Wellbeing and Reproductive Freedoms:
Assessing Progress, Setting Agendas

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This paper examines the linkages between wellbeing and reproductive rights with a view to looking at how reproductive needs are interpreted and assessed in international social policy forums. It is premised on the view that such assessments feed into the setting of agendas and the particularities of how they are formulated and subsequently addressed. Selected approaches to understanding wellbeing are reviewed in order to, firstly, tease out the significance of freedoms as part of wellbeing and, secondly, to discuss their implicit or explicit interpretations of processes of social differentiation. The 'fit' between these ideas and complex understandings of reproductive behaviour, health and rights are considered and a political perspective on 'needs talk' is used to problematise the negotiation of rights within social policy. For the most part, reproductive health policy-making has assumed what reproductive needs look like in different contexts, offering limited space for collective engagement with or accountability to civil society groups, and neglected a focus on social justice and problematic inequalities. It is argued that global monitoring of wellbeing has so far neglected rights dimensions and attempts to assess progress with respect to human freedoms are examined. The implications of the elaboration of reproductive rights as human rights for global monitoring of reproductive health is similarly assessed. Future challenges include the need to develop mechanisms for the interpretation of reproductive needs and to integrate concern for reproductive freedoms into both the monitoring of reproductive health and the setting of agendas for social policy about reproduction.

Introduction

An earlier paper (Locke 2001) examined the reproductive rights discourse in the context of globalised social policy and explored the opportunities and constraints for mainstream reproductive rights discourse to contribute to policy-making for improved wellbeing. It concluded that struggle over the definition of reproductive rights remained an important arena if their new orthodoxy is to add value to social policy commitments. This paper aims to contribute to this debate by examining the linkages between wellbeing and reproductive rights with a view to how reproductive needs are interpreted and assessed. Our focus here is on how reproductive health and its contribution to wellbeing has been understood and assessed. It is premised on the view that the interpretation of the meaning of universal reproductive rights is a process of central importance to setting the agenda for rights-based approaches to reproductive health policy.

We briefly review selected approaches to understanding wellbeing and rights and explore their implications for understandings of processes of social differentiation. We proceed to consider the 'fit' between these ideas and complex understandings of reproductive behaviour, health and rights. We go on to politicise 'needs talk' and problematise the negotiation of rights. We review approaches to assessing progress with wellbeing and reproductive rights and finally end by delineating future challenges arising.

Understandings of Wellbeing

Attempts to understand wellbeing have most prominently involved debates about human needs theory and have been concerned with developing understandings that can accommodate cross-cultural comparisons. However, useful insights can also be drawn from approaches that explore how different people seek and experience wellbeing, particularly those concerned with gender, poverty and livelihoods. We focus on Sen's (Sen 1990a)'capabilities' approach' which critically argues that the proper focus for understanding wellbeing is on what people can be and do, rather than simply on what they have. Freedom is integral to Sen's approach which distinguishes between people's capabilities and what they actually choose to do with them (their functionings).

Sen's original interest was in the way people's assets (endowments) have consequences for the claims they can make (entitlements) on goods and services (commodities), particularly in famine situations. He was concerned to construct a basis for international comparisons of wellbeing that reject utilitarian and libertarian approaches thus making the case for social justice on the basis of human need. Human needs theorists like Sen have constructed universal wellbeing in terms of locally specified functionings that make up a 'a good life' (Jackson 1997:146). The concept of human development promoted by the UNDP is an explicit attempt to construct a policy discourse which builds on Sen's understanding of wellbeing. The UNDP see human development as "the process of widening people's choices and the level of wellbeing they achieve". Their influential Human Development Index (HDI) is constructed using a 'capabilities' approach[1], and they have developed a number of related indices exploring social injustice, political freedoms, and empowerment (UNDP 1997:13-14). The notion of social justice is central to the UNDP approach and they have elaborated understandings of poverty and gender amongst other forms of discrimination.

Development thinking about wellbeing has also been profoundly influenced by new understandings of poverty, gender, the household, agency, and livelihoods amongst other things. These all contribute to a greater emphasis on the role of power relations in sustaining deprivation and to an improved understanding of the subjective experience of disadvantage. Poverty is now widely recognised to be about more than lack of income; it is multi-dimensional, encompassing intangible dimensions such as lack of power, lack of self-esteem alongside material and physical deprivations. It is also accepted that the experience of poverty is subjective and context specific and that the poor exert considerable agency to secure their livelihoods. The livelihoods approach recognises that the 'good life' that people are pursuing is not only productive but involves intangible resources such as social capital as well as reproductive goals. A dynamic and gendered notion of livelihoods can provide a frame for linking individuals within differentiated households to wider institutional processes of economic, social and cultural change. Analysis informed by such perspectives have shown that the strategic pursuit of livelihoods within particular contexts often involves trade-offs and ambiguities rather than clear-cut gains or losses. Recent understandings of gender relations within the household and beyond have stressed the diversity and negotiability of social relations and have provided critical theoretical links between material and discursive resources used for constructing a 'good life' (see Locke and Okali 1999, for a review of approaches to gender).

Many people have extended or drawn selectively on Sen's work and this is particularly clear with respect to 'entitlement analysis'. Although this has generated a mini-literature on the ambiguities and misuses of the term, the idea of entitlements in its extended form has the scope to link normative understandings of rights with analysis of effective claims in contexts where informal institutions are overwhelmingly dominant in safeguarding wellbeing. In all contexts, but particularly in developing country contexts, many rights can only be realised through informal institutions including the market, the community, the family and the household rather than through state protection, regulation or provisioning. For example, Kabeer and Aziz contrast women's 'kin-based entitlements' with their 'own-labour based entitlements' (Gasper 1993:697). Entitlements for our purposes are claims that are accepted as legitimate, but not necessarily moral (Gasper 1993) nor formally guaranteed in law, and we further use the concept of effective entitlements to refer to claims that can be realised in practice. This understanding of entitlement connects the concepts of informal rights and effective rights thus enabling a point of contact or bridge between the two discourses[2]. This is the root of many of the ambiguities of the concept but also the key to its appeal. The idea which it represents stands at the centre of current attempts to bring together thinking about human rights and human development: namely that the core challenge is to strengthen people's entitlements/rights to claim the goods, services, resources, respect and so on that they need to lead a 'good life'.

Entitlements have been critiqued as excessively passive thus neglecting the fact that rights "must be understood as the outcome of an earlier process of claim-pressing" (Dasgupta 1990). Gore drawing on the moral economy literature also stresses the need to move away from mechanistic and deterministic formulations of entitlement to look at how the rules of entitlement are negotiated and to see them as a site of struggle: "the assertion of entitlements also involves negotiation of the rules, confrontation, and struggles, in which 'unruly' social practice of various kinds are brought to bear" (Gore 1993:447). In any situation there are always multiple rule orders or a plurality of norms available for claim-pressers to draw on, to legitimate resistance or to redefine entitlements (Gore 1993; Jackson 1998). Leach et al emphasise that entitlements are often contested and stress the need for historical approaches that are sensitive to who has a voice in determining entitlements and difficulties certain individuals may face in controlling their own labour power and other assets (Leach 1999). This dynamic approach can connect well with the current recognition that basic freedoms must include being able to influence and call to account government outside of the normal electoral procedures through consultation and scrutiny of public services, policies and actions. The vision of Cornwall and Gaventa (2000) who see rights-bearers as actively engaging in making and shaping the social policies that affect their lives is one where the renegotiation of entitlement is explicit and ongoing.

Entitlements analysis has been particularly effective for thinking about the interface between individuals and institutions and has enabled disaggregated analysis of which groups can and can't make effective claims. Entitlements language has also been extensively used within social policy with the extension of welfare entitlements being seen as the cornerstone of social citizenship (Moran 1991). This usage of the

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[1] The HDI incorporates measures of the capacity to lead a long life (life expectancy), to acquire knowledge (educational attainment) and to access the resources they need for a decent life (per capita income).

[2] For Sen entitlements are used to connote rights: "a person's entitlements are the totality of things he can have by virtue of his rights" and can include "anything the person could conceivably wish to have, including non-molestation in the street, or the freedom to lecture on the immorality of the modern age to one's neighbour in the bus" (Sen 1982a:348 cited Gore 1993:430-1)

term draws attention to the terms and conditions of entitlement looking for example at the universality of entitlement or the way entitlement is mediated by professionals of one sort or another and asks what do entitlements mean for different people. This connects well with recognition that rights are always mediated to some extent or other by obligations (to behave in a socially acceptable manner or to fulfil a bread-winning role, for example).

‘Claims structures’ or ‘systems of entitlement’ rest within institutions (Dasgupta 1990 citing Gasper 1993:708 and Rein and Pettite 1983:26) and entitlement analysis can usefully explore processes of social exclusion/inclusion for specific social groups. However, Sen’s approach has also been criticised for the dualism of legal entitlements plus socially-enforced (extended) entitlements which are either downplayed or compartementalised into the domestic sphere. This denies feminist accounts of the importance of interplay between rules inside and beyond the household in creating entitlement (Jackson 1998) (Gore 1993; Razavi 1999) and neglects the relatively greater role of kin-based entitlements for women’s wellbeing (Scott 1999). Critically, Jackson notes that entitlements do not always enable male functionings and constrain female ones and she cites Kynch and MacGuire’s work on poor nourishment of men in their reproductive years as a result of gender provisioning roles (Jackson 1998). These extension of entitlements analysis put the analysis of power relations centre stage for an analysis of wellbeing that is concerned with social justice and the extension of freedoms.

