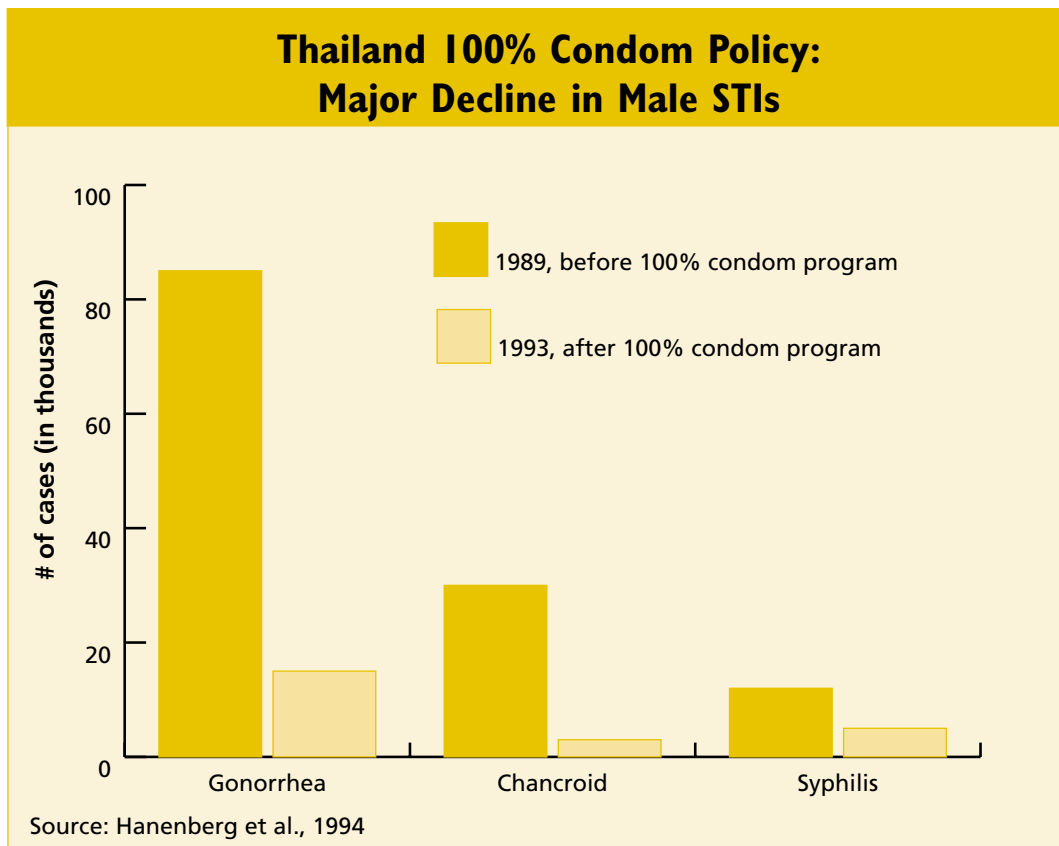


Figure 4-7

What Does the Rights Approach Mean?

There are questions that come to mind about a “rights approach” as it applies to public health:

- ◆ What does it mean for something to be a right?

- ◆ Whose obligation is it?
- ◆ What is the remedy when it does not happen?
- ◆ Which social goods are included as rights and which are not?
- ◆ Who decides what is a right and on what basis? Are there any priorities?
- ◆ What about the changing role of nation-states vis-a-vis rights? For example, some countries that formerly assumed responsibility for “rights” to jobs, have backed away.
- ◆ How can the rights community and public health community mutually support public health efforts?

There are “rights conflicts” in public health, when the liberties or rights of individuals conflict with the common good. Some examples include:

- ◆ Laws against drunk driving
- ◆ Prescription drugs (vs. over-the counter remedies)
- ◆ Gun control
- ◆ Mandatory seat belts
- ◆ Compulsory immunizations
- ◆ Quarantines
- ◆ Fluoridation of water

The question of what is a right sometimes devolves to practicalities. What is defined as a right is what can be enforced. Many different kinds of rights are spoken of—civil, political, social, cultural and economic rights. What is the relative weight of each of these rights when compared to the health interests of the public at large? Whose side do we take if there is a conflict between an individual’s right and the right of the public to be protected?

In trying to make the world a better place, there are merits to using both the public health approach and the rights-based approach. Although we all look at the world through different lenses, we must look for ways to harmonize our efforts.

References

- Hanenberg, R.S., Rojanapithayakorn, W., Kunasol, P. and Sokal, D. Impact of Thailand’s HIV-control programme as indicated by the decline in sexually transmitted diseases. *Lancet* 1994; 344:243-245.
- Moses, S. et al. 1999. *AIDS* 5:407-11.
- WHO. *Policies and Programs on Sexually Transmitted Infections: The Gap between Intent and Action*. Geneva, 1997.

5. Challenges in Promoting Women's Reproductive and Sexual Rights

Introduction

In recent years, there has been an increased exchange of ideas and strategies between practitioners in the fields of human rights and public health, and specifically between those who promote women's human rights and those seeking to improve women's quality of reproductive and sexual health. I hope we will continue to develop this exchange by identifying not only our shared goals but also how to work across and through the differences we may see between the two fields in approach, method and even desired result, in pursuit of those goals.

Among the challenges involved in this endeavor, first of all, are finding ways to make the promotion of women's human rights integral to strategies to improve women's access to and quality of reproductive health care. Second, we need to develop norms that will clarify how we can hold states accountable for ensuring that women's basic health needs are met.

It is critical that we move this dialogue forward because there is much to gain by joining forces. Yet we still operate largely in distinct spheres, with a few notable exceptions. Human rights people do not know how to think about public health issues, and many public health people do not see where human rights fits into their work. This is the case even though the relationship between the two is more and more recognized. For example, a recent report on safe motherhood in Eritrea noted that the country's high maternal mortality, one of the highest in the world, was in part attributable to women's low status in the society. It is important that the relationship between women's status and maternal mortality was noted, but the gaps remain when it comes to translating this awareness into policy and programmatic change. In the Eritrea example, when it came to establishing priorities for change, there was no effort to take on improving women's status alongside the other important goals of generally improving the country's health infrastructure and specifically expanding a safe motherhood initiative.

Why a Dialogue in Human Rights and Public Health?

I start from the assumption that we approach our dialogue with some shared goals. Stated most broadly, one goal is making the world a better place for women. But since that could mean almost anything to almost anyone, let us be more specific. One specific goal I would propose is improving women's status in a way that will last, that gives women greater control over their lives and that enables them to have access to and enjoy the benefits of quality health care. Let me also propose another goal: that programs and policies designed to promote public

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As a women's rights activist, I have seen time and again that no matter what the abuse we are investigating, whether it is rape of women in Kosovo, attacks on female refugees in Tanzania or forced virginity tests in Turkey, human rights abuses against women are almost always about controlling women's bodies, especially their reproductive and sexual lives.

health should respect and support women's fundamental human dignity. To my mind, those that do not do so risk creating their own problems, both in their purpose and in their prospects for lasting impact.

Why Human Rights?

As a women's rights activist, I have seen time and again that no matter what the abuse we are investigating, whether it is rape of women in Kosovo, attacks on female refugees in Tanzania or forced virginity tests in Turkey, human rights abuses against women are almost always about controlling women's bodies, especially their reproductive and sexual lives. In other words, much of the violence and discrimination and other intrusions on women's autonomy have, at least as part of their purpose, controlling women's reproductive and sexual choices. If we want to change the situation for women's health in these areas, and if we agree that women themselves must be active and necessary participants in making decisions about their own health, it makes

sense to tear down the barriers to their playing that role. I have recently worked in Uganda, a country like many others that does not consider rape in marriage to be a crime. What hope do women have to negotiate the terms of sex with their husbands if their husbands are entitled in law and in practice to force their wives to have sex under any circumstances and at any time?

The links between human rights and public health are also clear in that violations of women's human rights often carry with them serious consequences for women's health. Research has demonstrated powerfully the costs to women's health of violence and discrimination against them.

Domestic violence is both a source of injury and an obstacle to care and treatment. Women subjected to violence in conflict situations suffer grave physical harm, often as a result of sexual violence, and may have to deal with pregnancy resulting from rape. Women face pregnancy-based discrimination in the workplace; they are told that they will lose their jobs if they get pregnant. Forced to choose between their jobs and their rights, many of these women hide their pregnancies despite the risks to their own health and the lack of prenatal care. The bottom line is this: without respect for women's human rights, women will always be at the mercy of others in making fundamental decisions, like whether and when to have sex or to have children or whether to do what is needed to care for their health.

Women's rights advocates know well the reasons why the model of relying on others to make decisions in women's interest will not work. Most countries have traditions of abusing women's human rights and manipulating women's reproductive health and sexual rights and health for political purposes. For

example, in countries like Albania and Russia, pro-natalist government policies denied women access to family planning methods. In Morocco, the law submits women's choices about whom to marry to a male guardian's control. In other contexts, health care providers—sometimes at the behest of the state—get directly involved in violating women's rights in ways designed to control their sexuality, as is the case in Turkey, where doctors have performed virginity exams against their patient's wishes, and in Mexico, where factory doctors have tested job applicants for pregnancy and demanded to know the details of their sex lives and birth control use.

Women's awareness that the beneficence of others was not giving them the choices and dignity they desire is part of what led women to the human rights movement. Let us take a moment to explore the transforming power of human rights as an idea and the political rise of human rights as a movement. It is worth noting that the human rights system and movement did not make women their business. Instead, women have claimed human rights as their own. Women chose to make human rights tools a part of their efforts to change the circumstances of their lives, not as the only solution, but as an important part of the solution, because of the political resonance and potential of the existing system.

What Are Women's Human Rights?

The human rights system and movement that we know today trace their roots to 1948, when the United Nations adopted the Universal Declaration on Human Rights as a pledge by the countries of the world to act against future abuses and to avoid atrocities like those committed during World War II. From 1948-1953, the UN Commission on Human Rights drafted the two main human rights treaties that legally bind those governments that ratify them to respect and ensure basic human rights. These treaties, one on civil and political rights, the other on economic, social and cultural rights, only came into legal enforcement in 1976. For such a recent development, the movement has had quite an impact, including visibility in the press and in policy discussions, as well as the meaning it has for people in communities around the world.

Despite all the new attention to human rights and the progress made toward promoting human rights for all people—at the United Nations and by the many human rights organizations sprouting around the world—*something* was missing. Women's rights advocates will tell you that the *something* was women. In countries around the world, women saw that their governments had ratified human rights treaties, but that they had almost nothing to show how, or even if, these protections applied to women. What is more, the international human rights system did not press governments in this regard. On the contrary, governments were expressly skittish about seeing women's rights as human rights. Several governments accepted the obligation to eliminate all forms of discrimination under one "gender-neutral treaty," but declined to be bound by the same

obligation when it was found in a treaty dealing specifically with the rights of women.

Women's anger at and refusal to accept this disparate treatment led them to challenge the systematic exclusion of women's experience from international human rights law and practice and to challenge the political and theoretical underpinnings of that law and practice. The slogan "women's rights are human rights" served as the banner for women in many countries, working at many levels to challenge their governments' failure to protect the human rights of women and the failure of the international community to pressure those governments to change their ways.

Thus, for example, the women's rights movement in Brazil began to denounce violence against women in the family not only as a criminal act under domestic law, but also as a gross violation of human rights obligations if the government stood by and tolerated such violence. In this way, activists put additional pressure on their government to step up efforts to investigate and prosecute violence against women—and attracted international solidarity to their cause. This strategy helped to secure needed legal reforms at home and to influence the approach of the international human rights community to the problem of domestic violence, which had often been dismissed as a family matter, a private problem not in the state's purview.

Through international meetings, women's rights activists have pushed governments and other international actors to recognize new norms that apply human rights to women's lives and give governments responsibility for enforcing those norms. At the 1994 UN International Conference on Population and Development in Cairo, for example, women forced policymakers to recognize that population policies should be driven not only by a political agenda like fertility reduction, but also out of respect for women and the importance of their role in decision-making. At the Fourth World Conference on Women in Beijing the following year, the discussion focused not just on the deprivations that governments need to alleviate, but also on what governments must *do* as a result of their human rights obligations to ensure change.

As this international movement has grown, its opponents have denounced it as the agenda of a few that imposes a single feminist vision upon women and forces them to abandon other aspects of their identity. But as women's rights activists can demonstrate, this criticism looks like another way to limit women's choices. Rather than burying women's particular experiences, human rights has given women a way to make their local experience visible to the international community and to build new, collective strategies to change the rules that govern women's everyday lives.

Using a human rights approach has also produced specific change on the ground for women. For example, in Russia domestic violence is an enormous problem, and the state had traditionally accepted such violence through its total failure to protect women at risk and go after their batterers. In that case, human

rights have begun to make a difference by exposing the prevalence of violence and showing its consequences. Human rights documentation also helped activists show that the lack of state response to violence against women gives rise to a climate of impunity. Thus human rights tools drew attention to a hidden problem, made it a policy concern, and improved the quality of state services in part by generating the resources to support reform.

This example also shows how public health programs and human rights principles can come together to make change on the ground. Public health providers in Russia reinforced human rights goals by challenging social norms that accepted domestic violence and by articulating notions of reproductive and human rights. Health care providers also were able to intervene to prevent the violence. The message: there is no excuse for domestic violence, and the reproductive health care system is a good and safe place for victims to get help. As a result, service providers were better able to respond to domestic violence and health clinics played an advocacy role against domestic violence. This approach also improved preventive possibilities, by giving women information and support as they came into contact with the health care system.

