

## **B4 | Sexual and reproductive health**

The first global agenda for sexual and reproductive health and rights was agreed at the UN International Conference on Population and Development, Cairo 1994 (referred to in this chapter as ‘Cairo’). It marked a paradigm shift away from a narrow, technical, medical approach based on delivery of services and numbers rather than well-being – placing rights at the centre of population and development, and defining reproductive health as ‘a state of complete physical, mental and social well-being ... in all matters relating to the reproductive system and to its functions and processes ... Reproductive health implies that people are able to have a safe and satisfying sex life and have the capacity to reproduce and to have the freedom to decide if, when and how often to do so’ (UNICPD 1994).

This broader approach to reproductive health moved the Cairo agenda into political and economic debates over access and rights to knowledge, resources and appropriate services, making it highly contested (Lohmann 2003, Petchesky 2003, Sen and Barroso 1996). The macroeconomic conditions of the 1990s, described in part A, worked against it. Women and health movements in civil society and their allies in UN and national bureaucracies have undertaken strong campaigns to link public health, gender equality and development policy, and advocated nationally and internationally for the upholding of rights to be backed by the appropriate knowledge, services and funds.

This chapter maps out the economic and political debates determining the sexual and reproductive health and rights agenda, in order to understand where we are now and make proposals for moving forward. It reviews the Cairo consensus as the global normative rights framework, presents some of the reasons for the difficulties in meeting it, and concludes with recommendations for activists. In the spirit of the Global Health Watch it is strongly critical of the current mainstream approach to development, while advocating strategic engagement with governments and multilateral institutions.

### **The Cairo consensus**

The term ‘reproductive rights’ emerged in the 1980s on the second wave of feminism largely generated by the women’s movements in North America, Europe, Australia and Latin America. The consensus focused on women’s liberation and autonomy, violence against women, the fight for abortion and

'our body ourselves' (what was called 'body politics'). Women from the South expanded the concept to embrace maternal health and morbidity, childbearing and child-raising. The formation of the Cairo consensus was complex, bringing together the North and South agendas developed through regional and international meetings led by networks of southern-based women such as the Women's Global Network for Reproductive Rights, DAWN and the International Women's Health Coalition (Correa 1994, Petchesky 2003, Antrobus 2004).

These movements have different emphases but many shared concerns, and the global reproductive health and rights movement managed with the support of UN agencies (particularly UNFPA) and some governments to establish a consensual women-centred and rights-based framework. In Latin America women's health movements emphasized quality reproductive and sexual health services in the face of religious and state oppression and in the context of citizenship needs. In Asia women were concerned with population control and coercion, maternal mortality, the health of the girl child and all forms of violence against women. Activists in Africa were concerned with poverty and survival issues, maternal mortality and morbidity, sexually transmitted diseases and HIV/AIDS. European and North American women focused on autonomy and expression, the medicalization of reproductive health and the rising cost of services. Middle Eastern women were concerned with access and rights to holistic reproductive health care throughout the life cycle. Central and Eastern European women focused on public health, gender equality and women's rights issues (Bandarage 1997, IRRAG 1998, Harcourt forthcoming).

Cairo presented a rights-based framework for population stabilization, discrediting old population control programmes. Its goal is to make reproductive health care services universally accessible through primary health care no later than 2015. The new consensus discredits the targeted approach to population control, rejects incentives and targets in family planning and underlines the need for comprehensive reproductive health services. It also defines health services as encompassing family planning care during pregnancy, prevention and screening of sexually transmitted diseases, basic gynaecological care, sexuality and gender education and referral systems for other health problems. It adopts a life cycle approach with services for all aspects of reproductive health rights. Although it fell short of demanding universal safe and legal abortion, it asked countries to deal with the public health consequences of unsafe abortion and to ensure that where abortion is legal it is safe (The Corner House and WGNRR 2004).