The challenge of recognizing the importance of subjective wellbeing without regarding it as determining is particularly important for women whose perceptions and priorities are strongly shaped by gendered power relations that can ‘naturalize’ ill-being and altruism. Recent human needs theory has provided a basis for defending women’s *critical* autonomy to make wellbeing choices for themselves where they have knowledge that there are alternative courses of action thus balancing concerns about women’s rights and their human needs (Doyal and Gough 1991). This approach may go some way to a pragmatic incorporation of the relational nature of wellbeing and reproduction, particularly in contexts where Western liberal individualism is culturally inappropriate. Interestingly Doyal and Gough use this approach to defend the centrality of abortion for women (Doyal and Gough 1991) and support many other health advocates who note that women everywhere are making this ‘alternative’ choice often putting their health and social status at peril where abortion was illegal or stigmatised. Gasper supports this position of accepting “women’s informed and uncoerced but culturally-moulded consent to subordinate roles” with the caveat that we must accept these choices “without considering this stance always perfect or always clear” and we must consider it as open to negotiation (Gasper 1996:655). There remains consensus too on a balance between objective and subjective measures: there is a “need to include issues of bodily wellbeing within gender analyses of choice and agency” (Razavi 1999).

The tension between universal standards and economic, political, social and cultural diversity has characterized debates about International Human Rights since they were first declared in 1948. Formally, the framework for International Human Rights allows space for the local interpretation of how these rights may best be addressed. Such a framework complements the approach of human needs theorists who see the universal of the ‘good life’ as made up of locally-specified ‘beings’ and ‘doings’. Gasper’s analysis of development ethics shows how human need theory has provided a core area for consensus around basic needs but that attempts to extend the “needs ethic” can never secure the same support (Gasper 1996). However, Nussbaum and Glover’s volume demonstrates the feasibility of consensus about women’s rights in developing countries that leaves space for continued disagreements (Nussbaum and Glover 1995).

The current convergence of human rights and human development movements can “bring new energy and strength to the other” (UNDP 2000:2). Both have focused on securing basic freedoms, for human development this has traditionally meant focusing on enhancing capabilities (known in some circles as the ‘positive’ freedoms), whilst human rights have emphasised freedom from violence, coercion and freedom of expression. Until recently these movements developed in parallel promoting different agendas and developing different conceptual tools (UNDP 2000).

The social integration agenda associated with the WSDD is one manifestation of the growing support for their intrinsic inter-relation and this is also reflected in the growing support for rights-based approaches to development and the attempt to redefine concepts and strategies to integrate concern for human rights into development approaches. The UNDP see human development and human rights as mutually reinforcing – one is essential for the other - and argue that human rights can “add value” to human development by lending moral legitimacy and the principle of social justice to the objectives of development whilst human development contributes to building a long-run strategy for realizing rights by addressing resource and institutional constraints in the enabling environment (UNDP 2000:2). This kind of discourse redefines poverty eradication as a “major human rights challenge” and view the “denial” of economic, social and cultural rights as particularly widespread (UNDP 2000:8). The social integrationist agenda associated with these ideas also revisions processes of social differentiation. For instance, the UNDP sees increasing social fragmentation as a result of growing inequalities – both in terms of income (vertical inequalities) but particularly between groups (ethnic, religious, social) (horizontal inequalities) – and as a result of a range of insecurities all of which have been exacerbated by globalisation (UNDP 1999:36-37). This interpretation reinvigorates development concerns about a wider range of social injustices including processes of social exclusion.

In conclusion, then. wellbeing is about what people can and be, not just what they have and in this understanding freedom and rights integral to wellbeing. Importantly, though, freedom needs to understood as being able to play a role in negotiating the ‘rules of the game’ as well as in terms of making individual choices. Entitlements are negotiable, dynamic and contingent and they are the bridge to realising effective rights in practice. Wellbeing, or a ‘good life’, is universally desirable but is made up of locally specific functionings and consensus over the ethical core of rights and human needs can leave space for ongoing negotiation across time and cultures about the specific manifestations of these rights and needs. Wellbeing concerns need to go beyond a focus on either the individual or national aggregates to investigate processes of social justice and discrimination. Assessments of wellbeing need to balance objective measures (including of bodily wellbeing) with subjective experiences and this is particularly the case for improving understanding around women's wellbeing. Having reviewed approaches to understanding wellbeing, the next section goes on to consider how well these sorts of insights might relate to reproductive rights discourses.

Links to Reproductive Rights Talk?

The reproductive rights discourse takes for granted the central relationships between reproductive rights, reproductive health and women's (reproductive) wellbeing. It is assumed that these three concepts are mutually reinforcing, that women's wellbeing can be read from their 'reproductive' wellbeing, and has, for the most part, concentrated its attention on reproductive outcomes (such as improving rates for maternal survival and increasing contraceptive prevalence) . In contrast, strongly contextualized understandings of reproductive behaviours suggest that women's lives are more complex and that their reproductive strategies are strongly embedded in wider social processes in ways that can create unexpected or ambiguous meanings for specific outcomes (Petchesky and Judd 1998:9). Interdisciplinary approaches agree that individuals do not hold distinct reproductive goals, rather their reproductive behaviour and experiences are part of the 'relatively seamless whole' (Ortner cited Greenhalgh 1995:13).

To recap (Locke, 2001), sex and reproduction are key strategies for forging social relationships, and sexual or reproductive 'failure' and reproductive morbidity can be explicitly connected to processes of social exclusion. Women (and men) may explicitly and implicitly trade-off aspects of sexual and reproductive autonomy and wellbeing in order to create room for manoeuvre in other dimensions of their lives (Petchesky and Judd 1998:17, 19). Family and non-kin networks are sources of knowledge, skills and support for women that confer, enable and contest the bounds of accepted sexual and reproductive behaviour (Harcourt 1997). Institutional (McNicoll 1994) and anthropological (Greenhalgh 1995) approaches have emphasized the way in which reproductive health outcomes are iteratively shaped, experienced and given meaning. Social norms and practices, social policy and cultures of service provision relating to the management of fertility and sexuality both shape and are shaped by individual women's actions over time.

These insights point to the value of unpacking the relationships between reproductive rights, reproductive health and women's wellbeing. Sen's notion of wellbeing as located within the three spheres of capabilities, functionings and entitlements (Sen, 1990) usefully draws attention to the extent to which people are able to choose and achieve a range of reproductive aspirations in relation to their biological endowments. His framework has attempted to move understandings about wellbeing beyond the sphere of formal welfare entitlements, to say reproductive health services, and to accommodate gender relations within and beyond the household through the notion of ‘co-operative conflicts’ and ‘extended entitlements’. Sen’s ideas draw attention to the problems women may experience in identifying and pursuing their own wellbeing within the household: women’s negotiation power at home is weakened by their relative disadvantage if the household were to disintegrate and by prevailing perceptions of entitlements that put others’ interests above their own.

Petchesky and Judd (1998:13) develop a related concept that they call a ‘sense of entitlement’ to refer to ‘moral claims, especially on partners, kin and caregivers’. Importantly, ‘sense of entitlement’ cannot be equated with normative morality but is grounded in the ways women act to secure what they perceive to be their own and their children’s needs (ibid:14). Consequently, entitlement is dynamic and problematic, often displaying wide disjunctures between women’s private actions and their public justifications with respect to reproduction. As a result, women’s strategies to pursue the things they feel they and their children need may be manipulative and carefully concealed. Harcourt (1997) has referred to the ‘zones of silence’ that surround taboo sexual and reproductive behaviours. Breaking these open may be emotionally fraught and raise serious ethical dilemmas, but may be an important component of collective renegotiation over sexual and reproductive entitlements [Sawalha 1999#402].

Drawing on Sen’s notion of wellbeing for thinking about reproductive experiences suggests that understandings of how social policy impacts of reproduction need to also consider the choices that people can envisage, how they make the choices that they do, and how these affect their lives. This contrasts with the approach of much of the demographic literature which has often focused solely on reproductive outcomes and with that of the rights literature which has tended to focus only on the legal extension of rights or on the cataloguing of specific incidents of abuse. In contrast to these literatures, more deeply inter-disciplinary approaches to reproductive behaviour resonate well with the insights that can be drawn from Sen’s approach and from extensions of this approach by different authors (such as Petchesky and Judd 1998). Taking on board some of the criticisms of static nature of Sen’s original approach which did not allow for the renegotiation of entitlements, it is important to factor in processes of renegotiating reproductive entitlements both at an individual level but also in terms of influencing the development of official policy, the legal environment, service provision, and broad social norms.

Reproductive rights are implicated in tension between global standards and local values. However, feminist dialogue and international advocacy have enabled the development of an ethical core of reproductive rights that draws on philosophy, theory, advocacy and the everyday aspirations and strategies of women (see Locke forthcoming). Harcourt sees the international women’s health movement as having shown “great ability to accommodate sensitively diverse cultural positions” and as learning to pull together strategically (1999:7). The Women’s Declaration on Population Policies, reproduced in Sen et al (1994:31-34) and developed for lobbying at the Cairo ICPD is an example of such solidarity. Recent feminist emphasis on difference and diversity have ‘opened the door for a redefinition of rights that is more conducive to dialogue ‘ (Obermeyer 1995:367) and the advocacy of

Southern women's groups has influenced the meaning of reproductive rights and their contribution in linking women's reproductive health to a comprehensive human development framework has proved particularly significant in ensuring that the interests of women in developing countries are better articulated (Petchesky 2000:3, Correa and Reichmann 1994).