These examples highlight some of the strengths of taking a human rights approach to improving women's status: the political force of human rights language, and the impact of combining ground work with high level advocacy. In each case, the human rights approach took on only a particular aspect of women's situation that needed to change, but in doing so brought urgency and new actors into the solution.

Conclusion

There has been some success in joining forces with colleagues in public health. At Cairo, government and family planning advocates recognized that protecting women's human rights would improve women's ability to enjoy good reproductive health, access to health care and choices about that health care. Women's rights activists have begun to learn how public health strategies can strengthen the impact and extend the reach of efforts to improve women's rights. Joining forces helps to build consensus that the fundamental human rights notion of human dignity must convey respect for women's and men's decisions about their reproductive and sexual lives.

We have a two-step challenge before us: 1) seeing the relationship between public health and human rights, and 2) making it mean something. Many of us already see the value in working together. Women's rights advocates, for example, have long worked to reinforce the indivisibility of rights: Women need to enjoy their rights in *all* spheres—political and economic—if they are to challenge their

Public health providers in Russia reinforced human rights goals by challenging social norms that accepted domestic violence and by articulating notions of reproductive and human rights. Health care providers also were able to intervene to prevent the violence. The message: there is no excuse for domestic violence, and the reproductive health care system is a good and safe place for victims to get help.

subordination and secure equality and dignity. But work to articulate norms such as those governing the right to health has moved slowly in the human rights community, in part because key expertise in public health is needed.

To make it mean something, we must first make working broadly on women's human rights a part of solving public health problems. Second, we should look for ways that the public health and human rights communities can work together to promote women's reproductive and sexual health as a matter of right. In doing so, we should remember to take each community's methods and contributions seriously. From the human rights perspective, this means that we need to develop enforceable reproductive health norms and not just invoke the language of rights. And finally, it means that we do more to understand and address the social justice dimensions of health.

6. Family Planning and Abortion: A Human Rights Perspective

Introduction

Reproductive rights refer to the constellation of rights that enable women to control their bodies. This bundle of rights includes economic, social and cultural, as well as civil and political rights. Despite the recent international consensus on reproductive rights during the Beijing and Cairo summits, locating reproductive rights within a human rights framework continues to be a work in progress. Much more needs to be done to make the human rights framework for abortion and family planning a reality.

Scope of Reproductive Rights

The first key reproductive right is the *right to reproductive health care, including family planning*. The components of good health encompass more than just the basic needs of adequate food, shelter and clothing. In addition to these needs, people have rights to basic health information and care, including reproductive care. This right is mentioned explicitly in four human rights treaties: the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women (Women's Convention), the Convention on the Rights of the Child (Children's Convention) and the Convention on the Elimination of Racial Discrimination (Racial Convention).¹

The second component of reproductive rights is the right to reproductive self-determination, which is the principle that a woman must be able to control her reproductive and sexual life. This right includes nine constituent human rights for women:

- ◆ the right to decide the number and spacing of children and to have the information to do so
- ◆ the right to marry and found a family
- ◆ the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment
- ◆ the right to modify conditions that discriminate against women
- ◆ the right to be free from sexual assault and exploitation

¹ Articles 12.1 and 12.2 of the International Covenant on Economic, Social and Cultural Rights; Articles 12.1 and 14.2(b) of the Women's Convention; Article 5 of the Children's Convention; and Article 5 of the Racial Convention.

by
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- ◆ the right to privacy
- ◆ the right to life, liberty and security
- ◆ the right to enjoy scientific progress and to consent to experimentation
- ◆ the right to be free from gender discrimination.

Family Planning Services and Information and Human Rights

Family planning services and information should be provided in a manner that is consistent with the overall right to reproductive self-determination. In particular, the rights to privacy, liberty and security of the person are key, as is the right for women to decide on the number and spacing of their children.

There are two key dimensions to the provision of family planning services in relation to human rights. The first is that the provision of family planning services and information itself fulfills, promotes and protects a human right. The ICPD Programme of Action endorses the idea that “service” is a human right. The second dimension is that family planning services and information should be provided in a manner that is consistent with the overall right to reproductive self-determination. In particular, the rights to privacy, liberty and security of the person are key, as is the right for women to decide on the number and spacing of their children. This viewpoint is repeatedly endorsed in the ICPD Programme of Action.² Additional sources of the human right to access family planning and information include: the Women’s Convention;³ the Children’s Convention;⁴ and the International Covenant on Economic, Social and Cultural Rights, especially Article 12(2)(a).¹

Family planning rights have been and continue to be “fleshed out.” This right is being interpreted to impose an obligation on governments to provide family planning information and services, to ensure that such services and information are free from discrimination and to ensure that the services are provided in a manner consistent with the rights of persons to privacy, liberty and security. Yet, the full scope of the human right to family planning services has not been determined. International human rights treaties are not specific and do not address numerous questions. These include: a lack of definition of the term “family planning;” the identification of government agencies responsible for the implementation of such services; the manner in which to ensure that family planning services and information are made available to all; and the manner in which to deal with voluntary incentives and disincentives and their consequences.

In order to further the discussion on human rights and family planning, we must first view family planning as fulfilling and protecting a human right, or at a minimum, of not violating human rights. This perspective is helpful in building

² Paragraph 1.15, chapter on “Principles,” and 7.17.

³ Article 16.1(e), Article 12.1, Article 14.2(b) and Article 10(h)

⁴ Articles 24.2(f) and 13.1

constituencies, advocating for governments to provide services and enhancing law and policy efforts.

Next, we must incorporate a human rights framework within family planning service delivery. While there are various means by which this goal can be achieved, a minimum standard is to ensure that human rights are not violated. In addition, there are at least three key ways in which to ensure that rights become a reality. One strategy is to ensure that service providers are trained in human rights issues that emphasize quality of care, free and informed client choice of methods, balanced presentations on methods, safe use of contraception, avoidance of incentives and disincentives that may skew choice of methods, and services free of gender/ethnic/class biases. Another means to promote human rights is to establish mechanisms by which to address violations of human rights. Finally, a key tool by which to advance rights is review of existing legal and policy frameworks for family planning from a gender and human rights perspective.

There are at least three key ways in which to ensure that rights become a reality. One strategy is to ensure that service providers are trained in human rights issues that emphasize quality of care, free and informed client choice of methods, balanced presentations on methods, safe use of contraception, avoidance of incentives and disincentives that may skew choice of methods, and services free of gender/ethnic/class biases.

Abortion and Human Rights

The international community, including the human rights community, has yet to recognize a woman's right to terminate a pregnancy as a human right. Because of the general controversy surrounding abortion, international consensus has not endorsed abortion as being encompassed within the term "family planning." There exists no explicit human rights provision that either accords or precludes a right of a woman to terminate a pregnancy. However, the global community has begun to take note of the effect of unsafe abortion on women's rights to life and health. It has been slower to support a woman's right to choose abortion on the basis of the right to be free from gender discrimination and the right of autonomy in decision-making.

Nonetheless, a strong argument can be made for abortion as a human rights issue. Four key human rights are implicated in abortion: *the right to life; the right to health and eliminating discrimination against women in terms of health; the right to equality and freedom from gender discrimination; and the right to autonomy in decision-making in private matters.*⁵

Laws that criminalize abortion contravene these human rights. The disproportionate effects of criminalized abortion on *women's lives and health* were addressed in Cairo and Beijing and acknowledged at the Human Rights

⁵These rights are based on these human rights treaties: Women's Convention; Articles 12 and 16 (e); International Covenant on Civil and Political Rights, Articles 3, 6, and 17; Universal Declaration of Human Rights, Articles 2, 3 and 12; and International Covenant on Economic, Social and Cultural Rights, Articles 3 and 12.

Committee in its 1996 recommendations to the report filed by the Peruvian government to the Committee. The *right to equality and freedom from gender discrimination* encompasses abortion because restrictive abortion laws and policies can be regarded as discrimination against women, as defined by Article 1 of the Women's Convention. The Committee on the Elimination of Discrimination Against Women (CEDAW), which is charged with monitoring government compliance with the Women's Convention, has also issued relevant comments on abortion matters. The *right to autonomy in decision-making in private matters* is lost because restrictive abortion laws do not give women the right to “decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”⁶ There are also relevant decisions on this subject from the European Commission of Human Rights.

To further the discourse on abortion and human rights, abortion must be framed as an issue of women's rights and human rights. In countries that criminalize the procedure, we must focus on the promotion of legal reform and the elimination of such criminal laws. Where women are being prosecuted for obtaining illegal abortions, we must ensure that women have due process of law, and must document the discriminatory effect of such laws on low-income women and on young women. In countries with highly restrictive abortion laws, or where abortion is generally not legally available on numerous grounds, reproductive health care services should focus on providing abortion services in those circumstances in which abortion is legal and on post-abortion care and family planning counseling.

The main challenge here is *how* to promote such a perspective within legally restrictive environments. In addition, there is room for improvement even in countries with legal abortion. In these settings governments should focus on providing women with free and informed choice, balanced and objective information regarding all methods of terminating a pregnancy, access to safe abortion and bias-free services.

Conclusion

Family planning and abortion are not unrelated issues, but two equally important components of women's reproductive rights. Although there exists greater international consensus regarding family planning as a human right, there is little doubt that abortion is an important women's health issue that implicates several human rights, including the right of women to be free of discrimination. In the context of family planning and abortion, the power of the human rights perspective lies in its visionary principles and its ability to keep people focused on how the achievements of these principles would make the world a better place for all of us.

⁶ Article 16.1(e) of the Women's Convention

7. “It’s Not Fair:” AIDS, Gender and Human Rights

The title of my paper is based on a conversation my daughter and I had in 1992. (To believe that this really happened you should know that my daughter is like the kid in a popular cartoon, where an older kid says to a younger one: “I found a condom on the patio” and the younger kid says: “What’s a patio?” That younger one, that’s my kid!) She was seven years old then, and this conversation was what made me realize for the first time that my work on women and AIDS was work on human rights, not just on health.

Driving home from school one day, she asked me with considerable fear and apprehension how adults who had sex could protect themselves from HIV. (Apparently she had learned that day from a friend in school that AIDS is fatal.) In response, I began, as mothers are apt to do, with a long lecture on the value of abstinence and uncompromising fidelity, only to be interrupted with, “Yes, yes, all that is fine, but when I am grown up and want to have sex, what should I do?” So, I reluctantly described condoms and their use. “But that is what men use, right? What do women do?” she said. Almost without a second thought, I said, “Convince the man to use one.” To which she burst into tears and said with great anguish, “But that’s not fair, Ma! I want to live—it’s not fair! What if I can’t convince the man?” So, I entitled my talk today, “It’s not fair” to honor my daughter’s insight.

“Unfreedoms”

In his recent book *Development as Freedom*,¹ Dr. Amartya Sen, an ex-Board member of ICRW, who is also known for having won the Nobel Prize for Economics in 1998, analyzes the nature of economic development from the perspective of human rights. He defines development as “a process of expanding the real freedoms that people enjoy.” Development, therefore, he argues, requires “the removal of major sources of unfreedom.” I would like to paraphrase Dr. Sen and say that *health and well-being*—critical indicators of economic development—require the removal of major sources of unfreedom. As Dr. Sen points out there are many sources of unfreedom—poverty, malnutrition, lack of access to education and health services—but the one form of unfreedom that I am going to talk about today is inequality between women and men, which I will show is experienced by women because of many of the other sources of unfreedom that Dr. Sen lists—such as lack of access to education, health services and employment. More importantly, I will demonstrate how this basic unfreedom—inequality between

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¹ Sen, Amartya. 1997. *Development as Freedom*. New York: Alfred A. Knopf, Inc.

women and men—fuels the AIDS epidemic by increasing women’s vulnerability to infection, denying them equality in care, and burdening them with a disproportionate share of the responsibility of caring for others who are infected. Second, I will talk briefly about the challenges posed by the new, available and affordable anti-retroviral regimens for preventing the transmission of HIV from pregnant women to their infants, and the way in which inequality and discrimination stand in the way of the success of this medical intervention. And I will conclude with some recommendations for action.

More HIV+ Women and Children

The statistics on HIV/AIDS recently released by UNAIDS show us that despite new treatments and information campaigns, HIV/AIDS is rising rapidly around the world, still largely through heterosexual transmission. There are now 36.1 million people living with HIV/AIDS and more people have died from AIDS since the epidemic began (two decades ago) than the cumulative total of all those who died in all the deadly wars of the 20th century. We have now heard repeatedly about the damaging consequences of this deadly epidemic—life expectancy in the most hard-hit countries is likely to drop by about 12-15 years; the gains made in child survival are similarly affected; and companies doing business in Africa are hurting because of frequent illness and death among their workers. The new information also shows that 12 to 13 African women are currently infected for every 10 African men, and that over 90 percent of the children infected with HIV were born to HIV-positive women and acquired the virus at birth or through their mother’s breast milk. Biological factors, e.g., greater vulnerability of the vaginal tract to infection, leading to greater efficiency in the transmission of HIV from man to woman than from woman to man, account for some of the emerging imbalance in the sex ratio of HIV infections, but women’s gender also contributes to their vulnerability to infection.

Gender and Vulnerability

What is gender? It is a word frequently used but often misunderstood. Gender refers to the social construction of male and female roles—the widely held beliefs and expectations of the roles, responsibilities and obligations associated with being a woman or man. It is a culture-specific concept—what women can or cannot do in one culture differs greatly from what they can or cannot do in another. But what is consistent across cultures is that there is a distinct difference between women’s and men’s spheres of functioning. Typically, men are seen as being responsible for productive activities outside the home and women are responsible for productive and reproductive activities within the home. And we now know that women have less access than men to productive resources such as

income, land, credit and education. While the extent of this difference varies considerably from one culture to the next, it almost always persists.