The Cairo programme of action is not binding but has proved a useful lobbying and advocacy tool. It has also been used more broadly as a platform



**10 Policy-makers are gradually acknowledging men's household responsibilities.**

for women's rights because of its emphasis on gender equality and public health and development, and its links to the Beijing platform of action (Fourth World Conference on Women 1995). It was used to push for women's inclusion in decision-making in Brazil; to fight for changes in property rights in Kenya; and to lobby for human-centred health and development in the Philippines. It persuaded the government of India to abandon targets and overt forms of coercion. Governments now speak of reproductive rights, men's responsibility, women's empowerment and women's rights instead of population control, family planning methods and mother and child programmes. However, despite indications of success in reproductive health education, access to contraception, infant mortality and skilled care during childbirth, five- and ten-year reviews show that the programme is still far from being implemented.

### **What is undermining Cairo?**

Many macroeconomic factors undermine Cairo, linked to a growingly conservative environment and the predominance of World Bank policies. For example, the Millennium Development Goals do not include the sexual and reproductive rights agenda (Barton 2004, Harcourt 2004), a telling indication of how much ground the Cairo agenda has lost. The goals exclude sexuality, reproductive rights and health as determinants of gender equality, and focus on education for girls and maternal health and morbidity. This places women and children's right to health within a purely biological framework.

'As feminists and women's rights activists we must continue to maintain a critical surveillance of the implementation of MDGs in order to protect our interests in equality and nondiscrimination,' warns Sunila Abeyesekera from Sri Lanka (ARROW 2004).

The goal to reduce maternal mortality is nevertheless important as more women are dying in childbirth and suffering from chronic ill health following complicated deliveries than 10 years ago. Maternal mortality remains a priority in Sub-Saharan Africa and south Asia in particular. However, the absence of other reproductive health and rights concerns reflects the UN's reluctance to recognize or take a strong stand on other sexual and reproductive health and rights issues in many arenas, particularly women's autonomy to choose, abortion and sexuality (DAWN 2004).

The universal rise of fundamentalism has fired a 'morality' debate with many examples of how these conservative approaches are undermining the sexual and reproductive health and rights agenda. One is the rule imposed by President Bush in 2001 prohibiting overseas NGOs from receiving US government aid if they promote or provide referrals for abortion. In 2002, the US government withheld US\$ 34 million promised to UNFPA because it said it funded abortion in China. Meanwhile it is funding the anti-abortion lobby and promotion of abstinence overseas (using the ABC approach: Abstinence until marriage, Be faithful and Condoms where appropriate (Jacobson 2003)). The Vatican and conservative states consistently attack the sexual and reproductive health and rights agenda. Such strategies threaten many sexual and reproductive health and rights projects in the global South and are leading to increased unsafe abortion, closure of family planning clinics and shortages of contraceptive supplies.

Lack of donor funding is not the only obstacle. Broader underlying economic and political conditions are undermining women's health and their control over safe sex and childbearing. Health services are in decline and economically poor women in particular have little or no access to reproductive or other health services. Recent reports on poverty have tracked the deterioration of women's health, particularly those who are economically vulnerable. Global inequalities in income and health have been growing and hunger has increased despite falling population growth, as detailed in part D, chapter 3 (Yong et al. 2000, Desai 2004, Rao 2004).

Many activists are developing an alternative vision far more critical of the development establishment and globalization that goes beyond the Cairo consensus. They believe Cairo went along too readily with the neoliberal agenda that is proving so disastrous for the poor, the vast majority of whom are rural

women and girl children. Structural adjustment and trade policies are leading to greater exploitation of women's time/work and sexuality (see, for example, Rao 2004, Antrobus 2004, Harcourt 2004, The Corner House and WGNRR 2004). Structural adjustment packages or privatization of health services, if and when they provide reproductive health care, offer a narrow family planning package mainly for women plus some treatment for sexually transmitted illnesses and child health. It is often provided only as emergency care with a user fee, or only in urban areas.

Cairo took a passive line and as a result could not guarantee women the basics they need to make reproductive health choices. It failed to take into account the power imbalances in economic and social structures among and between countries and between men and women. Some say its tendency to focus on abortion and reproductive rights marginalized the basic issues of primary health care, social security and investment in health systems. In reality women's health is largely determined by economic and social constraints – it is difficult to separate out reproductive rights and health from other economic and political rights and needs (such as land rights, food security and communal harmony) that impact on economically poor women's lives.