This vision and particularly its appreciation of the relationship between reproduction and wellbeing is more radical than that offered by the Cairo PoA. However, the emphasis on choice and on mental and social wellbeing as well as physical wellbeing is intrinsic to the ICPD definition of reproductive health[3] and supports the argument of many advocates that rights and health are indivisible[4] This statement of reproductive rights and the compromises it contains have been discussed at length elsewhere (Locke 2001 and Locke forthcoming) and are summarised in table 1. It is appropriate in this discussion about the connection between reproductive rights and wellbeing to make some further comments about the relationship between reproductive rights, social reproduction and wellbeing and about the political process and accountability of policy-making about reproduction. The ICPD definitions of reproductive health and rights do not mention parenting and caring rights associated with social reproduction, however, this matter is addressed to some extent in chapter 5 of the PoA whose objectives are to support family-friendly policies that recognise a diversity of family forms, to develop social security for child-rearing and to promote equality of opportunity for all family members (UN 1994: Paragraph 5.2). These concerns that intimately link reproduction to wellbeing are specifically excluded from articulation as a right and receive the status of a supporting measure. Although PoA does include a vision that supports the involvement of women and men in shaping policy and programmes and in strengthening accountability (UN 1994: Chapter XV and Chapter XIII), engagement with the process of reproductive policy-making either by individuals or civil society organisations is similarly not described as a right.

Putting a concern for wellbeing at the centre of understandings about reproductive rights implies directing attention to problems of social justice that highlight the processes whereby some individuals and groups experience failures in their reproductive entitlements, pursue strategies that appear inimical to their reproductive health or are unable to translate reproductive entitlements into improved wellbeing. The PoA vision of reproductive rights differs from the ethical core constructed by feminist health advocates in the priority the latter accord to social justice and to the processes that create social inequalities. Whilst the PoA urges freedom from discrimination of all kinds, the lines of difference to

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[3] The formal ICPD definition is: "the basic rights of all couples and individuals to decide freely and responsibly on the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence" (UN 1994: Para 7.3).

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

which it gives prominence exhibit continuities from older population policies. Although disabled and indigenous groups are mentioned (Chapter VI), poverty is largely dealt with in respect of questions of economic and population growth (Chapter III) and the categories of social differentiation that are most used include girl children/adolescents versus boys, women versus men, and women with low parity, well-spaced births as opposed to women with high parity, closely-spaced births (see Locke and Zhang forthcoming). The difference in these ways of looking at inequalities in reproductive health implicitly reflect different understandings of wellbeing and of the challenges to be met by reproductive health policy in contributing to improved wellbeing.

Table 1: Summary of Tensions with Reproductive Rights

Tensions in the ICPD Vision of Reproductive Rights

- Bodied rights for women:
  - Risks enforcing gender stereotypes of motherhood, heterosexuality and context of marriage
  - Obscures men’s interests and interests of adolescents, single women, lesbian women, etc..
  - Distracts from material and social context of livelihoods
- Notion of reproductive decision-making:
  - Overly rational and individualistic neglecting ambiguous, emotive and relational factors
  - Neglects importance of ‘lived experience’ where meaning is shaped over time
- Dominance of reproduction:
  - Downgrades sexual health and rights
  - Avoids dealing with questions of sexuality
  - Falls short of articulating adolescents rights
- Falls short of defending rights to abortion
- Assigns rights to ‘individuals and couples’ to reproduce ‘freely’ and ‘responsibly’:
  - Avoids directly addressing power relations within the marital household
  - Downgrades importance of collective engagement in reproductive policy-making
  - Reserves space for elite judgements about what’s in an individual’s and society’s interest

Finally, despite the global packaging as international human rights, reproductive rights remain orientated to the fertility management in developing countries (see Keysers 1999). The continued paternalism towards developing countries obscures reproductive rights challenges in developed nations, neglects the definition of people in to un/wanted populations evident in immigration policies and disguises the continuation of northern anti-natalist agendas for developing countries (Keysers 1999). This orientation underlays the interpretation of rights derived from the Cairo agenda and perpetuates assumptions about reproductive needs in developing countries in a way that obscures a focus on wellbeing (see also Locke 2001). If reproductive health policy is an indicator of how local needs have been understood then it has been unimaginatively pursued and has forestalled asking challenging questions about the link between reproduction, policy and wellbeing in different contexts. For the most part reproductive health policy has been interpreted as improving quality of care plus an expansion of services to encompass ‘comprehensive reproductive health’ including attention to HIV/AIDs and other STDs and with a renewed push to eliminate ‘unmet need’ amongst a wider range of target individuals- most notably adolescents and men. As Macfarlane et al (2000) remark with respect to public health, the ‘sameness’ of these initiatives and their justification through highly aggregated depersonalised statistics (such as numbers of maternal deaths) manifests their exclusion of differences arising from in heterogeneous populations in varying social, political and cultural circumstances.

To sum up, wellbeing can not be ‘read off’ from reproductive health outcomes and the connection between reproductive health and wellbeing can be ambiguous. Adopting a capabilities approach to wellbeing implies looking at the reproductive choices people can envisage and understanding how they make and experiences their choices as well as considering reproductive health ‘outcomes’. There is considerable scope to broaden approaches to reproductive rights by factoring in the renegotiation of reproductive entitlements both individually and in relation to offical policy making, legal framework, service provision and broad social norms. Women’s and men’s ‘sense of entitlement’ may motivate strategies beyond normative morality and examining these behaviours may raise difficult ethical questions as well as providing positive impetus for change. Sadly, the ICPD discourse on reproductive rights, despite improvements on older population policies, remains relatively dislocated from wider wellbeing concerns and downplays issues of social justice. Women’s health activists and feminist researchers have, however, articulated and defended more radical interpretations of reproductive rights which are much more effectively embedded within wellbeing concerns. Official policy remains paternalistic towards developing countries and its relatively prescriptive uniformity betrays a lack of concern with local interpretation over the specifics of reproductive rights and needs in different social contexts. The following section proceeds to investigate in more detail how rights are interpreted as needs through policy processes and in particular how international monitoring and assessment of progress around reproductive rights has addressed concerns about the definition of rights and needs.

Defining Needs?

Whilst strengthening the idea of an ethical core for universal rights on the basis of philosophy, theorizing, advocacy and the everyday aspirations and strategies of women, we still ‘need to examine much more closely what we really mean by an individual human right to reproductive choice, freedom, or autonomy in a world as demographically complex and culturally diverse as ours’ (Freedman and Isaacs 1993:18). Considerable progress has been made in this respect within a growing literature of women’s visions and strategies for change in developing countries. However, with a few notable exceptions, relatively little attention has been given to the process of interpreting rights in diverse circumstances in international social policy, in donor policy and activity or in national social policy and provisioning. In comparison to human rights, even less official attention has been devoted to considering what reproductive rights might mean in specific circumstances (but see Petchesky 2000, Newman and Helzner 1999, and Keysers 1999). Exceptions include Brazil where an institutionalized ‘partnership’ has evolved between the national women’s health movement and the government agencies responsible for implementing the Cairo Programme of Action leading to substantial policy and legislative reforms and giving women’s health advocates an official voice in the planning and monitoring of reproductive health policy and service provision (Petchesky 2000:40-41). Also notable, is the success of the International Planned Parenthood Federation whose Charter on Sexual and Reproductive Rights was developed using a detailed review process enabling direct input from member associations and which makes plain the connections between human rights language and service delivery (Newman and Helzner, 1999:459).

Discursive views of rights create space for diverse interpretations of rights but practical politics mean that such negotiability can be used to undermine their radicalism. Unlike women's rights, such as the extension of the franchise, which have in most cases proved to be irreversible gains, Ramirez and McEneaney's (1997) study of the liberalization of abortion laws concluded that gains in reproductive rights were reversible and poorly institutionalized. There can be no complacency over the apparent legitimation of reproductive rights. This was evident in the United Nations' five-year review of progress since the Cairo conference when debates about fundamental principles were reopened (Petchesky 2000:30) and in President Bush's retraction, immediately on entering office in 2001, of US overseas assistance funds for programmes supporting abortion.

The moral force of rights is enhanced by perspectives that see them as absolute standards derived from 'human nature'. However, from a social science perspective, this conceals the fact that ideas about rights have developed over time and that particular interpretations of rights emerge from and lend themselves to specific ideologies. The difficulties enabling better translation between the normative language of reproductive rights (for which simplicity is often related to political impact) and the analytical language used in accounts of reproductive behaviour (which needs to get a reasonable grasp on complex reality) are not insurmountable. In improving the conceptual clarity guiding advocacy and policy practice we must, however, resist the temptation to resolve the complexity and ambiguity of these relationships. Whilst upholding the view that the expansion of reproductive rights is a 'good thing', we need to examine their operationalisation is we want to consider what rights-based approaches to social policy about reproduction might mean for women's wellbeing.