The effect of this gender difference and inequity on poverty and economic development has been discussed for over two decades, but its implication for the spread of HIV was not discussed until the early 1990s. I would like to share with you some of the research findings that contributed to this discussion. These are findings from the Women and AIDS Research Program, a grants program conducted by ICRW from 1990 to 1997, with funding from USAID. There were two phases to the program, which supported a total of 25 studies in 15 different countries. The findings from the studies gave us important insights into women’s sexual experience, which we have since labeled as the four P’s of sexuality:

- ◆ Practices
- ◆ Partners
- ◆ Pleasure
- ◆ Procreation.

The first two refer to aspects of behavior and the second two to underlying motives. What we learned is that there are gender differences in how each of these is experienced. We learned that there are many women and girls who enjoy sex and can express their sexual desires and needs. But far more overwhelming in the data were descriptions that showed that women have much less control over sexual interactions than men—much less control over when, how, where and with whom they have sex. Women experience and report the double standard of sexuality that dictates that women have to be virgins before marriage and consistently faithful afterwards, while men are not men if they do not have multiple partners.

For many women, sex is a burden to be accepted quietly, or a functional necessity to have children or a commodity to be sold to ensure survival or protection. And for far too many women, sexuality is associated with lack of control, abuse and resounding silence. Overall, the data showed us that in their sexual lives, far too many women worldwide are denied their right to basic human dignity and bodily integrity. We also gained some insights into male sexuality: the belief that men need sexual release at all costs, that men and boys are the ones who are supposed to be in charge of sexual interactions and even to be the sexual teachers. This is so even though they often have very little accurate information since most of what they know is picked up on the street. We learned that there is an immense pressure on men to live up to an image of being in control, to make new sexual conquests as proof of manhood and above all to do everything to ensure that they are not perceived as homosexual.

From all of this we inferred that there is a fifth *P* of sexuality—power, which is fundamental to how the other *P*’s are interpreted and experienced. The findings also showed us very clearly that women have less power than men in sexual

We learned that there is an immense pressure on men to live up to an image of being in control, to make new sexual conquests as proof of manhood and above all to do everything to ensure that they are not perceived as homosexual.

interactions and why women have less power than men do. Women know very little about their bodies and sex; there is much misinformation because in cultures in many parts of the world, female ignorance of sexual matters is a sign of purity. For this reason, women are denied their right to free and accurate information about their bodies. This lack of knowledge greatly contributes to their inability to protect themselves from infection, increases women's fears about condom use and limits their ability to identify abnormal gynecological symptoms.

The culture of silence surrounding sex affects women more than men, because we were told that women who talk about sex are presumed to be of easy virtue. We found that the powerful norm of virginity for unmarried women that exists in many societies increases young women's risk of infection—because they cannot ask for information out of fear that they will be thought to be sexually active. In high-prevalence countries, virginity also puts young girls at risk of rape and sexual coercion because they are presumed to be free of HIV infection and because of a widespread belief that sex with a virgin can cleanse a man of infection.

The data showed that violence is a daily reality in the lives of many women and that fear of violence and abandonment act as significant barriers to women's ability to demand fidelity from their partners or negotiate condom use. Clearly, for many women worldwide, denial of the right to safety from violence or the threat of violence contributes greatly to their vulnerability to infection.

We learned that women are economically vulnerable because their access to economic resources, such as land, income, employment and credit, is restricted. The majority of women in the labor force are confined to the informal sector, which is characterized by low wages, income insecurity and poor conditions of work. We also know that women constitute the majority of the absolute poor—70 percent of those who earn less than a dollar a day are women. The data showed that women's economic vulnerability makes it more likely that women will exchange sex for money or favors, less likely that they will succeed in negotiating protection and less likely that they will leave relationships that they perceive to be risky.

In sum, the findings showed us that gender-related discrimination and a denial of women's economic, social and cultural rights contribute to women's vulnerability to HIV infection. Or in the terms used by Dr. Sen, the sources of unfreedom that must be addressed in order to guarantee women health and protection from

HIV are women's social and economic vulnerability and the imbalance in power between women and men that constitutes gender inequality. We have since learned that women's social and economic vulnerability and gender inequality also lie at the root of women's painful experiences in coping with the stigma and discrimination associated with HIV infection.

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HIV+ Women—Extra Burdens and Hard Choices

They are infected and they are women. In the words of one woman in Africa: “Yes, it’s my responsibility to tell my partner, but it’s hard to tell. If the wife knows she’s positive, she won’t tell her husband, because she will be afraid of being told she is the one who brought it. As a woman, to tell your partner is impossible.”² There are data to show that there is gender-based discrimination in the care that is offered to HIV+ women within households. This is not surprising given the fact that in many societies there is a significant gender difference in the timing and quality of health care that is provided to girls and women as compared to boys and men. We also know now that women—wives, daughters, sisters, mothers, and grandmothers—bear a disproportionate burden of caring for others who are infected.

In many societies, being socially ostracized, marginalized and even killed (as happened to a woman in South Africa in 1999) are very real potential consequences of exposing one’s HIV status. For women with limited economic resources, fear of violence, abandonment and potential destitution acts as a significant barrier to agreeing to an HIV test. Yet, HIV counseling and testing are critical ingredients of the new prevention intervention for reducing mother-to-child transmission of HIV. This intervention requires pregnant women to be tested so that those women who are positive can receive a dose of an anti-retroviral (AZT or nevirapine) during pregnancy and/or during labor. The protocol also requires HIV+ women not to breastfeed their infants. While the nuances and details of this intervention are still being worked out, some countries, overwhelmed with the onslaught of the epidemic, have already begun its implementation. This new medical intervention poses new ethical complexities and conundrums, many of which are related to those ubiquitous hurdles—inequality and poverty.

For pregnant women, determining their HIV status exposes them to stigma and discrimination at a time when they are most vulnerable and require the most protection. Faced with the prospect of protecting and caring for another life yet to begin, pregnant women may find the potential consequences of being HIV+ to be worse than death. It is also overwhelmingly tragic that the intervention provides treatment to save an infant’s life, but does nothing to save that infant’s primary nurturer and caretaker—the mother herself. Over the years, this epidemic has gained a reputation for the difficult ethical choices it poses. This is yet another one—our very own “Sophie’s choice.” The only way to protect the rights of mothers and their children is to ensure that anti-retrovirals are only one of the many prevention options available to women who seek to protect their children from infection.

² van Woudenberg, Judith. 1998. Women Coping with HIV/AIDS: We Take It As It Is. *Royal Tropical Institute Bulletin* 322, Amsterdam.

Empowerment Is Prevention

The most significant option must continue to be primary prevention, because the best way to ensure that an infant is not infected is to protect the mother and father of that infant from infection. A significant component of primary

A significant component of primary prevention must be the empowerment of women—the protection of their rights—because fundamentally it is the imbalance in power between women and men and society’s disregard for women’s rights as human rights that restrict women’s ability to protect themselves from infection.

prevention must be the empowerment of women—the protection of their rights—because fundamentally it is the imbalance in power between women and men and society’s disregard for women’s rights as human rights that restrict women’s ability to protect themselves from infection. The power imbalance also does not permit women to feel safe in determining their HIV status, to seek support and care when infected and to make choices for their own welfare, independent of others.

But how should women be empowered to increase their level of autonomy? The answer lies in addressing the sources of their unfreedom, or put more positively, enhancing the sources of power—information and education, skills, economic assets, technologies and services, and social support. This means we must:

- ◆ Educate women; give them the information they need about their bodies and sex. Information is power and it is their right to receive it.
- ◆ Give women the skills they need to use a male or female condom — make them condom literate. Provide skills training on communication about sex—foster inter-partner communication.
- ◆ Improve women’s economic status. Ensure that they have property and inheritance rights, have access to credit, receive equal pay for equal work, have the financial, marketing and business skills necessary to help their businesses grow, have access to the agricultural extension services to ensure the highest yield from their land, have access to the formal sector for employment and are protected in the informal sector.
- ◆ Ensure that adequate resources are available for the development, improvement and increased accessibility of prevention technologies, particularly female-controlled and female-initiated prevention technologies such as the female condom and microbicides—because these will protect both women and men (and ultimately children) from infection.
- ◆ Integrate services wherever possible and ensure that they are gender-sensitive.
- ◆ Increase social support for women who are struggling to change existing gender norms to protect themselves from infection; promote sexual and family responsibility among young boys and men and allow them opportunities to re-examine the damaging effects of prevalent notions of masculinity.
- ◆ Allow opportunities for women to meet in groups, visibly in communities, to derive some strength from numbers and to be able to draw solutions from each other.

- ◆ Move the topic of violence against women from the private sphere to the public sphere. It is not a personal issue. It is a gross violation of women’s human rights and it has significant negative implications for the health of communities and for economic development.

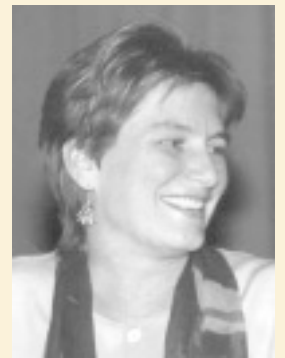
Let me conclude by urging us all to ensure that the term *empowerment of women* becomes more than just a linguistic icon whose meaning is inversely proportional to its use! Empowering women and guaranteeing them their economic, social and cultural rights is not optional. In the AIDS epidemic it prevents deaths. It ensures that one of the greatest sources of unfreedom or barriers to the health of populations and to economic development is eliminated—gender inequality. And I will say again, as I have said before: In the long run, empowering women is not a zero-sum game. Power is not a finite concept. Empowering women and guaranteeing their rights increases the power of women, men, households, communities and entire economies.

8. Violence Against Women: Impact on Sexual and Reproductive Health

Fifteen years ago, violence against women was not recognized as either a public health *or* a human rights problem. Major public health institutions did not mention it, and the human rights community was primarily focused on violations perpetrated in the public sphere, while violence against women tends to take place in private. We have come very far in the past 15 years.

The conclusions in this paper about violence and reproductive health are based on a global review of the published and unpublished literature available on violence, including methodical searches of MEDLINE, POPLINE, the WHO gender violence database and a variety of specialized violence libraries. Over 1,000 articles were reviewed, indexed and synthesized, including more than 35 population-based surveys of violence and 40 in-depth qualitative studies. The paper also draws upon research conducted by Mary Ellsberg as part of a research collaboration between Umeå University in Sweden and the León Medical School in Nicaragua (Figure 8-1). The Umeå/León research collaboration built upon an existing public health surveillance site that routinely collects vital events and other health data from 10,000 households in the province of León. The researchers conducted a population-based survey on domestic violence among a subset of households and included experiences of physical and sexual abuse as variables in a number of nested case-control studies designed to evaluate risk factors for under-5 mortality, adolescent pregnancy, high-risk sexual behavior and low birth weight.

by
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Heise

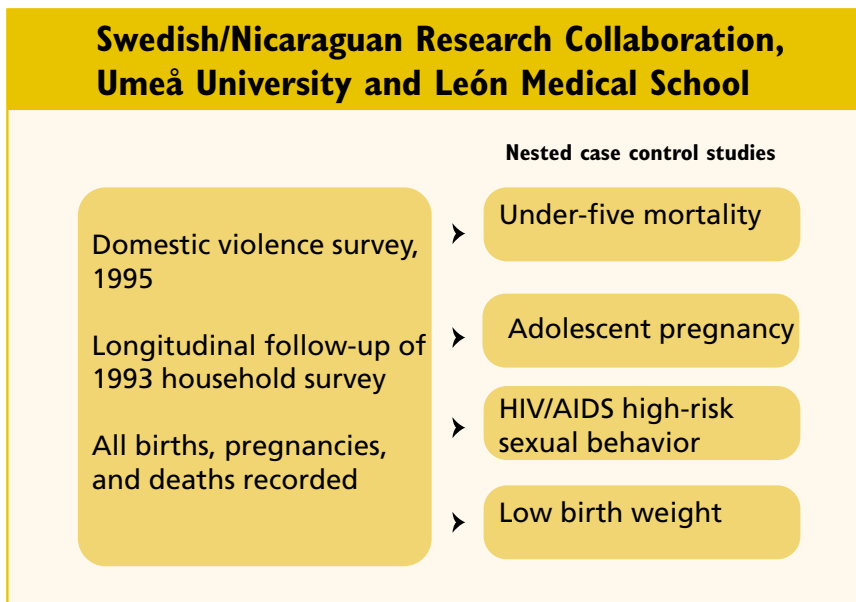


Figure 8-1

¹ At the time this presentation was made, Heise and Ellsberg were affiliated with the Center for Health and Gender Equity (CHANGE); they joined PATH on April 1, 2001.

Dimensions of the Problem

- ◆ A recent review of 50 population-based studies carried out in 36 countries indicates that between 10-60 percent of women who have ever been married or partnered have experienced at least one incident of physical violence from a current or former intimate partner (Heise et al., 1999).
- ◆ Although women can also be violent and abuse exists in some same-sex relationships, the vast majority of partner abuse is perpetrated by men against their female partners.
- ◆ Twelve-month rates of partner violence vary widely from fewer than 3 percent of ever-partnered women in the United States, Canada and Australia to 23 percent of women in Santiago, Chile; 33 percent of women in Managua, Nicaragua; and 52 percent of Palestinian women in the West Bank and Gaza strip (Heise et al., 1999).