This more critical agenda proposes that the sexual and reproductive rights framework must be embedded in an understanding of both human rights and macroeconomic policies. In the years after Cairo many more women's groups began to make the links between trade and health and gender inequality, arguing that the increased violence against women and rise in fundamentalism is linked directly to market-oriented globalization. The fundamentalism of the market joins the fundamentalisms of ethnic, religious and moral right-wing groups in dismantling women's livelihoods, economic security and control over their lives and bodies. All this threatens women's hard-won health rights and access to resources that enable choices promoting health and well-being (UNFPA 2002).

Prejudice against poor women is so great that it amounts to a neo-Malthusian approach, some argue, embedded in US-led economic, development and migration policy that bolsters racism and fear. 'The programme of action has been one of the most controversial and challenged UN agreements in the last 50 years,' says Steven Sinding, director general of the International Planned Parenthood Federation. 'Sexual rights and reproductive health have become targets of new attacks from conservative and religious right forces. We need to identify and understand the main forces that are threatened by the Cairo consensus, and are working actively to undermine it' (Sinding 2004).

Activists must therefore work beyond the Cairo consensus and form

alliances with a range of social movements striving for health, economic and social justice as part of the broader politics of social and economic transformation (see Box B4.1).

#### *Box B4.1 Resources*

*ARROW*, the Asian-Pacific Resource and Research Centre for Women, is an NGO committed to promoting and protecting women's health rights and needs, particularly in the areas of sexuality and reproductive health (<http://www.arrow.org.my>).

*The Corner House* carries out analyses, research and advocacy with the aim of linking issues, stimulating informed discussion and strategic thought on critical environmental and social concerns, and encouraging broad alliances to tackle them (<http://www.thecornerhouse.org.uk/briefing/index.shtml>).

*The Center for Reproductive Rights* is a nonprofit, legal advocacy organization that promotes and defends the reproductive rights of women worldwide (<http://www.reproductiverights.org>).

*DAWN* (Development Alternatives with Women for a New Era) is a network of women scholars and activists from the economic South who engage in feminist research and analysis of the global environment and are committed to working for economic justice, gender justice and democracy (<http://www.dawn.org.fj/publications/DAWNInforms>).

*The International Planned Parenthood Federation* (IPPF) is the largest voluntary organization in the world concerned with family planning and sexual and reproductive health. See in particular the score card system and the report of the Countdown 2015 Roundtable, London 2004 (<http://www.ippf.org/resource/index.htm>).

*International Women's Health Coalition* (IWHC) works to generate health and population policies, programmes, and funding that promote and protect the rights and health of girls and women worldwide. Its priorities are youth health and rights, safe abortion, sexual rights and gender equality, and HIV/AIDS and women (<http://www.iwhc.org>).

*The UN Population Fund* (UNFPA) is the world's largest international source

of funding for population and reproductive health programmes (<http://www.unfpa.org>).

*UNIFEM*, the UN women's fund, provides financial and technical assistance to innovative programmes and strategies that promote women's human rights, political participation and economic security (<http://www.unifem.org>).

*Women's Global Network for Reproductive Rights (WGNRR)* is an autonomous network of groups and individuals in every continent who aim to achieve and support reproductive rights for women (<http://www.wgnrr.org/frameset.htm>).

*WHO Reproductive Health and Research* comprises the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), and Programme Development in Reproductive Health (PDRH) (<http://www.who.int/reproductive-health>).

*WICEJ* is an international coalition representing organizations in all regions. It works to link gender with macroeconomic policy in international intergovernmental policy-making arenas from a human rights perspective (<http://www.wicej.addr.com/publications.html>).

## Where are we now – the challenges

Progress is being made in some areas of sexual and reproductive health, despite vocal and organized opposition, setbacks and an increasingly hostile economic and political context. Governments around the world have adopted the Cairo framework and reaffirmed it in regional meetings in 2003–4. These reviews and other global meetings have also signalled some important new concerns.

*Macroeconomic environment* Health activists need to understand how macroeconomic trends are determining women's autonomy, sexual and reproductive rights and health. Sexual and reproductive health and rights activists need to join others working for broad social and economic transformation.