Questions of representation of interests and needs have been problematised by post-modernism and this "has given new urgency to discussions about women's gender interests and how they can be known in a develop context" (Jackson 1997:150). Whereas 'needs' are subjective preferences for many orthodox economists, the basic needs school in development studies invests in a normative stance based on universal need, whilst post-modern perspectives see needs as "constituted by language with little or no reference to material relations" (Jackson 1997:146-7, 148). Jackson argues that work on embodied subjectivity and gender starts to deal with the need to retain a materialist element in understandings of gendered poverty. "This links the objective material needs of women with the subjective, culturalised ideas about, and constructions of, needs in a useful way, and denies the dualistic character of the words v things argument…. The 'subject is never separated from the material conditions of its existence, and the world is never free of the representations that construct it' (Moore 1994:80)" (Jackson 1997:148). In asking questions about what situationally specific needs that arise from a universal ethical core of rights might look like, we need to tread a path that avoids this dualism whilst resisting the elision of biomedical perceptions of women's and men's health with their wellbeing.

The administrative presentation of need in reproductive health planning contrasts with a feminist and/or discursive approach which sees the boundaries of need as a central political struggle. Feminist analysis of social policy has long drawn attention to its reinforcement of gender roles and ethnographies of policy processes have highlighted the very specific ways in which problems are constructed and needs identified and thus bounded. The call for reproductive rights is a new discourse of need that has been widely utilised, interpreted and co-opted in different ways by makers of social policy. The universalistic assumptions of this rights-based discourse raise dilemmas about the meaning of reproductive rights in different social settings for different social groups. The bureaucratic construction of 'needs' is a political process that involves struggles between different actors, including the state, civil society, and the private sector, over whose interests are legitimate and how these should be interpreted as administrable needs (Fraser 1989). This does not imply rejecting needs talk but means expanding the focus from needs alone to include discourses about needs and how they are establish, interpreted and met (1989:164). The operationalisation of reproductive rights in terms of administrable needs impacts directly on women's wellbeing so , following Fraser, central questions must include: who is in charge of reproductive needs talk?; and, what are the implications of dominant constructions of reproductive needs? There are a wide range of discursive resources that can be used in struggles for these three levels of need which include rights talk. Importantly, the strategic meanings of practical needs may not always be apparent to those experiencing them, but there are moment when these depoliticising processes are challenged and they can become 'runaway needs'. Conversely certain needs can be 'enclaved' and thus depoliticised and redirected to specific 'discursive publics'.

The new consensus about reproductive rights and their administration as reproductive health policy and programmes can be seen as an example of this process (see Locke 2001 and Locke forthcoming). In comparison to mainstream understandings of reproductive rights and appropriate policy action, more radical interpretations place greater emphasis on the connections between reproduction and wider wellbeing, often calling for transformation of the global economic order, and on reproductive freedoms in addition to reproductive health. The so-called globalisation of international social policy (see Locke 2001) has been characterised by a lack of attention to the process of interpreting needs and this can be evidenced with respect to the development of rights monitoring. We look briefly at the international situation with reference to the monitoring of human rights accountability which implicitly elaborates views of what rights and wellbeing look like and examines how they build in or screen out space for negotiation over these views.

The formal architecture of IHRs sets out universally applicable individual rights and the obligations of governments to meet these claims. Recent interest in human rights has been accompanied by real progress in developing mechanisms to monitor national compliance. The IHRs framework is supported by conventions designed to ensure that particular groups are able to claim these rights which include provisions for treaty monitoring that have international legal standing. The development of indicators for monitoring human rights is being encouraged by the office of the High Commissioner for Human Rights, the human rights treaty bodies provide guidelines for statistics required from reporting countries and civil society organisations are developing their own databases (UNDP 2000:92). Pressure for action on human rights and reproductive rights is not solely reliant upon this international legal architecture. Multi-dimensional strategies that include building advocacy networks and social movements are more likely to be effective in lobbying the state and other significant institutions, particularly the international financial institutions, donor organisations, NGOs and the corporate sector, to realise their obligations in developing country situations.

International accountability for reproductive rights is being developed through the treaty monitoring committee for the Convention for the Elimination of Discrimination Against Women (CEDAW). This legal framework holds country's accountable for their obligations but is not so far systematically linked to systems of national accountability under which individual grievances can be raised[5]. Ratifying countries must report regularly on their compliance to the committee and are guided by the committee's General Recommendations in preparing these reports. These refer specifically to governments obligations to respect, protect and fulfill women's health rights: "Governments are, thus, obligated systematically to address in their reports to CEDAW their national experience of respecting, protecting and fulfilling women's rights relating to reproductive and sexual health" (Cook and Dickens 1999:57). CEDAW also accepts 'shadow' country reports from NGOs and after discussion of a government's report issues Concluding Observations that may include specific guidance on meeting rights challenges. The Concluding Observations on Mexico's 1998 Report included: concern about the accessibility of reproductive health services for indigenous women; a request for information about actions to address adolescent pregnancy; recommend review of the criminal law with respect to rape and abortion; and suggested training in human rights for health professionals (Cook and Dickens 1999:57-8).

The process of review of reproductive health and rights also forms part of the ongoing ICPD activities, most notably Cairo+5. However, the PoA is not legally binding on countries and this forms a relatively 'weaker' form of accountability than monitoring under CEDAW (Cook and Dickens 1999). The PoA urged all countries to establish systems for monitoring and accountability in "partnership with NGOs, community groups, the media, the academic community, and with the support of parliamentarians" (UN 1994: Paragraph 16.10). The PoA further urges governments to develop national databases for assessing progress towards the goals and objectives of Cairo for periodic reporting and asks for the Economic and Social Council to provide guidance on monitoring and to review of the UN reporting system in the light of Cairo (UN 194: Paragraphs 16.23-16.29). Cairo+5 revisited the issue of monitoring data and made some specific recommendations on the need to collect and disseminate reproductive health data that is both qualitative as well as quantitative, on men as well as women and data disaggregated not only by sex and age but also by income and poverty status and by population sub-group, including for indigenous people (UN 1999:Paragraph 37).

The review process also called for “increased efforts” by the UN to “develop and agree on common key indicators” for reproductive health programmes (UN 1999: Paragraph 55). International monitoring and guidance for national monitoring of reproductive health status (rather than compliance with the Cairo PoA) under the ambit of the WHO and UNFPA has been modified to take into account the shift in focus and the broadening of concerns that Cairo exemplified and will be discussed in more detail below. The WHO has progressively attempted to integrate reproductive health into its estimates of the Global Burden of Disease (GBD) which rely’s on calculating disability-adjusted life years (DALY’s) and this method will be discussed further below (Bastian 2000, Nygaard 2000). The WHO have also provided guidance on reproductive health indicators for national and international monitoring purposes (WHO 1997a and 1997b) which takes into account the UNFPA’s indicators for reproductive health. We will again return to these below but suffice it to say at this stage that despite a considerable broadening of focus these indicators remain concerned with biomedical understandings of health and do not approach either reproductive freedoms, women’s or men’s lived experiences or the accountability of social policy processes including determining and addressing reproductive health needs.

Maine et al (1994) emphasise the dissonance between what ‘the system’ thinks is ‘good’ for a woman and her own perception of her wellbeing and emphasise that in a rights-based approach the latter must win out. They show simply and elegantly why conventional assumptions about traditional indicators need examining. For instance, they note that increased family planning in Matlab did not make pregnancy any safer although it did reduce maternal mortality by virtue of reducing the overall number of pregnancies. Another illustration they use it that despite unmet need of 58% in Pakistan and contraceptibve knowledge of over 50% contraceptive use remains at 12% because women are “caught in a double bind” where society disempowers them and the population policy reinforces social attitudes by denying women full agency over reproductive decisions by requiring family/spousal consent for contraceptive services, particularly abortion (Maine et al 1994:217). Maine et al warn that “the use of seemingly scientific evidence to justify, in the guise of improving health, measures designed to regulate the behaviour of individual women whose lives – whether by choice or necessity – defy conventional norms of wifehood and motherhood, has a long tradition in law and policy” (1994:222). We shall return to the specifics of indicators for assessing progress and setting targets for reproductive rights below, but note here that monitoring under CEDAW appears to offer greater potential for monitoring progress in reproductive rights broadly perceived as a contribution to wellbeing.

More interesting that the ICPD review process for our purposes is the proposal by the UNDP in its 2000 report for indicators for international accountability (see Appendix A Table 1) complemented by a composite index for international accountability (see Appendix A Table 2). The indicators they propose for international accountability are grouped around four objectives: asking whether states respect, protect and fulfill rights; ensuring that key principles of rights are met; ensuring secure access; and

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[5] Links have been established in specific regions, for instance under the UK’s Human Rights Act, individual grievances can now

identifying critical non-state actors. The index they propose has three dimensions looking at whether states have ratified conventions and their complaints procedures; whether they have participated in established international monitoring procedures; and the extent of their adequate response to requests and recommendations by treaty monitoring bodies. The UNDP see the development of human rights accountability as involving the diversification of sources of information, realising the right to information and strengthening procedures of accountability. These indicators are relevant both for the developing formal accountability mechanisms associated with the ratification of human rights treaties and the monitoring of commitments made in the UN conferences (see table 2 below) but also for particular countries and donors who are increasingly using human rights criteria to design policy and programmes (UNDP 2000:89-90). Although there are potentially difficulties around interpreting rights with establishing suitable lower level indicators - for example, that states fulfill rights - this framework could be operationalised in ways that build in negotiation over what rights might look like in a specific situation for specific groups.