Physical Violence Is Usually Accompanied By Sexual and Emotional Violence

Violence against women is often categorized as physical, sexual or emotional violence, but in intimate partnerships, these types of violence frequently overlap. For example:

- ◆ Among 613 ever-abused Japanese women, 57 percent experienced all three types of abuse (Yoshihama and Sorenson, 1994).
- ◆ Globally, one-third to one-half of all physically abused women also report forced sex (Koss et al., 1994; Leibrich et al., 1995; Ellsberg et al., 2000).
- ◆ Most physically abused women also experience severe emotional abuse. In the León, Nicaragua study, 97 percent of women who were physically abused by a partner were also emotionally abused (Ellsberg et al., 2000).

Although violence against women is ubiquitous, rates of abuse can vary greatly, even in areas of close proximity. For example, in the state of Uttar Pradesh, India, the percentage of men who admitted hitting their wives in the last year varied from 11 percent in Naintal district to 33 percent in Banda district (Narayana, 1996). This variation raises an interesting question: what combination of factors best accounts for this three-fold difference in rates of violence between neighboring districts? If we can answer this question, we will have gleaned important insights for future prevention efforts.

Low Socioeconomic Status Also Increases Risk of Violence

Although violence cuts across all socioeconomic groups, studies in the United States and numerous other countries indicate that women living in poverty

are at increased risk of physical abuse by an intimate partner (Heise et al., 1999). It is as yet unclear why poverty increases women's risk of violence—whether it is due to low income itself or to other factors that accompany poverty, such as crowding or hopelessness. For some men, living in poverty is likely to generate stress, frustration and a sense of inadequacy for having failed to live up to their culturally defined role of provider. Although low socioeconomic status appears to be a marker for increased risk, the relationship between poverty and risk of abuse deserves far more study.

What we do know is that violence against women is a product of the gender subordination of women. Four factors are consistently associated with violence (Heise, 1998; Levinson, 1989):

- ◆ Norms of male entitlement and ownership of women.
- ◆ Male control of wealth in the family.
- ◆ Notions of masculinity that are tied to dominance and honor.
- ◆ Male control of decision-making in the family.

Violence Has Many Culturally Ascribed Meanings

In many parts of the developing world, wife beating is conceptualized as a form of chastisement—the husband's right to “correct” an erring wife. As one husband said in a focus-group discussion in Tamil Nadu, India: *“If it is a great mistake, then the husband is justified in beating his wife. Why not? A cow will not be obedient without beatings”* (Jejeebhoy, 1998).

In many developing countries women share the notion that men have the right to discipline their wives by using force. Beating is considered acceptable as long as it is for a “just cause.” Indeed, the acceptability of violence generally involves a complex equation of who does what to whom, and for what reason. One of the most commonly accepted justifications for wife beating is refusal of sex or transgression against other gendered norms.

The concept of beating as discipline has been found in qualitative research throughout the world. As an indigenous woman in Mexico said, *“I think that if the wife is guilty, the husband has the right to hit her...If I have done something wrong...nobody should defend me. But if I haven't done something wrong, I have a right to be defended”* (Gonzalez Montes, 1998).

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The Origins of Violence Are Multi-Causal

Increasingly, experts are using an “ecological model” to understand the interplay of personal, situational and sociocultural factors that combine to cause

abuse (Figure 8-2). An ecological approach to abuse argues that no one factor alone “causes” violence but rather that a number of factors combine to raise the likelihood that a particular man in a particular setting will react violently. In the ecological framework, social and cultural norms—such as those that assert men’s inherent superiority over women—combine with individual level factors—such as whether a man was abused himself as a child—to determine the likelihood of abuse. The more risk factors present, the greater the likelihood that violence will occur.

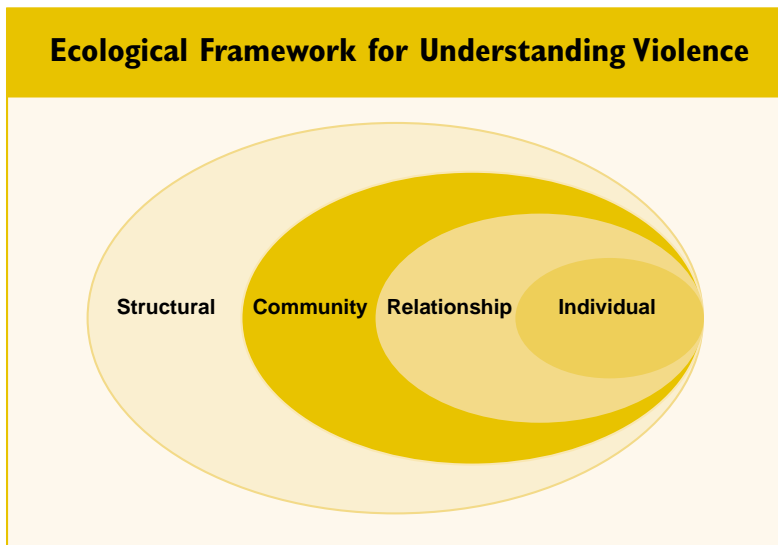


Figure 8-2

Health Consequences of Abuse

Like smoking, victimization is a risk factor for a variety of unhealthy outcomes. In addition to causing immediate physical injury and mental anguish, violence increases women’s risk of future ill health. A wide range of studies shows that women who have experienced physical or sexual violence, whether in childhood or adulthood, are at greater risk of subsequent health problems. Compared to non-abused women, women who have been victimized have: 1) reduced physical functioning, 2) more physical symptoms, 3) worse subjective health, 4) more life-time diagnoses of health problems and 5) higher health care utilization. The impact of abuse persists long after the abuse has stopped. The more severe the abuse, the greater the number of symptoms and the more severe the effect on women’s physical and mental health (Leserman et al., 1996). The sections below describe the variety of negative health outcomes linked to abuse.

Violence Increases Risk for Gynecological Problems

Sexual and physical violence appear to increase women’s risk for many common gynecological disorders, including: 1) vaginal bleeding, 2) painful menstruation, 3) vaginal discharge, 4) sexual dysfunction, 5) pelvic inflammatory disease and 6) painful intercourse.

Abuse may also be linked to the etiology of chronic pelvic pain, a debilitating condition that frequently has no identifiable cause. In Europe and the United States, chronic pelvic pain is responsible for ten percent of all gynecological visits and one-quarter of hysterectomies (Walker et al., 1992). Although chronic pelvic pain can be caused by adhesions, endometriosis or infections, in about half the cases there is no identifiable pathology. A number of studies have found that women suffering from chronic pelvic pain are more likely to have a history of childhood sexual abuse (Walker et al., 1992), sexual assault (Chapman, 1989; Rapkin et al., 1990) or physical and sexual abuse by their partners (Schei, 1990).

Fatal and Non-Fatal Outcomes of Abuse

The following table outlines the fatal and nonfatal outcomes, including physical and mental health problems, and behavioral and reproductive health consequences of three types of abuse.

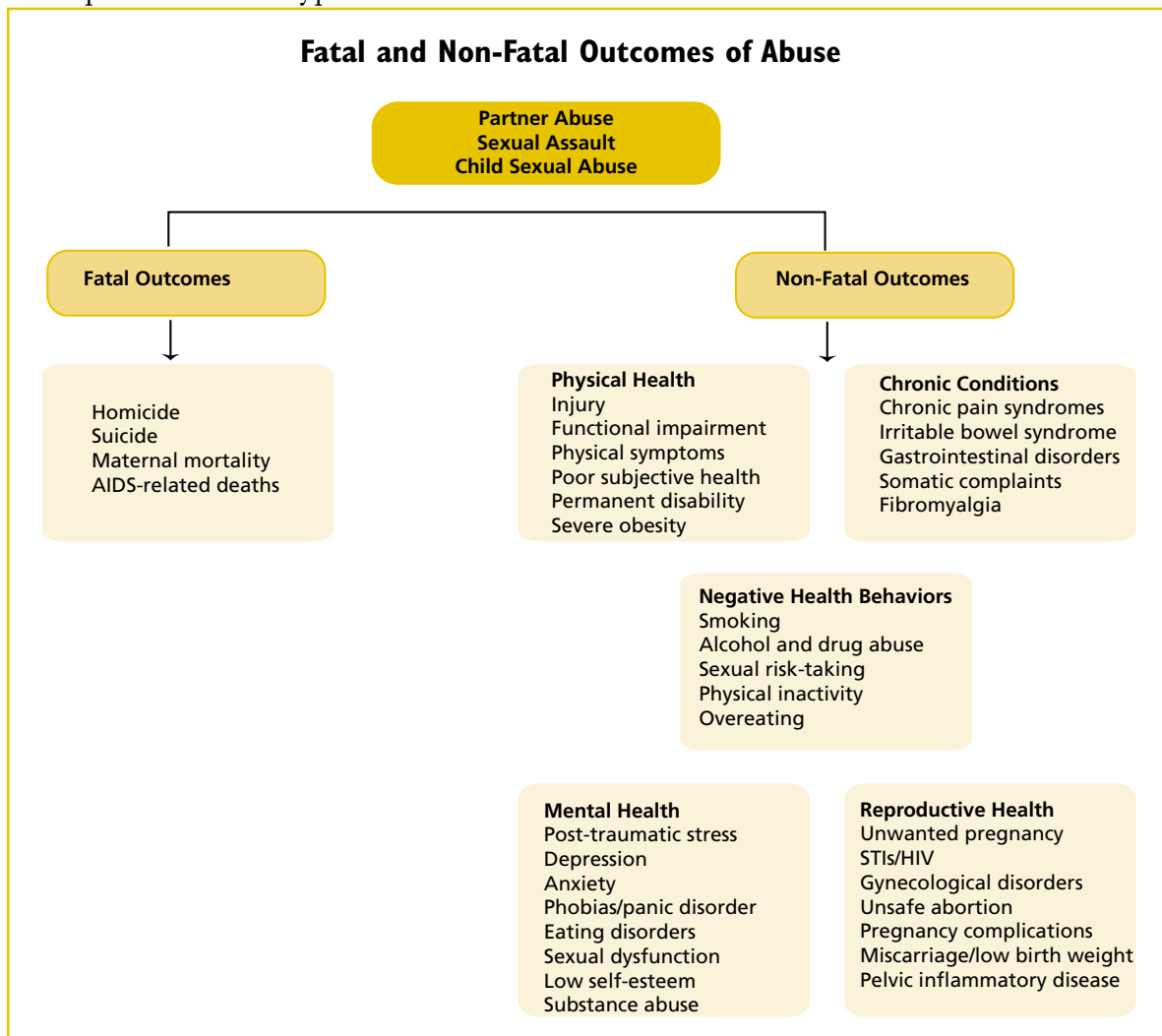


Figure 8-3

Violence Leads to Unwanted Pregnancies

If women cannot control their sexual encounters, they are at risk of unwanted pregnancy. Studies from Bolivia, Chile, India, the Philippines and the United States have all found that partner violence is more common in families with four or more children (Larrain, 1994; David and Chin, 1998; Jejeebhoy, 1998; Najera et al., 1998; Martin et al., 1999; Rosales et al., 1999; Tjaden and Thoennes, 2000). Researchers have argued for years that perhaps having many children increased the likelihood of abuse, either by increasing stress or provoking marital disagreements. Recent research from León, Nicaragua, however, suggests that the relationship may work the other way, with violence serving as a risk factor for having large families. Through life table analysis, the Nicaraguan study indicated that partner violence generally began early in the marriage, preceding the arrival of many children. In the León study, 80 percent of the women who had ever been abused said that the abuse began in the first four years of marriage (Ellsberg et al., 2000).

Violence Undermines Women’s Contraceptive Use

Numerous studies indicate that violence reduces women’s sexual autonomy and increases women’s fear that raising the topic of contraception will have violent consequences. The following studies, conducted in 10 countries with a variety of

female subjects, have examined the relationship between contraceptive use and violence.

Sometimes a woman’s fear of violence is warranted and sometimes not, but fear cuts off the discussion of contraceptive use. In Ghana, where 51 percent of women and 43 percent of men agree that a husband is justified in beating his wife if she uses family planning without permission, a woman explains:

Violence Undermines Women's Contraceptive Use	
Bolivia	Aymara market women (Choque et al., 1994)
Brazil	Female factory workers (Goldstein, 1994)
Cambodia	Abused women (Zimmerman, 1995)
Ghana	Married women (Ezeh, 1993)
Guatemala	Pregnant women (Lundgren et al., 1992)
India	Married women (George and Jaswal, 1993)
Jamaica	Low-income workers (Chambers et al., 1992)
Mexico	Family planning clients (Folch-Lyon et al., 1981)
Peru	Community members (Fort, 1989)
Uganda	Married women (Blanc et al., 1996)

Figure 8-4

“I cannot even speak of family planning in passing to my husband. Every morning, whenever he hears people discussing family planning over the radio, he gets so angry...he fumes and shouts, cursing under his breath. If he can threaten a wireless, an inanimate thing, what would he do to me if I open the topic?” (Bawah et al., 1999).

Violence Reduces Women’s Sexual Autonomy

In many parts of the world, marriage is interpreted as granting men unconditional sexual access to their wives, a “right” enforced through force if necessary. Among 98 percent of currently married women in Uttar Pradesh, India, 68 percent report being coerced into sex by their husbands; 31 percent report being forced through beatings (Khan et al., 1996). The high level of nonconsensual sex occurring in marital unions is supported through both qualitative and quantitative data.