*Fundamentalisms* A concerted effort is needed to ensure that different forms of fundamentalism do not undermine the rights agenda. The politico-religious

fundamentalisms are most prevalent, from Christianity to Islam and Hinduism. The rise of the fundamental political right in extremist movements across Asia, Latin America and the US is having a grim impact on women.

*Poverty* A major Cairo victory was to link poverty, development and population concerns to a range of social justice goals – gender equality, women’s empowerment, and human rights. Today’s agenda must recognize that this linkage requires a critique of the current development model, and public investments and resources to restore public health systems. Public health decision-making must be accountable to women, the poor, minorities, migrants, indigenous peoples and youth, enabling them to voice their own needs.

*HIV/AIDS* The pandemic has worsened dramatically since Cairo. Linkages should be made between HIV/AIDS and sexual and reproductive health, mainstreaming it in policies, programmes and practices. This requires reaching out to networks of HIV-positive people and affected communities, linking in terms of funding, advocacy and policy. Activists must also take into account the sexual and reproductive health rights and needs of youth, men who have sex with men, injecting drug users and sex workers. Practical measures are needed such as voluntary counselling and testing, condom promotion and access, programmes to prevent mother to child transmission, antiretroviral access and management and treatment of sexually transmitted illnesses. Social and cultural factors that define masculinity and their implications for their sexual partners, male and female, must also be addressed.

*Abortion* Unsafe illegal abortion is still a major cause of maternal death, particularly among young, poor and rural women. The Cairo discussion on abortion focused primarily on the public health impact of unsafe abortion. It also affirmed a woman’s right to make decisions about her reproductive health and whether and when to have children. Many obstacles remain despite efforts in numerous countries to change laws and make safe services more accessible. Abortion must stay on the agenda. Making it safe, accessible and legal requires an alliance between many actors. Communication strategies are needed to influence public attitudes.

*Sexuality* Sexuality is now more openly discussed in policy debates, although sometimes in moralistic or victimizing terms in relation to women’s sexuality and choices. It is important to ensure sexuality can be spoken about in relation to rights, equality, personhood, and freedom from shame and fear. The



debate on sexuality that Cairo stimulated needs to be continued among people of all ages in ways that address gender roles, power relationships, sexual diversity and sexual orientation. This is particularly important in the face of a re-emergence of the abstinence and virginity debates, continuing discrimination against gay men and women, and taboos against sexual pleasure.

*Maternal health* Reducing maternal mortality and morbidity demands more funding and attention. It should be understood as a complex political, socio-economic and cultural issue that requires major changes in health care and services, and cultural and political attitudes. The empowerment of women, families and communities and a shared sense of responsibility for pregnancy are needed so that women are in a position to ask for and receive access to good quality care. Functioning, well staffed health services are essential to prevent deaths from obstetric emergencies.

*Women's rights and men's responsibilities* Cairo shifted the focus from demographic targets to individual rights and needs, but women's rights are now under attack. Even if terms like gender, rights, sexuality and violence against women are on the mainstream health agenda, the challenge is to find the means to apply them in ways that will bring real change. Beyond the economic underpinnings there are also cultural and social needs to increase men's involvement and responsibilities through recognizing how masculinity operates in traditional power relations. More work and funding are needed to encourage men in non-violent behaviour, and to support women's rights and gender equity.

*Youth rights and health* Youth has become a much stronger issue since Cairo, in terms of both participation in the movement and their own needs and rights. It is now recognized as essential to respect and promote young people's human rights, including their sexual and reproductive rights. Youth – like women – is diverse, and rural youth, married adolescents, and out-of-school youth are especially likely to be marginalized. Health services should be youth-friendly, guaranteeing confidentiality, tolerance and understanding. Secular and religious education, the media and the Internet are all critical in promoting knowledge and honest and open discussion of sexual pleasure and identity, self-esteem and self-image. Involving youth in decision-making and policy formulation is vital.