Table 2: UNDP Justification of Indicators for Accountability for Human Rights (UNDP 2000:89)

Indicators are Tools for:
• Making better policies and monitoring progress • Identifying which actors are having an impact on the realization of rights • Revealing whether the obligations of these actors are being met • Giving an early warning of potential violations, prompting preventative action • Enhancing social consensus on difficult trade-offs to be made in the face of resource constraints • Exposing issues that had been neglected or silenced

The analysis presented provides support for greater attention to discursive processes of interpreting reproductive rights and needs but qualifies the space for negotiation with the need to strengthen the universal ethical core of rights in directions that accomodate broader understandings of how reproductive and sexual entitlements relate to wellbeing. Critical questions about policy processes that define and address reproductive rights and needs include: who is in charge of rights talk? and, are processes of constructing needs enclaving reproductive rights? Strategies proposed for the international monitoring of human rights accountability appear to give greater room for such investigations than specific proposals for monitoring reproductive rights (through CEDAW) and reproductive health (through ICPD review and WHO). The framework for monitoring human rights accountability has the potential to build in explicit scrutiny of processes of interpreting rights in specific situations for specific groups and monitoring under CEDAW offers space for alternative views of reproductive rights and health to influence the focus of reviews of progress. Both these avenues can potentially accomodate a more sophisticated understanding of the link between reproductive rights and wellbeing, the adaptations of global reproductive health monitoring proposed by WHO prioritise biomedical health, neglect women’s and men’s subjective wellbeing, as well as their individual freedoms and collective rights to engage with reproductive social policy making. The next section briefly reviews practical attempts to measure rights and wellbeing.

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be brought and referred to higher levels within the European Union for legal ruling.

Measuring Progress with Rights and Wellbeing?

A basis for a convergence between rights and wellbeing has long existed within development thought but despite the apparent attention to freedoms within Sen's formulation, quality of life approaches have seldom paid equal attention to the 'negative' as compared to the 'positive' freedoms (Dasgupta 1990). There have been attempts to measure these freedoms but, as we shall see later on, they have for the most part been in parallel with concerns about wellbeing and have for the most part not dealt with reproductive freedoms. In 1992 the UNDP could say : "People now see freedom as an essential element in human development… Any report on human development must thus include a professional analysis of human freedom" (1992:27). A social development challenge for the future is to make an assessment of reproductive freedom a normal component of a report on reproductive health.

This section of the paper will initially review a range of attempts to measure wellbeing and health, particularly reproductive health, including those emerging from the official international organisations, in order to consider the extent to which they effectively connect concerns about rights, wellbeing and reproduction. As before, our intention is to add clarity to thinking about interpreting reproductive rights and we see attempts to assess rights and health status and to measure progress in this respect as central to focusing policy attention to 'what really matters'.

Attempts to assess wellbeing globally are mostly orientated to making international comparisons, often using single composite indices although these attempts are complemented or supported by more complex statistical databases and by qualitative analyses of country situations. Although this arena has been strongly influenced by Sen's capabilities approach and ensuing debates, little progress has been made in assessing the status of rights and freedoms or in integrating this analysis into assessments of wellbeing. Although the importance of subjective accounts of wellbeing is increasingly being recognised, even for instance by institutions like the World Bank through their participatory poverty assessments, such information is seperately bounded and has yet to achieve the 'standard reference work' status of publications like the World Development Reports.

The UNDP Human Development Reports are clear that the concept of, for example, human poverty is much bigger than a measure such as the human poverty index and that it is not possible to reflect all dimensions of complex concepts within a single quantifiable composite indicator (1998). However they see their indicators as drawing attention to a few essential elements of human life (see table 3 below). They have developed indicators that variously capture inequalities in relation to poverty and gender (HPI, GDI) as well as overall progress (HDI) and have used this methodolgy to illustrate other kinds of inequalities, such as those between ethnic or caste groups, in their reports (UNDP 2000). UNDP also argued coherently that acknowledging the complexity of human freedom and the necessity for qualitative description does not imply that imperfect composite quantitative measures are redundant: they see measurement as important for advocacy, planning and research (1992).

Table 3: Human Development Report Indices (UNDP 2000)

Indicator	Measures	Comprises
HDI (Human development index)	progress for a community/country as a whole	Longevity (life expectancy), knowledge (educational attainment), decent living standard (income)
HPI (Human poverty index)[6]	the extent of deprivation, the proportion of people in a community/country that are left out of progress	Longevity (life expectancy), knowledge (educational attainment), decent living standard (income) and in developed countries social exclusion (long term unemployment)
GDI (Gender development index)	Progress for a community/country as while whole but taking into account inequality in achievement between women and men	The HDI adjusted downwards for gender inequality

The above indices concentrate on what the UNDP call the ‘basic capabilities’ and, as they argue, on economic and social rights, so in 1991 they proposed a human freedom index (HFI) based on 40 criteria related to Humana’s *World Human Rights Guide* (UNDP 2000:91). Subsequent comment revealed that “much more conceptual and methodological work is required for the quantification of freedom” (UNDP 1992:3) and in 1992 they proposed a political freedom index (PFI) to “assess the status of human rights according to generally accepted concepts and values” (1998:3). The PFI measured clusters of rights in five broad categories (see Appendix A Table 3) that the UNDP claim reflected “values common to all cultures, all religions and all stages of development”: namely personal security, rule of law, freedom of expression, political participation, and equality of opportunity (1992:29-31). Incidentally, their illustrative checklist of indicators made no specific mention of reproductive freedoms.

The methodology they proposed involved independent panels of experts scoring the status of different clusters of rights, harmonising these scores and then combining a simple average of the scores to arrive at the PFI. They offer the PFI as a modest start in an area where much more research is required. Neither of these were subsequently developed or continued by the UNDP for a variety of reasons: they were based on qualitative judgements not quantifiable empirical data; they provided summary answers to complex questions and without data or examples were unable to empower the reader to understand the judgements; and finally because neither were transparent about the reasons behind the scores allocated, their assessment could not be effectively translated into policy advocacy (UNDP 2000:91). In contrast, the Human Development Report’s index for gender empowerment (GEM) has however been seen as robust enough to remain in use. It aims to measure the extent to which women as opposed to men are able to actively participate in economic and political life. It combines measures of gender inequality in women’s and men’s share of administrative and managerial positions, of professional and technical jobs, and of parliamentary seats (UNDP 2000:271).

In assessing progress in human rights, the UNDP highlight three priorities: use diaggregated data for assessing progress in human development and human rights; focus on the most deprived; and focus on

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[6] Interestingly the UNDP construct two sets of HPI, HPI-1s for developing countries and HPI-2s for developed countries. The measures attempt to reflect almost the same fundamental capabilities but the actual variables used vary between developing and developed countries to reflect the fact that poverty and deprivation is manifested in different ways in these societies.

inequality gaps (UNDP 2000:111). They argue that human rights indicators include not only human outcomes but also pay attention to policies and practices of legal, administrative agencies and of public officials (UNDP 2000). Human rights assessments need additional data both on violations but also on the processes of justice and "there is an even greater emphasis of data that are disaggregated – by gender, ethnicity, race, religion, nationality, birth, social origin and other relevant distinctions" (UNDP 2000:91).

Human rights NGOs, such as Amnesty International, are active in documenting individual violations but rarely document the pervasiveness of such abuses within society. Freedom House offers an annual survey of political and civil rights in each country as well as an assessment of whether the situation is improving, worsening or static. The survey methodology explicitly seeks to go beyond legalistic concerns to examine how civil society actually operates and relies on qualitative judgements by expert observers to score country performance. The Freedom House survey does includes a question on "personal social freedoms" in constructing its annual scores for political and civil rights for all countries, but this conflates gender equality with choice of marriage partner and size of family (Freedom House 2000). Like the UNDP's GEM the Freedom house survey is concerned with positive freedoms's but unlike the GEM also builds in concern for negative violations in society as a whole and attempts to assess the full spectrum of rights in a systematic manner. The methodology has been criticised, amongst other things, for relying on the qualitative judgements of panels of experts and although supported by annual reports for each country which detail their human rights situation, these judgements can not be fully evidenced.

Notwithstanding these attempts, information on human rights status tends to focus on negatives, in other words on violations of freedoms (UNDP 1992). Razavi (1999) notes that the methodological problems of measuring wellbeing increase when we look at the more complex capabilities of power, agency and choice and feminists generally promote more sophisticated approaches to looking at freedoms that enable exploration of ambiguities within 'lived' experiences. For instance, Kabeer (1999) is critical of indicators that compress information and inevitably embody assumptions about meaning. For her, accounts of agency need to incorporate an understanding of the structures of constraint, of the consequences of choices made (such as collusion in gender discrimination) and an account of bodily wellbeing. The greatest research effort to document these capabilities has probably occured within feminist literature but has also featured within development literature concerned with poverty. This is too large to review here (but see Nussbaum and Glover 1995), but it can be noted that this concern spans studies that attempt to measure women's autonomy through various proxy indicators, including their mobility, their educational status, their control of income, and even their contraceptive use, to more nuanced accounts of women's, and increasingly men's, 'lived' experiences. Whilst the latter end of the spectrum approaches our concern here with the deep connections between reproduction, wellbeing and rights, it must be admitted that such studies are reliant on highly-skilled and sensitive social researchers with an intimate knowledge of their research situation and a capacity to represent a diversity of views alongside critical analysis of social problems. The intensity and specificity of such research and its inevitable ambiguities is not necessarily easy for policy-makers to engage with and will always need to be contextualised within broader and more generalised assessments.