In Egypt and Ghana, 70 percent and 33 percent of women respectively agree that a man is justified in beating his wife if she refuses sex, as compared to 7 percent of women in Nicaragua (Rosales et al., 1999). In Papua New Guinea, 63 percent of high school boys agree that men are justified in hitting their wives if they talk back or disobey them (Bradley, 1985). These attitudinal data suggest a strategic point for intervention because the practice of violence against women is belief-driven and beliefs can change.

Reproductive Health Sequelae of Childhood Sexual Abuse

Violence operates through multiple pathways to affect women’s sexual and reproductive health. Physical violence and sexual abuse can put women at risk of infection and unwanted pregnancy if women are forced to have sex, or fear using contraception or condoms because of their partners’ reaction. A history of sexual abuse in childhood also can lead to unwanted pregnancies and STIs indirectly by increasing sexual risk-taking in adolescence and adulthood.

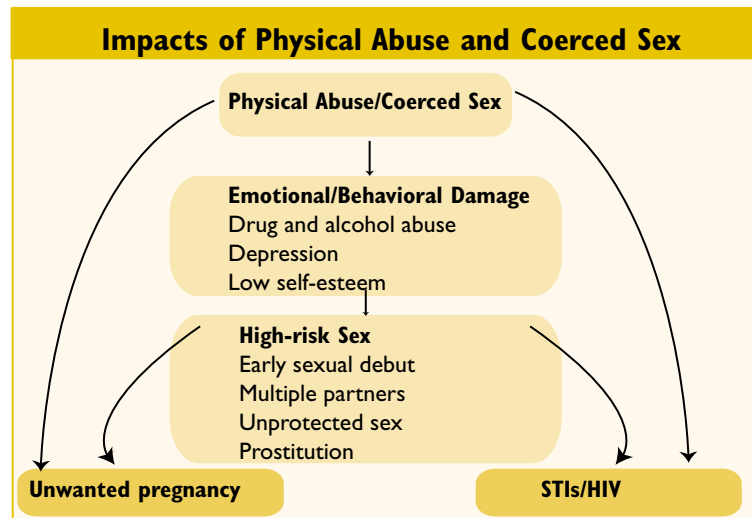


Figure 8-5

Violence Contributes to Teenage Pregnancy

Studies in the United States have established the link between childhood sexual abuse and increased risk of teen pregnancy (Beitchman et al., 1991; Boyer and Fine, 1992; Butler and Burton, 1990). Childhood sexual abuse is associated with earlier age at first intercourse and an increase in certain risky behaviors, such as having sex with many partners. We now have data from developing countries to substantiate this relationship. Specifically, a case reference study in Nicaragua found that after controlling for education, area of residence and poverty, the risk

of adolescent pregnancy was 2.5 times higher for women who had been abused in childhood. About 15 percent of adolescent pregnancies in this setting could be attributed to sexual abuse in childhood (Elmer Zelaya, unpublished data).

Violence Increases STI/HIV Risk and Undermines Prevention Programs

On average, women who have been sexually abused as children are more likely to engage in unprotected sex, have multiple partners, and trade sex for money or drugs—all risk factors for contracting STIs/HIV. Moreover, women who experience forced sex are at higher risk of contracting HIV. In a recent case control study in rural Uganda, coerced sex in the last year emerged as one of the most potent risk factors for acquiring HIV infection in the past 12 months (Quigley et al. 2000).

Studies from 12 countries identify fear of abandonment and fear of violence as major obstacles to women's willingness and ability to negotiate condom use. At the 12th International AIDS Conference held in Geneva in 1998, investigators repeatedly noted that pregnant women cited fear of a violent response by husbands as the reason that they did not want to be tested for HIV or, if tested and found to be HIV+, did not want to take AZT therapy during labor for fear of revealing their HIV status to their husbands (Brown, 1998).

Violence Leads to Adverse Pregnancy Outcomes, Including Low Birth Weight

The literature shows that violence during pregnancy is associated with: 1) late entry into prenatal care, 2) increased smoking and substance abuse during pregnancy, 3) premature labor, 4) bleeding during pregnancy, 5) vaginal and cervical infections, 6) miscarriage and abortions and 7) low birth weight. Links between violence against women and low birth weight have been found in numerous studies in the United States, as well as studies conducted in Norway, Mexico, and Nicaragua. Although the findings are inconclusive, several studies suggest that violence during pregnancy contributes substantially to low birth weight, at least in some settings.

In one study at the regional hospital in León, Nicaragua, for example, researchers found that after controlling for other risk factors, violence against pregnant women was associated with a threefold increase in the incidence of low birth weight. Violence in pregnancy accounted for 16 percent of low birth weight among the infants studied and posed a greater risk of low birth weight than such factors as pre-eclampsia, bleeding and smoking (Valladares et al., 2000 forthcoming).

Violence Has a Significant Impact on Child Mortality

Violence may undermine child survival as well. In León, Nicaragua, women with no history of abuse were matched in a case-control study with women who had experienced physical and/or sexual abuse by an intimate partner. After adjusting for age, parity, education, residence, and poverty status, the researchers found a six-fold greater risk of under-5 mortality and an almost eight-fold risk of infant mortality for women who had experienced physical and sexual abuse by a partner. We need to explore this issue in more depth to begin to understand the reasons for these outcomes. In terms of population-attributable risk, one-third of child deaths in this region can be attributed to physical or sexual abuse of the mother by an intimate partner (Asling-Monemi et al., 2000). Similar findings emerged from studies conducted in India and Zimbabwe.

Nicaragua’s 1999 Demographic and Health Survey, which included a module on violence, also found a link between partner abuse and infant and under-5 mortality (Rosales et al., 1999). The rates of diarrhea and malnutrition are somewhat higher and the rates of immunization somewhat lower among children of women who have experienced partner violence. This suggests that women with violent partners have less access to resources, less mobility, weaker bargaining power, and are thus less able to maintain their children’s health. This finding also warrants further exploration.

Studies on Violence and Low Birth Weight	
United States	
Amaro, 1990	Dye, 1995
Berenson, 1994	McFarlane, 1996
Bullock, 1989	O’Campo et al., 1994
Cokkinides, 1999	Parker, 1994
Curry, 1998	Webster et al., 1994
Norway	
Schlei	Valledares, 1998
Mexico	
Valdez, 1997	

Figure 8-6

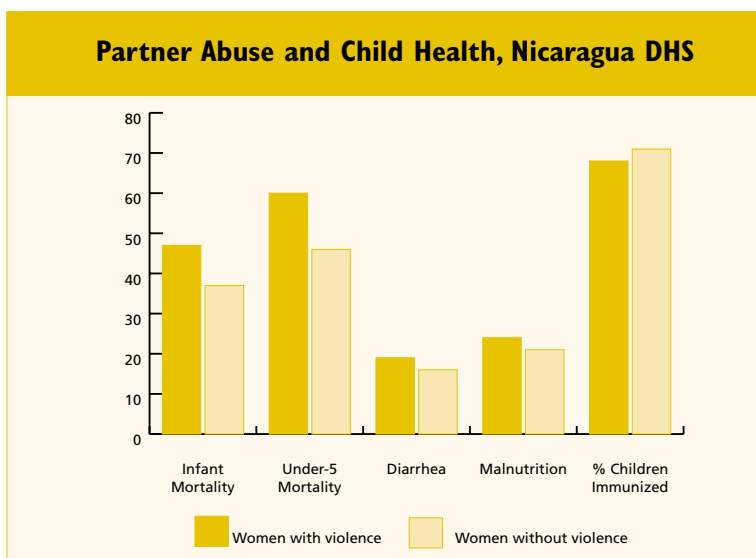


Figure 8-7

Conclusion

Partner abuse and sexual coercion have a grave impact on the health of women and children, and reproductive health workers need to screen and give appropriate care to women exposed to violence. While the public health approach has given us the data we need to demonstrate the magnitude of the problem, we also need the added value of the human rights perspective to get beyond efficiency arguments. What if we had found low odds ratios for the impact of violence upon health outcomes? Even if the health impacts of violence against women were inconsequential, the human rights approach tells us that we cannot justify ignoring this phenomenon: it is a violation of women's rights regardless of the costs. As a first step, we need to create among women a collective sense of entitlement to a life free of violence. Human rights education—translating the discourse of human rights to make it meaningful to women at the grassroots level—is a critical mechanism in this process to both prevent and combat violence against women. It will be a major contribution.

References

- Asling-Monemi, K., Pena, R., Ellsberg, M. and Persson, L-A. (submitted 2000). "Violence against women increases the risk of infant and child mortality: A case-reference study in Nicaragua."
- Bawah, A. A., Akweongo, P., Simmons, R. and Phillips, J. F. (1999). "Women's fears and men's anxieties: The impact of family planning on gender relations in northern Ghana." *Studies in Family Planning* 30: 54-66.
- Beitchman, J. H., Zucker, K. J. and Hood, J. E. (1991). "A review of the short term effects of child sexual abuse." *Child Abuse and Neglect* 15: 537-556.
- Blanc, A. K., Wolff, B., Gage, A. J., Ezeh, A. C., Neema, S. and Ssekamatte-Ssebuliba, J. (1996). *Negotiating reproductive outcomes in Uganda*. Institute of Statistics and Applied Economics and Macro International Inc: 215.
- Boyer, D. and Fine, D. (1992). "Sexual abuse as a factor in adolescent pregnancy." *Family Planning Perspectives* 24: 4-11.
- Bradley, C. S. (1985). "Attitudes and practices relating to marital violence among the Tolai of East New Britain." *Domestic Violence in Papua New Guinea*. Boroko, Papua New Guinea Law Reform Commission: 32-71.
- Brown, D. (1998). "In Africa, fear makes HIV an inheritance." *The Washington Post*.
- Butler, J. R. and Burton, L. M. (1990). "Rethinking teenage childbearing: Is sexual abuse a missing link?" *Family Relations* 39: 73-80.
- Chapman, J. D. (1989). "A longitudinal study of sexuality and gynecologic health in abused women." *Journal of the American Osteopathic Association* 89: 619-624.
- Choque, M. E., Schuler, S. R. and Rance, S. (1994). *Reasons for unwanted fertility and barriers to use of family planning services among urban Aymara in Bolivia*.

- Arlington, Virginia, John Snow, Inc.: 19.
- David, F. and Chin, F. (1998). *Economic and psychosocial influences of family planning on the lives of women in Western Visayas*. Iloilo City, Philippines, Central Philippines University and Family Health International.
- Ellsberg, M., Peña, R., Herrera, A., Liljestrand, J. and Winkvist, A. (2000). "Candies in hell: women's experiences of violence in Nicaragua." *Social Science and Medicine* 51: 1595-1610.
- Ezeh, A. C. (1993). "The Influence of spouses over each other's contraceptive attitudes in Ghana." *Studies in Family Planning* 24: 163-174.
- Folch-Lyon, E., Macora, L. and Schearer, S. B. (1981). "Focus group and survey research in family planning in Mexico." *Studies in Family Planning* 12: 409-432.
- Fort, A. L. (1989). "Investigation of the social context of fertility and family planning: A qualitative study in Peru." *International Family Planning Perspectives* 15: 88-94.
- George, A. and Jaswal, S. (1993). "Understanding sexuality: Ethnographic study of poor women from Bombay." *Preliminary Findings, ICRW: Women and AIDS Research Program*. Bombay, Tata Institute of Social Sciences.
- Goldstein, D. M. (1994). "AIDS and women in Brazil: The emerging problem." *Social Science and Medicine* 39: 919-929.
- Gonzalez Montes, S. (1998). *Domestic violence in Cuetzalan, Mexico: Some research questions and results*. Third Annual Meeting of the International Research Network on Violence Against Women, CHANGE.
- Heise, L. (1998). "Violence against women: An integrated, ecological framework." *Violence Against Women* 4: 262-290.
- Heise, L., Ellsberg, M. and Gottemoeller, M. (1999). "Ending Violence Against Women." *Population Reports*. Baltimore, Johns Hopkins University: 27.
- Jejeebhoy, S. J. (1998). "Wife-beating in rural India: A husband's right?" *Economic and Political Weekly (India)* 23: 588-862.
- Khan, M. E., Townsend, J. W., Sinha, R. and Lakhanpal, S. (1996). *Sexual violence within marriage*, New Dehli, India, Population Council.
- Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Keita, G. P. and Russo, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community*. Washington, D.C., American Psychological Association.
- Larrain, S. H. (1994). *Violencia Puertas Adentro: La Mujer Golpeada*. Santiago, Chile, Editorial Universitaria.
- Leibrich, J., Paulin, J. and Ransom, R. (1995). *Hitting home: Men speak about domestic abuse of women partners*. Wellington, New Zealand, New Zealand Department of Justice in association with AGB McNair.
- Leserman, J., Drossman, D. A., Li, Z., Toomey, T. C., Nachman, G. and Glogau, L. (1996). "Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status." *Psychosomatic Medicine* 58: 4-15.
- Levinson, D. (1989). *Violence in cross cultural perspective*. Newbury Park, California, Sage Publishers.
- Lundgren, R., Bezmalinovic, B. and DuFlon, W. S. (1992). *Guatemala City*