*Funding* The estimated cost of universal access to sexual and reproductive

### *Box B4.2 Youth rights in Africa*

The implementation of social and economic policies for youth is still only a dream. Of particular concern is the lack of policies addressing sexual and reproductive health and rights for young people, for example access to youth-friendly health services with information on sexual and reproductive health – without which adolescents are at a much greater risk of contracting STIs/HIV/AIDS, sexual abuse or unwanted sexual relationships and unwanted pregnancies. (Neema Magnana, Africa Regional Youth Initiative, April 2004)

health services is US\$ 23 billion for 2005. Donors therefore have to triple their commitment. This is not just a question of activists lobbying governments on the basis of the promises made in Cairo; it requires governments, officials, parliamentarians and NGOs to work together to prove the economic and social benefits of sexual and reproductive health for all. Gender budgeting, introduced in the late 1990s and now practised in many countries, is a useful strategy to ensure that government resources are being spent on programmes and services that address women and men in an equal way and take gender needs into account. 'Gender budget analysis provides women with an indicator of government commitment to address women's specific needs and rights to health care, education and employment' (UNIFEM 2005).

### **Recommendations**

Sexual and reproductive health and rights activists have two key strategies: to build on the Cairo consensus, and to join with others to change economic and political realities. The first approach assumes that empowerment is possible if current institutions and access to funding change, and if the UN systems and the rights framework deliver the Cairo and millennium goals. The second sees change as possible only with profound power shifts and radical social and economic change; it is not a question of negotiating with institutions or waiting to be empowered.

A mixed approach would be most effective. Only a reformist agenda negotiated with those in power may be possible for some groups, while for others a more pluralistic agenda working from the grass roots is possible, taking power while analysing the political and economic terrain. For example, joining forces with social movements to lobby for an end to debt will help release resources to create better conditions for poor women and men's health. In both cases

the sexual and reproductive health and rights agenda has been well mapped out – the question now is how to convince others to understand those maps and strive to make the vital changes needed.

*Strengthen the human rights framework* Globally and nationally activists should work with human rights activists to ensure that human rights norms and standards, legal obligations and mechanisms of accountability for sexual and reproductive health are in place. Both groups need to strengthen capacity and understanding. The 2005 national, regional and global reviews of the Millennium Declaration and the Fourth World Conference on Women are important avenues for civil society to work with women's rights activists to ensure that the UN system continues to address violence against women and reproductive health and rights.

*Work in alliances for economic and social justice* Activists should develop strong links with women's groups working on economic and social justice issues to develop a framework based on macroeconomics, rights and gender justice that takes a holistic approach to women's livelihoods, health, and sexual and reproductive rights. They should build alliances with social movements engaged, for instance, in the World Social Forum, the People's Health Movement and peace movements.

*Fight against fundamentalisms* NGOs and governments should work together to counter the strategies of the fundamentalists and conservative right that are undermining the gender equality, sexuality and reproductive rights agenda. Activists should reach out to progressive religious voices and challenge those who distort religious teachings through violence, suppression, discrimination, shame and guilt.

*Support policies for greater bodily integrity* Activists should work with women's, youth and community organizations, policy-makers, trade unions, health and legal professionals, researchers and journalists to improve access to family planning services, and to establish, preserve and implement laws, norms and regulations that make safe, legal abortion accessible and available. These recommendations should be based on WHO guidance (WHO 1995) and implemented in line with principles of social justice and human rights.

*Hold donors, governments and institutions to account* Holding governments and key institutions accountable is critical – building on the work of many

global networks. Sexual and reproductive health and rights must be strengthened in the Millennium Development Goals (see UNDP 2003 and IPPF and WGNRR newsletters).

*Measure progress* Better ways to measure and assess progress and thereby ensure more appropriate knowledge are needed. Measuring and assessing progress since Cairo has been led by WHO and Population Action International indicators and reports. Innovative approaches like the IPPF reproductive health report cards should be supported and extended to measure the contributions of different actors.

*Produce better research* Health and social science researchers should evaluate reproductive health successes and failures more accurately, working with health workers and NGOs to develop community-level data. Individual reproductive health and the quality and use of programme services at community and national level should be assessed. There is a need to understand links and causes as well as measuring multiple indicators. Governments and research institutes should produce gender-disaggregated data, and use more innovative research methods that draw on information from diverse sources.

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