Although there are undeniably complementarities between detailed accounts and the use of indices at various levels, the neglect of rights within human development approaches represents a significant challenge for constructing generalised accounts. There has been little methodological progress or interest in making international comparisons of rights using indices or on integrating rights into indices for wellbeing. Current methods for documenting human rights focus on particular abuses and tend to neglect ‘positive’ freedoms. There are unresolved methodological problems and relative lack of legitimacy about alternative approaches such as the Freedom House surveys of civil and political rights. Connections between rights and wellbeing appear to be most effectively explored through detailed accounts that balance ‘lived’ experience and assessments of bodily wellbeing with analysis of the (dis)abling nature of social, economic, political and cultural environment. These difficulties are mirrored within the approaches that have so far been used to assess reproductive health, rights and wellbeing which are reviewed below.

Assessing Reproductive Health, Rights and Wellbeing?

Moving on to consider health monitoring, it is assessments of health status that come closest to measuring health within a wellbeing framework, the majority of health assessments being highly specific, dealing for example with the epidemiology of particular phenomena such as obstetric complications. Most assessments of health status have generally been orientated around the five D’s (death, disease, disability, discomfort and dissatisfaction) and within this on the ‘hard outcomes’ of death and disease (Graham 1998:1927). However, there is multitude of health indices currently being employed including instruments developed for measuring quality of life such as the health-related quality of life index (Hawthorne et al 2001, Bhatia and Cleland 2000, McAlearney et al 1999). These indices are constructed from complex information bases and variously include considerations of mortality, morbidity and various adjustments based around age, quality of life preferences, health perceptions, productivity and frequency of symptoms (McAlearney et al 1999). Perhaps the most commonly used of these indices is a weighted measure called disability-life adjusted years (DALYs) that permits the combination of life expectancy and levels of dysfunction into a single measure (Graham 1998, AbouZahr and Vaughan 2000). Although DALYs go some way to addressing the complaint that it is inadequate to measure reproductive health by focusing on mortality alone, there has been considerable debate about their use and the measurement has been criticised on a number of widely known grounds including gender bias (see AbouZahr and Vaughan 2000 and table 4 below). WHO recognise that DALYs are not a useful tool for estimating the differential burden for a given condition, regardless of whether the burden is different by gender, poverty, or any other criteria (WHO 1998). WHO do not see DALYs in isolation as criteria for setting priorities which should include “criteria such as issues of justice and equity, human rights, community preferences, etc." (WHO 1998 Section 1 Page2).

Table 4: Criticisms of the DALY Methodology for Reproductive Health

Criticisms of the DALY Methodology for Reproductive Health
• Relies on a panel of experts developing weightings for disabilities incurred and "excludes socio-economic, cultural and environmental factors" including the discomfort, pain suffering, stigma or social and economic consequences of conditions such as obstetric fistula or infertility (WHO 1998: Section 2.7 Page 6).
• Also ignores implications for other family members – for instance the wife's social and economic wellbeing may be affected by a husband's infertility – as works only on individual level.
• Ignores people's own perceptions of health and disease and how they value those states.
• Neglected sexual and reproductive conditions in those below or above reproductive age.
• Many conditions are short-term physical events, such as miscarriage, but the burden of psychological, social or economic consequences is long term and not valued.
• Excludes pre-existing conditions that are aggravated by pregnancy, such as malaria or diabetes.
• Gender insensitive ignoring the impact of ill-health on women's caring roles and caring burdens, neglecting the differential impact of the same conditions on men and women, both physically, socially and experientially, and in access to resources to alleviate its burden.

The percentage of DALYs lost contributed by reproductive health problems can be internationally compared (see for example World Bank 1993). The WHO held an informal consultation on the use of DALYs for measuring reproductive health in estimating global disease burden (GBD) in 1998 (WHO 1998). The DALY assessment for reproductive health that was incorporated into the 1990 GBD predated the full elaboration of reproductive and sexual health at the 1994 ICPD and was highly restrictive relying primarily on information about maternal mortality. It included only the five major obstetric complications that result in maternal death[1] and the prevalence of major STDs, HIV/AIDs and reproductive cancers were included. It neglected obstetric, gyneacological and contraceptive morbidities, including RTIs, other STDs and violence related to sexuality and reproduction, ignored still birth (unless counted as obstructed labour), psychological morbidity, the non-availability of contraception and menstrual disorders. Infertility is only counted as a consequence of other conditions. The consultation recommended that "a more transparent and inclusive process be used to develop disability weightings" at the appropriate level (WHO 1998: Section 4.3 page 3). Despite continuing improvements to DALYs and other health indices, their method remains focused on weighing up the burden of ill-health and leads to highly aggregated and decontextualised figures.

The construction of indices and definition of indicators are important because they direct attention in assessing health situations and in setting agendas for the future by highlighting certain issues and back-grounding others. Taken literally the ICPD definition of reproductive health suggests that the most salient aspects of reproduction are: can people (couples? individuals?) choose freely and responsibly the number, timing, and spacing of their children?; and, can they obtain the highest standards of sexual and reproductive health? In practice, evaluations of reproductive health policy have been concerned centrally with quality of care in reproductive health services which have integrated older indicators (see table 5 below) such as CPR, whose meaning is prejudged as more is better, with newer indicators capturing the nature of the interaction between provider and client, such as Bruce's Quality of Care Framework (Bruce 1990). These investigations are not concerned with the impact of reproductive health services on the wider lives (wellbeing) of the women and men that they serve or with aspects of these lives that might have implications for the reproductive behaviour, including health seeking behaviour, of different women and men (entitlements).

Table 5: Typical Indicators Used to Evaluate Population Policies or Family Planning Programmes (drawing on Jain and Bruce 1994)

Indicators	Use	Disaggregation
Crude birth rate (CBR)	Judge impact of population policy	Uses registration data or estimated from surveys.
Total fertility rate (TFR)	Judge impact of population policy or programme	Uses census or survey data of (married) women of reproductive age, often disaggregated by rural/urban areas, by women's age, parity, educational level and sometimes ethic or religious affiliation.
Contraceptive prevalence rate (CPR)	Proxy measure to judge impact of population policy/programme	Uses census or survey data of (married) women of reproductive age and often disaggregated by women's age, parity, educational level and sometimes ethic or religious affiliation.
KAP Indicators	KAP surveys	Used to estimate 'unmet need' for family planning , the extent of knowledge about contraception and its relation to actual use. Uses census or survey data of (married) women of reproductive age and often disaggregated by women's age, parity, educational level and sometimes ethic or religious affiliation.
Couple years of protection (CYP)	Proxy measure to judge impact of population policy/programme	Uses only service statistics, agglomerates different methods. Disaggregation depends on nature of related service statistics.

The UNFPA have developed indicators to cover all areas of reproductive health as defined at Cairo and the 69 they suggest include indicators for national and programme level monitoring as well as global monitoring. Yamin and Maine (1999) looking more specifically at global monitoring of maternal mortality argue that the outcome indicators prioritised at Cairo and Beijing are unhelpful because the data for these indicators is most unreliable in situations where need is greatest and because they do not give any practical indication of how states should move forward in addressing their human rights obligations. Instead they recommend the use of process indicators around Emergency Obstetric Care in relation to GDP, accompanied by simple data of real access and of variations, and hence discrimination, within nations and regions. In 1997, WHO, UNICEF and UNFPA jointly published Guidelines for Monitoring the Availability and Use of Obstetric Services (Maine et al 1997) and this they argue has real scope in tracking and pushing for improvements in maternal health. The UNFPA approach for reproductive health monitoring adopts a similar strategy and includes national policy processes. Whilst undoubtedly useful, these strategies may however be limited by their primary focus on provision of services which may down play or even exclude other measures of social and institutional change, may prejudge what needs are and what services should look like, and stop short of directly evaluating reproductive health, freedom and wellbeing.

The WHO guidance on a minimal list of indicators for tracking progress in reproductive health reviews existing indicators, including those developed by UNFPA in the wake of ICPD 1994, is part of an ongoing process of reviewing reproductive health indicators for global monitoring. Whilst the WHO believes that indicators for monitoring progress should capture the types of information detailed in table 6 below, they argue that 'health policy indicators' and indicators for measuring the 'enabling environment' are problematic because they are qualitative and thus present measurement problems, particularly in marking progress over time (WHO 1997b:4). They further argue that social and economic indicators can be assumed to be monitored already as part of general health monitoring and therefore the indicators they propose are, by their own admission, mainly measures of reproductive health care provision and reproductive health status (WHO 1997b:4).