- women: *Empowering a hidden risk group to prevent HIV transmission*. Guatemala, Interamerican Development Advisory Services, Ltd.: 91.
- Martin, S. L., Tsui, A. O., Maitra, K. and Marinshaw, R. (1999). "Domestic violence in northern India." *American Journal of Epidemiology* 150: 417-426.
- Najera, T. P., Gutierrez, M. and Bailey, P. (1998). *Bolivia: Follow-up to the 1994 demographic and health survey, and women's economic activities, fertility and contraceptive use*. Research Triangle, North Carolina, Family Health International.
- Narayana, G. (1996). "Family violence, sex and reproductive health behavior among men in Uttar Pradesh, India." Unpublished.
- O'Campo, P., Gielen, A., Faden, R. and Kass, N. (1994). "Verbal abuse and physical violence among a cohort of low-income pregnant women." *Women's health issues* 4: 29-37.
- Quigley, M. A., Morgan, D., Malamba, S.S., Mayanja, B., Okongo, M.J., Carpenter, L.M. and Whitworth, J.A. (2000). "Case-control study of risk factors for incident HIV infection in rural Uganda." *J Acquir Immune Defic Syndr* 23: 418-425.
- Rapkin, A. J., Kames, L. D., Darke, L. L., Stamper, F. M. and Naliboff, B. D. (1990). "History of physical and sexual abuse in women with chronic pelvic pain." *Obstetrics and Gynecology* 76: 92-96.
- Rosales, J., Loaiza, E., Primante, D., Barberena, A., Blandon Sequeira, L. and Ellsberg, M. (1999). *Encuesta Nicaraguense de demografia y salud, 1998*. Managua, Nicaragua, Instituto Nacional de Estadísticas y Censos, INEC.
- Schei, B. (1990). "Psycho-social factors in pelvic pain. A controlled study of women living in physically abusive relationships." *Acta Obstetrica et Gynecologica Scandinavica* 69: 67-71.
- Tjaden, P. and Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. Washington, D.C., National Institute of Justice, Centers for Disease Control and Prevention: 72.
- Valladares, E., Ellsberg, M., Peña, R., Högberg, U. and Persson, L. Å. (submitted 2000). "Physical abuse during pregnancy: A risk factor for low birth weight."
- Walker, E. A., Katon, W. J., Hansom, J., Harrop-Griffiths, J., Holm, L., Jones, M. L., Hickok, L. and Jemelka, R. P. (1992). "Medical and psychiatric symptoms in women with childhood sexual abuse." *Psychosomatic Medicine* 54: 658-664.
- Webster, J., Sweett, S. and Stolz, T. (1994). "Domestic violence in pregnancy: a prevalence study." *Medical Journal of Australia* 161: 466-470.
- Yoshihama, M. and Sorenson, S. B. (1994). "Physical, sexual, and emotional abuse by male intimates: Experiences of women in Japan." *Violence and Victims* 9:63-77.
- Zelaya, E. (2000). Umeå University, Epidemiology and Clinical Medicine. Personal communication with author.
- Zimmerman, K. (1995). *Plates in a basket will rattle: Domestic Violence in Cambodia: A summary*. Phnom Penh, Cambodia, Project Against Domestic Violence.

9. Transforming Family Planning Programs: Towards a Framework for Advancing the Reproductive Rights Agenda¹

One of the central challenges posed by recent international agreements and women's advocacy movements is the application of both public health and human rights principles to reproductive health programs. The Programme of Action of the 1994 International Conference on Population and Development (ICPD), for example, calls on governments and international donor agencies to *expand and transform* existing programs, and to offer services that are comprehensive, integrated, universally accessible and delivered in a manner consistent with health and rights objectives.

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

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

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

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The Rights and Health Agenda

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

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

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

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

² See for example, Bruce, 1989; Germain and Ordway, 1989; Jain, 1995.

The rights and health agenda therefore rests on the following basic assumptions:

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

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

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

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

Public Health and Human Rights: Different Perspectives

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

The field of public health is concerned with improving the health status of populations. Success is measured in terms of outcomes—births averted, lives saved—and the goal is to achieve the greatest good for the greatest number. Public health resources are allocated according to priorities that reflect the ability to

prevent illness and death on a large scale, and to reduce the prevalence and incidence of disease across a population. Public health theory weighs relative risks and recognizes that in the quest to improve the health of populations, some individuals will continue to face risks due to individual behavior, environment, economic conditions and lack of access to health care, among other things. It is understood that resources are finite, and that decisions need to be made to ensure that investments yield the greatest possible return.

Human rights concepts and methodologies focus on protecting the rights of individuals. Human rights standards are universal, indivisible and inalienable. Rights language refers to a “right to health” and a “right to health care,” which in the context of limited resources can leave the public health official at a loss.

Although a rights framework theoretically seeks to promote rights as well as to protect individuals from violations, the focus for much of the past several decades has in fact been on documenting violations. During most of the 20th century, the human rights community focused on abuses of individual civil and political rights by public actors—the state and its representatives. Only in the last two decades have rights advocates and legal scholars established the basis for women’s human rights, and following from this, reproductive and sexual rights. These rights are now recognized in a number of conference documents, including the 1993 World Conference on Human Rights and the 1995 Fourth World Conference on Women, as well as the ICPD. Violations of women’s rights by governments are now documented through a variety of formal means, including through the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the

By focusing only on blatant violations—such as sterilization without consent—human rights methodologies also can miss subtler, but more widespread and persistent violations of rights.

U.S. State Department’s *Country Reports on Human Rights Practices*.

Traditional human rights documentation relies on reports from and interviews with key informants in a given setting. By its nature, such reporting often is based on small numbers of discrete cases; these reports frequently raise a red flag about problems that affect larger numbers, but do not *prove* that a given problem exists on a large scale. As a result, human rights findings often are not persuasive to public health practitioners who, in the absence of population-based data, often remain unconvinced that these findings represent more than a few isolated cases, or a new priority to be addressed. For this reason, proof of a small number of cases of sterilizations without consent, for example, may be viewed by public health institutions and program managers—especially those with a vested interest in the reputation of a program—as being more an exception than the rule, and therefore remedied through palliative measures focused merely on the individual case rather than on a systemic problem. In Mexico, for example, evidence gathered by human rights organizations that government doctors performed sterilizations without the client’s consent was largely dismissed until large-scale surveys conducted in the 1980s and 1990s by both the government and various donors showed the problem to be significant and pervasive.

On the other hand, by focusing only on blatant violations—such as sterilization without consent—human rights methodologies also can miss subtler, but more widespread and persistent violations of rights. In Mexico, for example, a 1996 United Nations Population Fund analysis of service delivery points throughout the country revealed that only a limited number of contraceptive methods were offered, and that providers were required to strongly encourage and persuade women with more than two children to adopt IUDs or undergo sterilization (UNFPA, 1996). Since most women were coming for and leaving with a method, and since there appeared to be “consent,” this type of practice might not be perceived as a violation of rights. According to the interpretation of a rights approach posed by this article however, these are violations. A program that offers limited methods in the interest of reducing women’s fertility takes advantage of women’s extremely limited sense of rights to achieve externally posed demographic goals. Such a program, which fails to instill a sense of broader choices and entitlement in its clients, does not meet the test of contributing to the promotion of reproductive rights.

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

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

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

The real world, however, is still far from this ideal and both women and men are at risk of the consequences of unsafe sex. Cultural and social norms may inhibit partners from talking openly with each other about having sex, sexuality, contraception and infection, thereby putting them at risk of unwanted pregnancy and of

To explore the practical meaning of a rights framework for current and future programs, it may be helpful to start from the act of heterosexual intercourse, the domain of conventional family planning programs. In the ideal world, sexual partners decide together whether or not they want to have children, and if not, how to protect themselves from unwanted pregnancy. They negotiate the timing and frequency of sexual encounters. If one partner suffers from a sexually transmitted infection, they work together on ways to protect the other. The real world, however, is still far from this ideal....

disease. Taboos and traditional practices may prevent them from seeking health care even in dire circumstances. Women and men may know little about their bodies and how they work. Women may be particularly vulnerable because they face constraints posed by inequitable gender-based power relations that undermine their ability to negotiate sexual and reproductive decisions equally with their partners. An individual woman may sometimes—perhaps frequently—be forced to engage in non-consensual sex, or she may be raped by an intimate partner. Unwanted pregnancy may be a persistent concern, either because a woman cannot control the timing of intercourse and therefore protect herself, or because she lacks access to methods of fertility regulation that truly fit her

particular needs. Access to safe abortion is likely to be limited if it is available at all. Emergency obstetric care may be equally scarce. All of these conditions contribute to high rates of reproductive morbidity and mortality among women.

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

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

A rights approach starts from this reality and asks: What can and should be done programmatically to address these issues? Instead of offering a limited range of contraceptive methods because they are effective or efficient in meeting the program's goals, a rights-based program is client-centered and offers several methods and reaffirms at every level the client's right to choose among them. Instead of relying on providers to do all the work of informing and educating clients in the span of a few minutes, it offers community-

based reproductive health education, builds community support for reproductive health and rights, and uses a variety of communication strategies to instill a sense of entitlement among people. A rights-based program is part of the process of establishing new social norms that encourage partnership, communication and cooperation. Instead of assuming that unwanted pregnancy is the only problematic outcome of sexual intercourse within their professional interest, it

A rights-based program is part of the process of establishing new social norms that encourage partnership, communication and cooperation. Instead of assuming that unwanted pregnancy is the only problematic outcome of sexual intercourse within their professional interest, it recognizes that the risks of infection and coercion are—at the very least—of equal importance and are additional risks many women face each and every time they engage in the act of intercourse.

recognizes that the risks of infection and coercion are—at the very least—of equal importance and are additional risks many women face each and every time they engage in the act of intercourse. A rights approach puts as much emphasis on the ethical and value-oriented aspects of a program as it does on technical skills. Finally, a rights approach acknowledges that health providers also are individuals with rights, and that changing the system is as important as changing the individual.

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

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

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

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

- ◆ Address sexual violence and coercion, especially as it relates to restricting women’s choices, and exposes women and girls to higher risks of morbidity and mortality
- ◆ Incorporate multi-source reproductive health and rights education strategies, and seek to instill a sense of entitlement among people and a rights-based ethos within programs

- ◆ Incorporate communication and behavior change interventions encouraging the prevention of disease, the practice of safe sex, and changes in social norms that encourage equitable partnerships
- ◆ Establish means of ensuring the accountability of programs to the population, and means of redress for violations of rights.

The terms “health,” “rights” and “gender” are now ubiquitous in the rhetoric and the policy statements of the population and health fields, suggesting that institutional actors at least nominally support this vision. But evidence suggests that...progress in making the fundamental changes in family planning programs required by a rights framework is uneven at best.

Obstacles to Change

On the face of it, the rights agenda is now a mainstream idea. Today, a majority of governments (and by extension, key institutions such as donor agencies) are signatories to international agreements that recognize reproductive and sexual rights as human rights. The terms “health,” “rights” and “gender” are now ubiquitous in the rhetoric and the policy statements of the population and health fields, suggesting that institutional actors at least nominally support this vision.

But evidence suggests that on the whole, progress in making the fundamental changes *in family planning programs* required by a rights framework is uneven at best. There are a number of obstacles to the transformation of family planning programs, some of which are explored briefly below.

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

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

In Mexico, where national reproductive health policies extol the ICPD agenda, data from the late 1980s through the late 1990s show that problems with both informed choice and informed consent are embedded in the public sector’s family planning program.³ Complex contextual and social issues that are at the core of truly informed choice and consent include women’s low sense of entitlement to choose their own contraceptives due to the power imbalances between clients and providers—as well as between women and their partners.

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

³ Based on research conducted by the Center for Health and Gender Equity (CHANGE) in cooperation with Monica Jasis, Co-Director of Centro Mujeres in Baja California Sur.

Governments and donor agencies have their own political agendas and institutional imperatives that diverge from ICPD principles. Their internal systems often are set up to protect these agendas, making it difficult for civil actors to gain access to information on programs or spending.

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

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

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

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

In recent years, the far right also has used the human rights agenda to its own ends. In 1999, leaders of the conservative right crafted a law—the Tiarht Amendment—mandating monitoring of U.S.-funded programs for violations of informed consent, and requiring that funding be withdrawn from any program in which such violations are found. While seemingly in accord with the rights agenda, this law can actually shut down many imperfect programs that are receiving rights-oriented training and are in the process of making positive changes—before they have a chance to fully implement the improvements. Instead of funding activities to enhance informed consent and other rights-based principles in family planning programs, the effect of this legislation is to diminish choice altogether.

Despite these setbacks, several initiatives intended to incorporate concern for gender and rights perspectives into USAID's family planning/reproductive health programs are underway. In 1997 the Office of Population formalized an Inter-Agency Gender Working Group (IGWG) composed primarily of representatives of USAID cooperating agencies and a few USAID staff. This group has done important work in reviewing the Agency's strategic objectives and exploring the practical implications of male involvement. It has now issued guidelines for the incorporation of gender-sensitive indicators into the Agency's "Request for Proposals," the mechanism by which it funds new or continuing projects. The long-term impact of the IGWG work remains unclear; however, the Agency has now mandated consideration of gender issues for all new proposals.

3. Key concepts remain ill-defined.

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

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

In fact, ICPD is a 20-year program of action and the rights framework does allow for progressive realization of goals. However, the interim steps needed to achieve priority ICPD goals over time have not yet been fully explored by the rights and health communities in specific settings to provide sufficient guidance to

even its strongest supporters on how to move forward. Realizing this, women's health and rights advocates are taking on these issues. For example, a groundbreaking article by Alicia Ely Yamin and Deborah Maine (1999) suggests a methodology for marrying human rights and public health standards in efforts to measure progress in reducing maternal mortality and morbidity. The article examines in detail how international human rights principles, concrete data collection and measurable indicators of progress can be used simultaneously to analyze the scope of a problem, set achievable goals and mark progress. Similar work in other key reproductive health and rights, such as STIs and unsafe abortion, can be used to design or improve programs.