Table 6: Types of Indicators for Monitoring Progress (WHO 1997:Step 2 Page 2)

Types of indicator required to monitor RH	Types of indicators defined to monitor HFA (Health for All)
• An enabling environment • Empowerment of individuals to promote their own reproductive health • The provision of accessible and effective health care	• Health policy indicators • Social and economic indicators related to health • Indicators of the provision of health care • Health status indicators

The WHO identified a minimal list of reproductive health indicators through a process that drew on technical expertise as well as inter-agency dialogue and country experiences. This process involved consideration of a total of 148 indicators variously proposed by UNFPA, WHO indicators for reproductive health and HIV/AIDS and relevant indicators from those they identify to monitor progress for Health for All, UNICEF indicators for monitoring progress reducing maternal mortality and those developed with WHO to monitor progress on the goals established at the World Summit for Children, as well as those developed by USAID to measure various components of ICPD. The majority of indicators proposed relate to traditional reproductive health ‘programme areas’ and the 33 developed for abortion care, adolescent reproductive health, FGM, violence against women, reproductive tract cancers and infertility have only emerged since ICPD (WHO 1997b:2). The WHO have reached consensus around 15 indicators and identified priority areas for development (see table 7 below). The fairly detailed account of reasons for and against potential indicators shows that the stringent criteria that the process applied to screen out ‘poor’ indicators has had a major impact on what is to be measured (see WHO 1997b: Annex 5). They are recognised as partial and imperfect: “being merely a reflection of a real thing” or “a partial measure of a complex situation” (WHO 1997b:Conclusions: 1) - and their approach is deliberately minimalist in view of the difficulties they have experienced with poor returns for global monitoring[7] (WHO 1997a:2). Although it is now well accepted that focussing only on reproductive outcomes, such as ‘total fertility rate’, or user statistics, such as ‘contraceptive prevalence rates’, prejudges the meaning of reproductive experiences for women’s wellbeing, these remain central to global monitoring of reproductive health. Of the five newer ‘programme areas’ only three are reflected in some way in the final indicators selected: namely abortion care, FGM and infertility.

Table 7: Global Reproductive Health Indicators

Minimal List of Reproductive Health Indicators for Global Monitoring
1. Total fertility rate
2. Contraceptive prevalence rate
3. Maternal mortality ratio
4. % women attended at least once during pregnancy by skilled health personnel (not TBA)
5. % births attended by skilled health personnel (not TBA)
6. Number facilities with functioning basic essential obstetric care per 500,000 population
7. Number facilities with functioning comprehensive essential obstetric care per 500,000 population

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[7] For 58% of the indicators selected by WHO for monitoring progress with Health for All in 1994, only countries whose populations make up 25% of the world population reported statistics (WHO 1997a:2)

8. Perinatal mortality rate
9. % live births of low birth weight (<2,500g)
10. Positive syphilis serology prevalence in pregnant women aged 15-24 years
11. % women of reproductive age (15-49 years) screened for haemoglobin levels who are anaemic
12. % obstetric and gynaecology admissions owing to abortion
13. % prevalence of women with FGM
14. % women (15-49 years) at risk of pregnancy who report trying for a pregnancy for 2 years plus
15. Reported incidence of urithritis in men of reproductive age

Priority areas for indicator development

- Abortion
- Violence against women
- Quality of care
- Access to care
- Antenatal care
- Postpartum care
- Adolescent reproductive health
- ‘Male factor’
- Reproductive health policy
- HIV/AIDS
- Reproductive Tract Infections
- Preventative behaviour
- Cervical cancer

The World Bank and the Population Council in 1996 also held a technical meeting to think about measuring the achievements and costs of family planning programs in the light of the new focus on reproductive health and rights goals (1996). This meeting reiterated that traditional monitoring, particularly the use of couple-years of protection was inappropriate and that total fertility rates and contraceptive prevalence rates were not useful for “gauging program performance and reproductive choice and health” (1996:44). This meeting felt that modifying measures of unwanted fertility, unmet need for family planning, contraceptive continuance rates and the HARI index (see below) were potential starting points for developing more appropriate indicators.

Clinical views of reproductive health have been criticised for focussing largely on negative outcomes and falling into the “measurement trap” whereby lack of information reinforced neglect, as for example with domestic violence (Graham 1998, also Wellings and Cleland 2001). “The contraceptive prevalence rate.. while easily measurable and long used to demonstrate improvements in reproductive health, is in reality a poor reflection of the benefits (health and non-health) that accrue from avoiding unwanted fertility” (WHO 1998 Section 3.3 page 4). Although information about reproductive health status is inadequate it has improved considerably over the last 15 years. Knowledge of HIV/AIDS and the burden of disease caused by other STDs has increased, epidemiological data on reproductive cancers is growing and there is some data on the health impact of harmful practices like female circumcision. However, little is known about the extent of disabilities from pregnancy-related complications, about RTIs or about the burden of mental and physical suffering associated with violence and sexual abuse (WHO 1998). There are real difficulties in measuring reproductive health functionings – some of which are generic to health assessments and other which are fairly specific and include the rarity of events like maternal mortality necessitating large sample sizes with alternatives, such as the sisterhood method, presenting difficulties of measuring short term changes in localised programmes (Graham 1998), as well as difficulties around the sensitivity of issues leading to refusals to participate or be examined.

Some reproductive ill-health may remain asymptomatic for many years, particularly for women, only becoming apparent when extensive damage has been done (WHO 1998).

Recent discussion about the measurement of reproductive health has tried to address some of the perceived weaknesses of traditional data and has included developing methodologies to assess specific morbidities, rather than just mortalities, and has drawn on women's own assessments of their reproductive health status. Wellings and Cleland (2001) note an increasing number of studies combining biomedical measurements of morbidity with subjective interpretations of symptoms and consequences and taking place within community settings. However, the later has been driven primarily by the motivation that women's self-reporting of morbidities might be a cheap and effective way of epidemiological assessment that avoids the need for clinical examination. The general perception is that they are not (see for example Sloan et al 2001 and Bhatia and Cleland 2000),but several authors remark that this is missing the point – women's subjective experiences are an important data in and of themselves. Graham warns against "hasty" rejection noting that "what works" in reproductive health needs to factor in the views of women and their families (1998: 1929). Women, and to a lesser extent men's, self-perceived health needs are at the centre of the new agenda. Maine et al (1994) stress that "choice has a 'health value' in its own right" and argue for respect for women's choices in reproductive health programmes in all cultural settings. They cite Lapham and Mauldin's well-known survey that found that contraceptive prevalence increases by about 12% for each additional method offered (1985 cited Maine et al 1994:219). Sadana (2000:640) similarly sees "self-reported morbidity and observed morbidity measure different phenomena and therefore different aspects of reproductive health and illness" and argues that women's perceptions are the correct basis for examining reproductive health burdens.

Although some commentators persist in seeing contraceptive use as an indicator of the extent to which women control their reproductive lives (Doyal and Gough 1991), this has to be seen more broadly than simply contraceptive choice. Jain and Bruce made a contribution to this debate by proposing that family planning programmes be evaluated in terms of clients' behaviour (rather than by service delivery point or given method), in ways that accommodated the variability of client's choices, including the desire not to regulate fertility, enabled the disaggregation of distinct subgroups with different needs, and that factored in health outcomes in terms of morbidity as well as mortality (1994:199). Jain and Bruce propose the modified HARI (Helping Individuals Achieve their Reproductive Intentions) index constructed from a panel survey of women of reproductive age. The index is defined as 100 minus the percentage of women who have an unplanned or unwanted pregnancy or who experienced severe morbidity while trying to avoid pregnancy. They maintain that it can be disaggregated by client's reproductive intentions (eg. spacers, limiters, delayers, etc..). They call for high priority to be given to defining indicators associated with morbidity incurred whilst trying to avoid pregnancy and the design of panel studies that track individual's reproductive intentions and link them to their subsequent reproductive experiences. The former call is echoed by Maine et al with respect to maternal morbidity in developing countries (1994:207). Although commendable, evaluating outcomes in terms of women's a priori subjective preferences remains an incomplete description of both reproductive experiences and of wellbeing (see Locke 2001, and Locke forthcoming). Discussions of reproductive agency need to engage closely with the complex relational context of 'decision'-making and the processes whereby social and cultural institutions shape choice, giving it meaning over time. This means we need to take seriously women's narratives of their experiences as they unfold and we need to balance these accounts with more objective assessments of their wellbeing.

Analysis of reproductive health status are rarely disaggregated by social class, wealth rank, ethnicity or caste, rarely include men at all, and often assume rather than demonstrate any relationship with wellbeing. Some of the exceptions to this fall within the category of the population and development literature that has been primarily concerned to examine the factors triggering transition to lower societal fertility. This literature has examined different fertility behaviour by social class, by religious affiliation, by ethnicity/caste and have shown some concern with male fertility ambitions. Many important things have been learnt from this literature, including the fact that some men and women in particular social and economic circumstances may not desire lower fertility thus providing a powerful critique of CPR as a key indicator of reproductive autonomy. However, the fact remains that this literature was not concerned with the subjective experience of reproductive behaviour and its implications for wellbeing and frequently regarded 'culture' as a static barrier to more modern, read 'better', fertility behaviour (Greenhalgh 1995). Assessments of family planning programmes health have in contrast paid some attention to the impact of place (rural/urban), distance, age, parity and educational level on women's fertility behaviour. Women's (and men's) fertility aspirations have been investigated through KAP surveys that have been highly restrictive and decontextualised in their focus on desired family size and birth intervals, on contraceptive knowledge and use. There is also within the population and development literature a particular tradition of looking at women's status/autonomy and reproductive behaviour which retains a reductionist and instrumental interest in how education and employment/income generation impact on women's fertility.