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

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

There is little concrete evidence on how health reforms are affecting access to and the quality of care, whether positively or negatively—or both. We need to know much more about the implications for reproductive health and rights of efforts to decentralize, redistribute staff, institute user fees, privatize services and overhaul drug management systems in various settings. It is essential that rights advocates actively engage in health reform efforts to ensure that they advance, rather than undermine the ICPD agenda.

5. Insufficient human capacity exists.

Finally, lack of capacity in the women's movement is another constraining factor. Over the past two decades, the capacity of the international women's movement to influence rhetoric and policy, lobby, use the media and engage with international bodies to advance women's rights has expanded dramatically.

However, now that we have won globally, we have to act locally. The real transformation of programs occurs at the national, state and district levels and the burden of monitoring has therefore increased enormously. However, given the critical importance of monitoring programs, including the impact of health-sector reforms, the numbers and skills of women's health advocates will have to grow correspondingly. This requires financial support and training.

Towards a Framework for Advancing the Reproductive Rights Agenda

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

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

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

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

include support for the rights of providers, particularly female staff, as actors and potential agents of change within institutions, as it supports the rights of clients.

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

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

References

- Bruce, J. (1989). *Fundamental elements of the quality of care: A simple framework*. Population Council, New York.
- Correa, S. and Petchesky, R. (1994). Reproductive and Sexual Rights: A Feminist Perspective. In: *Population Policies Reconsidered: Health, Empowerment, and Rights*. G. Sen, A. Germain and L.C. Chen (eds). Cambridge, MA, Harvard School of Public Health.
- Germain, A., Nowrojee, S. and Pyne, H.H. (1994). Setting a New Agenda: Sexual and Reproductive Health and Rights. In: *Population Policies Reconsidered: Health, Empowerment, and Rights*, G. Sen, A. Germain and L.C. Chen (eds). Cambridge, MA, Harvard School of Public Health.
- Germain, A. and Ordway, J. (1989). *Population Control and Women's Health: Balancing the Scales*. New York, International Women's Health Coalition.
- Jain, A. and Bruce, J. (1994). A reproductive health approach to the objectives and assessment of family planning programs. In: *Population Policies Reconsidered: Health, Empowerment, and Rights*. G. Sen, A. Germain and L.C. Chen (eds) Cambridge, MA, Harvard School of Public Health.
- Jain, A. (1995). Implementing the ICPD's message. *Studies in Family Planning* 26 (5), September/October: 296–298.
- United Nations Population Fund. (1996). *Evaluation Report: Quality of Family Planning Services*. Number 8. New York, United Nations Population Fund.
- United States Agency for International Development. (1999). *From Commitment to Action: Meeting the Challenge of the ICPD*. Washington, D.C., USAID.
- Yamin, A. and Maine, D. (1999). Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations. *Human Rights Quarterly* 21(3), August.

10. Integrating Women into HIV Programs in Africa: A Personal Story

I want to share a personal story—my life with HIV—with the objective of helping others. I aim to put a face to the many statistics about HIV/AIDS. It is difficult for me to understand the theoretic concepts of reproductive and human rights, because I come from a region and a culture where absence of such rights or violation of those rights is a common and constant reality. Nevertheless, I am gratified to know that human and reproductive rights are now being spoken of in the context of HIV/AIDS. I hope that these discussions will help other women who face situations similar to mine.

My Story

I was born and raised in Kenya. I married in 1984 and bore two children. I exhibited “good” behavior according to cultural customs. I remained faithful to my husband and committed to providing all he needed and wanted, including sexual activity. I had a job, but always fulfilled my domestic responsibilities first. My husband’s extramarital sexual encounters not only caused problems in our marriage, it also led to my HIV+ status. My husband’s behavior was not abnormal. Adultery by men, and the broader notion that men are entitled to control women while exercising their own unlimited freedom, was accepted and even promoted by cultural tradition.

Before the birth of my first child, I was twice stricken with a sexually transmitted infection. Further investigation revealed my infection with HIV. Due to the lack of knowledge and resources in my community, I could not access necessary medical care. I was overtaken by denial—I didn’t fit the typical at-risk model, so how could I be infected? Caught up in emotional turmoil, I left my children and husband and home. I lived temporarily with my brother, until his wife’s fear that her children would be infected became too great. This was indicative of the prevalent ignorance about the disease throughout this region, and in too many other regions throughout the world.

I felt alone and afraid. Social stigma deterred me from disclosing my status and seeking assistance. I returned to my husband’s home and my children. Shortly after that, my husband died, on the first World AIDS Day celebrated in Kenya. In 1994, I suffered from my first opportunistic infection. I was fired from my job with a local bank when my status was discovered.

by
Naisiadet Mason,
Vice-President,
Society for Women
and AIDS in Africa



Addressing Women's Vulnerability to HIV in Africa

Shortly after losing my job, I became involved with Women Fighting AIDS in Kenya (WOFAK), an affiliate of an international nonprofit organization, Society of Women and AIDS in Africa (SWAA). This organization was founded in 1988 with the objectives of mobilizing women in Africa against HIV/AIDS and acting as a voice for women with HIV/AIDS. I am now the organization's vice-president. Based in Senegal, SWAA collaborates with local groups and has representation in 40 countries. Members include all types of women: mothers, schoolgirls, prostitutes, rural and urban dwellers, among others. This networking of local and national groups is essential for fighting AIDS. Another characteristic of the organization is its promotion of AIDS issues in the political arena. This is a key element for effective response to the AIDS crisis.

SWAA works on a variety of projects, wherever the need is great. For example, SWAA is working in Homeabey, a town in Kenya devastated by HIV/AIDS. The disease has widowed many of the local women. SWAA has trained 70 women leaders in this area to educate and provide emotional support for those infected with or affected by HIV/AIDS. Neem trees, known for their medicinal properties, were planted to commemorate AIDS victims and raise public awareness of the problem's magnitude and scope. Support groups were developed for widows. In order to foster economic independence of women, an important factor supporting reproductive and human rights of women, SWAA developed income-generation projects. The inner city slum Kaioli is another project site. Here SWAA addresses a significant problem in this area, and also throughout much of Africa: orphaned children who have lost one or both parents to AIDS. The increasing number of orphans overburdens traditional extended family support. SWAA is working to enhance men's participation in its projects in all regions. In addition, SWAA reaches students in local high schools, providing AIDS education and development of negotiation skills.

Recommendations

There are daunting but not insurmountable challenges presented by the struggle to protect women and all people against AIDS. In addition to changing behavior, there is a need to:

- ◆ Empower African women with communication skills and provide a forum for women to utilize their skills, with the support of African men.
- ◆ Provide job skills for women's economic independence.
- ◆ Provide more support systems for women to supplement public and familial systems.
- ◆ Incorporate women's perspectives into AIDS research and program development.

- ◆ Alter traditional power dynamics in many African cultures, especially in regard to sexual rights and activity.
- ◆ Strengthen participation of men in HIV/AIDS and women's programs.
- ◆ Foster and coordinate support at both the community and national levels, with civil and political participation.
- ◆ Increase resources—material, technical and financial.
- ◆ Increase availability and decrease cost of condoms, male and female.
- ◆ Develop and make available better means of protecting women from sexual diseases and pregnancy.
- ◆ Provide women better access to medical treatment and increase availability of drugs to treat persons with HIV.

I was fortunate to have the opportunity to seek care outside Africa, but there are many others who are not as fortunate. It is imperative that domestic health systems and resources in developing countries be improved and made accessible to all people living with HIV/AIDS. AIDS is a global epidemic and interventions, including effective treatment and health care, must also have a global reach. Resource-rich countries must expand their political will to address HIV/AIDS beyond their borders and immediately increase assistance to resource-poor countries in the struggle against this devastating disease.

AIDS is a global epidemic and interventions, including effective treatment and health care, must also have a global reach. Resource-rich countries must expand their political will to address HIV/AIDS beyond their borders and immediately increase assistance to resource-poor countries in the struggle against this devastating disease.

II. Conclusion: Reproductive Health and Human Rights in the Real World

by
Amy E. Pollack,
President,
EngenderHealth¹



It is both a privilege and a challenge to summarize an important discussion of reproductive health, gender and human rights. Those engaged in this dialogue laid before us their knowledge and thoughts for our reflection. I am taken by the range of experience represented and by the continuing commitment—reflected here to grapple with the relationship of human rights and reproductive health as we move beyond Cairo.

We have learned in rich detail how women’s status, rights and empowerment act as determinants or risk factors for women’s health. We have learned how policies, gender relations and other socioeconomic factors can hinder or promote information and access to desperately needed health care. These factors can reduce or increase people’s vulnerability to disease and infection, and promote or retard their efforts towards self-determination and opportunity. At the same time, we have learned how personal health and the means to control reproduction are preconditions to negotiating power, asserting rights and making choices. Our contributors addressed issues of health and rights from the standpoint of both the individual and the public. Where these two perspectives intersect, daunting challenges emerge and the rights framework must then recognize and accommodate ethical complexity and the fact that in many circumstances—from a policy standpoint—there is no single right answer and no one solution that meets the needs of all individuals.

I am struck by the consensus among us. We are all searching for ways to embrace and understand human rights in relation to other sectors as a transforming idea. We have discovered it *is* possible to find circumstances in which norms have been changed, or old norms overcome, when confronted by both the need and the mandate to improve the lives of women within the context of linking health and rights together.

Asha Mohamud and Elaine Murphy gave an instructive overview of sex and sexuality and how one’s sexuality is often distorted by social environment, cultural, economic and political factors. Although few programs have gone beyond the “plumbing” to address sex and sexuality in the context of gender and human rights, those that have find that such awareness-raising changes people forever.

Allan Rosenfield, in looking at maternal mortality from a gender and human rights perspective, reminded us of the short history of human rights—

¹Formerly AVSC International

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conceptually—in the world, and of just how recent many of the important universal declarations and treaties setting out these rights really are. He made the point powerfully and from many angles that maternal mortality is undeniably a human rights matter and that the human rights perspective has to move forward. Ensuring the human rights approach may bring progress that has not been heretofore seen in providing access to services for households and communities in developing countries.

Jim Shelton emphasized that tensions arise around the more basic needs of coverage. Lack of resources—physical, human and financial—is not the only problem, but is a real constraint. We are unlikely to ever see equal distribution of wealth and financial resources. Therefore, we must find ways to get the “what” and the “how” correct. The public health community must be concrete, in terms of stating goals and objectives, so that we can focus on how to allocate resources. Using Disability Adjusted Life Years (DALYs) is an attempt to bring this together for the better; however, DALYs do not meet the human rights test.

Regan Ralph explained why a rights perspective is needed in promoting access to and quality of reproductive health care and traced the history of rights activism, highlighting intersections between reproductive health and rights. She provides compelling evidence that without awareness of their human rights, women’s health is at grave risk. With such awareness, women have the tools to begin to fight for their right to health.

Anika Rahman reviewed many of the treaties that specifically define rights in relation to family planning and reproduction. She explained that human rights address both access to services and those treatments and choices afforded individuals by service providers and service sites. She also addressed gaps in the treaties that affect, and often hinder, their effective implementation. On abortion and human rights, Anika reminds us that advances have been made to decriminalize abortion, but that the controversy surrounding this aspect of reproductive health and rights is far from being resolved. Interestingly, it seems that precisely because family planning, and especially abortion, are so controversial in some national, religious or cultural contexts, these reproductive health services have in fact been examined from a rights perspective more than any other.

Geeta Rao Gupta made almost tactile the urgent need to look at health and rights together in the real context of societal complexity. She stressed that individual behavior cannot be viewed as entirely volitional, as in the case of sexual risk-taking. Instead, individual behavior is often the outcome as much as the cause of social, cultural and political determinants—forces generally outside individual control. She urges us to move beyond a traditional public health model. She speaks to women’s powerlessness and poverty and the need to address and change both. Geeta touches on the complex ethical conundrum in relation to HIV drug availability for women in pregnancy, especially in poor Southern countries or as

part of clinical trials, reminding us in this context how much power and economic status affect rights and health. As always, she asks us to look broadly at larger socioeconomic circumstances, such as gender inequality and the distribution of power, factors that have an impact on all aspects of individual health, behavior and rights.

Lori Heise and Mary Ellsberg powerfully portray the relationship between human rights and violence. They note that women constitute 70 percent of the world's absolute poor and that being poor is a risk factor for domestic violence and abuse. They raise the question of norms of behavior that can permit or even encourage wife-beating as an acceptable act within a particular social context. I was overwhelmed by their data on violence, sexuality and health, as I have never before seen such a comprehensive analysis of the many ways that the denial of women's basic rights to equality and security of the person can work to condemn them to ill health and a life of restricted choice. As someone who long ago worked in public clinics where as many as 65 percent of the clients had been sexually abused, I have long been familiar with these connections, but I have never seen the whole picture woven together with such force. Lori and Mary concluded by encouraging work at the grass roots where real change must begin. But, there must also be a commitment at national levels...and what of men as a target of change?

Jodi Jacobson illustrated that some government reproductive health services and donors are beginning to integrate rights- and health-based policies as they respond to the mandate to change historically demographic approaches to service delivery. Traditional programs have largely focused on numbers of contraceptive users rather than on quality of care at the client-provider level and have ignored women's risks of STIs and sexual coercion. Jodi cautions us, however, that policy change may not necessarily mean real change, and that researchers and activists must monitor the situation.

Naisiadet Mason's personal story reminded us just how desperate is the need for the public health community to address cultural norms and to move beyond efforts to "address risky sexual behavior." She shared with us her own history, which illustrates that we must embrace multi-sectoral approaches in order to begin to have a meaningful impact on power dynamics, especially those between partners and within families.

In 1971, I was in rural India. Health services were scarce. I watched a woman bleed to death in childbirth in the presence of her husband and children. They wailed with gut-wrenching agony. Have you ever seen a woman die in childbirth? I cannot describe for you a much more horrible event. It is war individualized. In the final moments it is two hearts and two souls exposed in death. It is, in at least three-quarters of the cases, preventable and therefore, simply

In India...I watched a woman bleed to death in childbirth in the presence of her husband and children. They wailed with gut-wrenching agony. Have you ever seen a woman die in childbirth?...It is war individualized. In the final moments it is two hearts and two souls exposed in death. It is, in at least three-quarters of the cases, preventable and therefore, simply put, it is one of society's greatest failuresWhen you have been there as a participant in this failure, or as a witness, a part of those souls remain with you for your lifetime.

put, it is one of society's greatest failures...in one little room somewhere... as the life of one more woman slips away. When you have been there as a participant in this failure, or as a witness, a part of those souls remain with you for your lifetime.

Earlier this year I visited the region of Kaolack, in Senegal. There is a health center where many women come for delivery because they are told that it is safer than delivery at home. Picture this if you can. The building is in decay. The ceiling is falling down. In the room where women deliver, the beds are all rusted with broken springs and bits of yellow mattress, blood stained. There are no window screens. There are flies, lots of flies. There is no sign of running water. In the back of the room there is screaming. A woman is lying on a wooden palette. Her legs are held up by another woman. She is having a D-and-C (dilation and curettage) procedure without anesthesia. In Kaolack, in the area served by this health center, anywhere from 850 to 1,300 women die in childbirth for every 100,000 live births.

As an obstetrician and gynecologist, I relate this picture of reproductive health services because it is the part of the equation with which I am most familiar. What does it really mean to talk about the rights framework in this context? The right to safe services? The right to information, to informed choice? The right to be empowered to minimize the preconditions of life, gender inequity, political, economic and sociocultural inequity that make it impossible to *be* an individual with rights?

As a physician, I struggle to see beyond the most immediate cause of my distress—the tangible horror of bad health services. What I am looking for is common ground in the search for the policy commitment, services and life circumstances that will support the right of individuals to have and choose services that are the best possible, given the constraints, but without neglecting the one for the many or the many for the one.

For me, the rights framework creates a check and balance for the sometimes overly utilitarian and paternalistic thinking of policymakers and health professionals. This framework helps us screen for what is clearly unacceptable, even if it fails to answer all the hard questions for us. The rights framework gives health professionals and advocates a common language for assailing the unacceptability, for example, of substandard and inhumane maternity wards. It helps us focus on the fact that decent and acceptable services, which prevent maternal death and treat women with dignity, are entitlements because they are fundamental to what it means to be human. But we need the framework to accommodate both policy ideals and real constraints and to bend when the rights and needs of different individuals are at odds. There is no “one size fits all” solution.

I have a reputation for dealing with controversial issues in reproductive health so I would like to conclude by quoting a controversial author. This should serve as food for thought regarding the magnitude and significance of the Cairo Agenda and what we as advocates are striving for: *“There is nothing more difficult to carry out nor more doubtful of success nor more dangerous to handle than to initiate a new order of things”* (Machiavelli).

12. Next Steps

We are well pleased with this thought-provoking dialogue on commonalities and differences between the human rights and public health approaches to reproductive health. However, we are also aware that another “A” word is crucial—action. All of us, individually and together, can make a difference. As Anne Wilson noted: “If you are breathing, you can do something!” We also need to follow-up on Machiavelli’s challenge and do something really dangerous: we need to implement reproductive health programs that address not only women’s needs but also women’s rights.

PATH and the Global Health Council are working with our other partners—CHANGE, CRLP, Columbia University School of Public Health, The Futures Group International, George Washington University School of Public Health, Human Rights Watch, the Pan American Health Organization and the World Bank—and other groups to hold follow-up seminars and to make presentations on reproductive health and rights at professional conferences. We feel it is important to educate Congress on these issues, so we are also organizing briefings on the Hill in collaboration with the Women’s Political Caucus, the Human Rights Caucus and the International AIDS Task Force. [See Appendix D for a list of follow-up activities that have occurred since the dialogue took place.]

This dialogue has been a source of new insights and inspiration. We know that this is just the beginning as we work together to advance reproductive health, gender and human rights issues. We thank all involved, including the more than 160 participants who came from all over the United States and even overseas, and the presenters who updated their papers for this publication.

*by
Elaine Murphy,
Director, Women’s
Reproductive
Health Initiative,
PATH
and
Carol Miller,
Director of
Advocacy, Global
Health Council*

Appendix A:

Agenda, Dialogue on Reproductive Health, Gender and Human Rights, December 8, 1999

8:45-Welcome

Anne Wilson and Elaine Murphy, Program for Appropriate Technology in Health (PATH), and Karen Mason, World Bank

9:15-Reproductive Health, Gender and Human Rights: the Sexuality Connection

Asha Mohamad, PATH

9:40-Maternal Mortality as a Human Rights and Gender Issue

Allan Rosenfield, Columbia University School of Public Health

10:00-Discussion

Facilitated by Martine de Schutter, Pan American Health Organization

10:30-Break

10:50-Women's Reproductive Health: The Public Health Perspective

Jim Shelton, USAID

11:10-Challenges in Promoting Women's Reproductive and Sexual Rights

Regan Ralph, Human Rights Watch

11:30-Discussion

Facilitated by Norine Jewell, The Futures Group International

12:00-Summary of Morning Sessions

Tom Merrick, World Bank

12:30-Lunch

1:30-Family Planning and Abortion: A Human Rights Perspective

Anika Rahman, Center for Reproductive Law and Policy

1:50- "It's Not Fair:" HIV/AIDS, Gender and Human Rights

Geeta Rao Gupta, International Center for Research on Women

2:10-Violence Against Women: Impact on Sexual and Reproductive Health

Lori Heise, Center for Health and Gender Equity (CHANGE)

2:30-Discussion

Facilitated by Rosalia Rodriguez-Garcia, George Washington University, Center for International Health

3:00-Break

3:20-Transforming Family Planning Programs: Towards a Framework for Advancing the Reproductive Rights Agenda

Jodi Jacobson, Center for Health and Gender Equity (CHANGE)

3:50-Integrating Women into HIV Programs in Africa: A Personal Story

Naisiadet Mason, Society for Women and AIDS in Africa

4:10-Discussion

Facilitated by Anu Kumar, MacArthur Foundation

4:40-Conclusion: Reproductive Health and Human Rights in the Real World

Amy Pollack, EngenderHealth

5:00-Next Steps

Elaine Murphy, PATH, and Carol Miller, Global Health Council

Appendix B:

List of Participants

Participants are listed under the organizations with which they were affiliated at the time of the December 1999 conference. Organizations are listed alphabetically.

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Appendix C:

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Appendix D:

Follow-up Activities to the Dialogue on Reproductive Health, Gender and Human Rights

Conferences are all too often singular events that stimulate participants, raise awareness and galvanize attention to a particular issue or cause. However, without concerted follow-up efforts, the enthusiasm and commitment generated by the high caliber of presentations and dialogue may quickly fade away. The partners responsible for organizing this conference were determined to keep the issues fresh, alive and in front of our constituents. Subsequent to the December 1999 Dialogue on Reproductive Health, Gender and Human Rights, the co-sponsoring organizations—PATH's Women's Reproductive Health Initiative, the Global Health Council (GHC), the Center for Health and Gender Equity (CHANGE), the Center for Reproductive Law and Policy (CRLP), Columbia University School of Public Health (CU), The Futures Group International (TFGI), George Washington University School of Public Health (GWU), Human Rights Watch (HRW), the Pan American Health Organization (PAHO) and the World Bank (WB)—and sometimes other groups—built on this successful and stimulating day by organizing and/or making presentations at the following events:

Date	Topic of Meeting	Location of Meeting	Organizing/Presenting Partners
1/00-3/01	Co-organized and co-moderated four Men & RH meetings.	Washington, DC	USAID, PATH and IPPF/WHR
2/24/00	Behavior Change Communication in Reproductive Health	World Bank	World Bank and PATH
3/13/00	Microbicides Political Education Day	U.S. Congress	CHANGE, PATH and Microbicide Alliance
3/21/00	Brownbag seminar on vesico-vaginal fistula (VVF)	PATH (DC)	CHANGE and PATH
3/21-22/00	Psychosocial Workshop on Reproductive Health	Los Angeles	PATH, CHANGE and TFGI made presentations
3/23-24/00	Population Association of America conference	Los Angeles	PATH organized and moderated panels on RH and on Men & RH; TFGI made presentations
5/24/00	Trafficking Seminar (co-organized and co-sponsored with WRHI)	U.S. Capitol	Global Health Council, PATH, CRLP, TFGI and Human Rights Law Group

Date	Topic of Meeting	Location of Meeting	Organizing/Presenting Partners
6/12/00	Brownbag presentation by Iyeme Efem, Nigerian AIDS specialist, on brideprice and women's vulnerability	PATH (DC)	PATH
6/13/00	Presentation by Mila Tan on harm reduction for sexually exploited children	GHC conference, Washington, DC	PATH and GHC
8/23/00	Briefing on "Nations in Crisis and Women's Reproductive Health"	U.S. Capitol	GHC, CRLP, AVSC and PATH
9/3/00	RH, Gender & Human Rights plenary session at the Congress of the World Federation of Public Health Associations; other talks on FGM, CPI & user-friendly family planning methods	Beijing, China	PATH, World Bank, WHO and Georgetown U. Institute for Reproductive Health (GU/IRH)
9/18/00	Meeting to develop index to monitor countries' compliance with Convention on Elimination of All Forms of Discrimination vs. Women (CEDAW)	American Bar Association, Washington, DC	ABA organized meeting; PATH, CRLP, and HRW participated
10/11/00	USAID MAQ Co-chairs meeting	USAID	PATH and AVSC chaired Client-Provider Interaction Committee
10/12/00	Presentation on WRHI's Stop-Traffic listserve (www.stop-traffic.org)	Washington, DC	PATH
11/13-15/00	American Public Health Association meeting; WRHI organized panel on RH, Gender & Human Rights; gave talks on ICPD-friendly curricula for schools of PH & on men & RH indicators	Boston, MA	PATH, Columbia U. SPH, ICRW, Women's Health Exchange and IPPF/WHR

Date	Topic of Meeting	Location of Meeting	Organizing/Presenting Partners
11/16/00	Congressional briefing on FGM	U.S. Capitol	GHC, CRLP and PATH
12/4/00	Meeting to plan conference on violence against women	Washington, DC	PATH and American College of Nurse-Midwives (ACNM)
2/01	Panel on client-provider interactions at Society for Reproductive Care meeting	Bali, Indonesia	GU/IRH, AVSC & PATH
3/1-2/01	"Power in Sexual Relationships" conference	Washington, DC	Population Council, IPPF/WHO, ICRW, PATH and USAID Men and Reproductive Health Committee
3/26-27/01	Presentations on men & RH and on adolescent RH at Psychosocial Workshop	Washington, DC	PATH
3/28-31/01	Two panels on quality of care in RH services at Pop. Assoc. of America conference	Washington, DC	GU/IRH & PATH; other partners also presenting
5/29-6/1/01	Plenary sessions on women's health and rights; panels on trafficking, on adolescent RH and on FGM at GHC conference	Washington, DC	GHC, PATH, Human Rights Law Group, Pacific Institute for Women's Health, Advocates for Youth, FOCUS, CARE & Population Council
9/11-13/01	Anti-trafficking Programs & Indicators	Katmandu, Nepal	Population Council, PATH, Human Rights Law Group, GATTW

The mission of PATH's Women's Reproductive Health Initiative (WRHI) is to advance the implementation of the policies agreed upon at the UN International Conference on Population and Development (ICPD), held in Cairo in 1994. ICPD policies promote access to a broad range of client-centered reproductive health services, within the context of informed choice, confidentiality and privacy. ICPD also addresses gender inequity and human rights abuses, including gender-based violence, trafficking, early marriage and FGM. It encourages the constructive involvement of men to help overcome these problems and to meet their own reproductive health needs. With the support of the John D. and Catherine T. MacArthur Foundation, the Ford Foundation, and the PATH Fund, WRHI publishes articles and reports, disseminates "ICPD friendly" curricula to schools of public health, and organizes seminars to provide information and to foster action on these issues.

PATH is an international not-for-profit-organization whose mission is to find and implement solutions to critical health problems, especially those affecting women and children. PATH is widely recognized for its collaborative work with local and international partners and its success in building and sustaining public- and private-sector partnerships. PATH develops and adapts technological “hardware” for improving health, such as new contraceptive devices, diagnostic tests, and single-use syringes. Working with its local partners, PATH also develops technological “software,” — behavior change communications, community and social mobilization strategies, and research-based advocacy to successfully introduce new technologies, improve health outcomes, end harmful cultural practices, and promote gender equity and human rights. Through its technological innovation and programs, PATH strives to achieve a favorable and sustainable impact on the health and well-being of our global constituents. PATH is based in Seattle, Washington, and has 20 program offices in 12 countries.

path

Program for Appropriate Technology in Health

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