There are however more provoking accounts of changing reproductive freedoms emerging from feminist literature both from academics and activists. Critique of reductionist linkages between women's education, employment and income generation and their fertility gave rise to a rich feminist literature that adds considerable depth and complexity to understandings of women's reproductive autonomy. Sen and Snow (1994) and their contributors investigate the social control of reproduction. Presser and Sen's (2000) provides an excellent volume of recent work in this vein set within an overview of where the debates have got to and where future challenges lie. Mirsky and Radlett's (2000) contributors describe the work of women's networks in campaigning for change, enforcing standards, co-ordinating alliances and raising awareness including around issues of reproductive health. There have also been audits of reproductive freedoms and assessments of legal changes. For instance, Pillai and Wang (1999) have attempted an analysis of reproductive rights across 101 developing countries and conclude that gender equality, broadly understood, rather than education or economic development, is the critical ingredient for reproductive rights. Khanna reports on the use of the law to expand reproductive rights in Ghana, Colombia and Canada and stresses the importance of understanding differences in legal traditions and of exploring how attempts to legislate around reproductive rights can be circumvented or counterproductive (1999). Ramirez and McEneaney (1997) examine the process of liberalisation of abortion rights across 155 countries in the context of growing political citizenship including women's enfranchisement. They found that reproductive rights may be vulnerable to reversals, more usually incremental but in 10 cases severe, and that by 1990 nearly 50% of countries had liberalised abortion laws. Significantly, they too found that liberalisation was not straight forwardly related to modernisation but to a complex range of political characteristics including the timing of independence, proximity of states with progressive legislation, participation of women in the labour force, the involvement of women in political movements, the social activism of the state, and membership of international NGOs.

We are not aware of any systematic register of reproductive rights (such as the Freedom House annual register of political and civil rights or the US State Departments Country Reports on Human Rights Practices) and more generalised monitoring of human rights tends to give little if any space to reproductive rights violations. However, a number of organisations have attempted to assess progress since Cairo for the Cairo+5 process and as part of international human rights monitoring through CEDAW (see for instance the Center for Reproductive Law and Policy (CRLP) in New York and non-governmental submissions to CEDAW). CEDAW mechanisms offer most space for assessment of reproductive rights that balance concern with reproductive health with reproductive freedoms because of their in-built scope to receive varied kinds of submissions from a variety of stakeholders. Coliver (1995) has identified a list of human rights standards for monitoring government practice with respect to reproductive health information and these are based around free speech doctrine. However, this has been justifiably criticised by Whitty as relying on the notion of a 'market place of ideas' that reduces reproductive health information to 'mere facts' and thus "ignores the power differential between various actors and cloaks the state in a mantle of artificial neutrality" (Whitty 1996:234,236). Jacobsen comments on the gap between legal approaches to human rights reporting and public health approaches to recognising and validating priority issues: "Traditional human rights documentation relies on reports from and interviews with key informants in a given setting. By its nature, such reporting is often based on small numbers of discrete cases which frequently raises 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 represents more than a few isolated cases....."(Jacobsen 2000:23-24). She continues to say that : "by focusing only on blatant violations, again, such as sterilisation without consent, human rights methodologies can also miss subtler, but more widespread and persistent violations of rights" (Jacobsen 2000:24). Whilst a legal approach may deal with formal entitlements and public health approaches may deal with services, both are disengaged from the social reality of the entitlements women can claim in practice through informal as well as formal channels.

There are a growing number of studies that examine differential entitlements to reproductive health although these focus mainly on access to reproductive health services rather than on social institutions. Considerable research has shown that reproductive experiences are differentiated not only in terms of sex, age, and parity, but can also be differentiated in terms of gender, life-stage, social identity, wealth, ethnic group, caste, location, political affiliation and other lines of inequality (see Greenhalgh 1995). For example, Lane et al (1998) looking at the 'economics of abortion safety' in Egypt confirm that reproductive rights are differentiated by poverty (1089). Ram (1994) shows how class and caste shape women's experiences of medical institutions around childbirth in Tamil Nadu and Reysoo (1999) describes how a complex series of life stages structures women's sexuality in Morocco. In addition, there is work looking at how reproductive rights are interpreted cross-culturally (Petchesky and Judd's 1998 IRRAG study) and are interpreted in different ways to claim social justice (for example Jackson (1999) discusses the way women activists opposed foetal sex determination in India on the grounds of supporting women's collective rights to be valued members of society). In view of these kinds of understandings, Khanna (1999) calls for social science research to provide a reality check for rights-based approaches to reproductive health by extending "government's record in expanding choices to be monitored" (1999:8).

Although there is debate amongst the international agencies over the 'best' indicators for reproductive health, Graham points out that this rarely includes sufficient attention to the fact that 'best' depends on the purpose for which you want to use the data (1998). She stresses that most studies are motivated in one of two directions: either trying to ascertain the health outcomes attributable to a specific health intervention or trying to understand the different contributors to a specific health outcome, and notes the emphasis on efficiency as opposed to efficacy. "Although the lack of positive health outcomes has been decried for many years and across many health fields, real progress at both conceptual and methodological levels has been dismal; reproductive health has been no exception. Concerted research effort is needed is those activities related to wellbeing, rather than to ill-health, which were endorsed in the Cairo ICPD are to be tracked for progress." (Graham 1998:1926). Maine et al (1994) draw an embedded understanding of reproductive behaviour to show that reproductive health is about managing not only the health risks associated with sex, pregnancy and childbirth but also about managing social risks and in particular risks to the gender order. They draw attention to the abuses of data on reproductive health risks highlighting the need for a much firmer ethical basis for developing monitoring and for its use in guiding policy action.

To conclude, health assessments focus on ill-being and predominantly death and disease and health-related indices such as QALYs or DALYs have proved blind to social differentiation, including gender differentiation, and unhelpful for investigate issues of social justice, human rights and for addressing different social and cultural values. Nevertheless, DALYs have been used to quantify the burden of reproductive ill-health and continue to be developed for this purpose. The ICPD definitions of reproductive health and rights are not directly addressed by existing global reproductive health indicators. This is in spite of review by the WHO and associated agencies leading to the exclusion of older measures (such as CYP), and the addition of newer indicators (such as quality of care indicators and indicators for new programme areas associated with reproductive health issues). Global guidance on national and programme monitoring for reproductive health by the UNPFA usefully includes policy and process indicators and have the scope to investigate some dimensions of inequalities as well as some aspects of the enabling environment. However, global reproductive health monitoring excludes policy indicators and retains a central, and I have argued misplaced, concern with fertility rates and contraceptive use. It is acknowledged that there are real methodological difficulties monitoring reproductive health but current strategies tend to fall into the ‘measurement trap’ and attempts to improve measures frequently mis-count the value of women’s views.

Attempts to take this further have so far met with little acceptance and stop short of valuing ‘lived’ experiences. Disaggregation of official data remains around traditional population concerns but alternative approaches add depth to understanding about reproductive autonomy, empowerment, and the extension of formal reproductive rights, everyday violations and informal (dis)entitlements. Despite an ongoing debate, there is little evidence of progress in improving the tracking of reproductive health as it relates to wellbeing, including rights, creating serious ethical challenges about the use of out-moded monitoring data in guiding policy action.

Conclusions

The criteria by which a concept is defined and measured matter. All too frequently these indicators become the need identified and the target aimed at even when they began life as a proxy. We argue that the shift in social policy about reproduction has so far been inadequately reflected in thinking about identifying needs and measuring outcomes and processes within reproductive policy and programming (see Graham 1998). A general tendency towards simplification in monitoring (that inclines to focussing on ‘key’ indicators or indices) compounds this difficulty. However, choosing the right ‘key’ measure can provide political leverage particularly if it is also well contextualised.

At present, the assessment of ‘new’ reproductive rights lies between two traditions: the tradition of human rights monitoring and a medical/public health tradition which respectively concentrate on cataloguing individual abuses and focus on highly aggregated population statistics. The former approach does not situate the abuse either with respect to its incidence in society or with respect to the processes or practices that generate it and the latter prejudges the meaning of specific indicators and to some extent decentres what really matters. Alternative approaches found largely within ‘grass-roots’ activist NGOs and academic research investigate the extent of different women and men’s entitlements and their strategies and ability to negotiate over reproductive matters. They use rights in an embedded way to link reproduction to broader issues and neither tend to offer comprehensive assessments.

The analysis suggests that developing new ways of monitoring reproductive health and freedoms is a major challenge. This challenge needs to be met in ways that ensure that policy action is directed in appropriate ways to strengthening women’s and men’s entitlements to reproductive health and freedom. This means addressing a number of serious lacunae including: balancing objective assessments of health with subjective experiences; going beyond looking at outcomes to consider the alternatives that women and men feel they have, the choices they make and the consequences as they experience them; embracing informal entitlements as well as legal entitlements and considering processes of realising and negotiating those entitlements; putting questions of social justice and of social differentiation in reproductive health and rights centre stage; including policy processes and considering collective political dimensions that enable rights-bearers to make and shape policy; creating space for local specification of reproductive functionings whilst defending a universal ethical core of rights; and last, but far from least, situating analysis around reproductive health and freedom within a broader human development framework.

The CEDAW mechanisms appear the most promising for the development of monitoring around reproductive rights in large part because they permit submissions from a variety of stakeholders taking a variety of approaches towards reporting. The official guidance from the WHO on reproductive health monitoring in the light of Cairo is disappointingly conservative. The much broader based guidance from UNPFA is useful at several levels but remains tightly focused on reproductive health policy and services and remains disengaged from some of the central concerns of this paper. Emerging methods for monitoring human rights accountability might have potential for monitoring reproductive rights accountability in ways that make space for local interpretations. The challenge of transforming assessments of reproductive health and rights is both methodological but also political. Gaining acceptance for new techniques is vital to ensuring that concerns around reproductive freedoms and a deeper understanding of reproductive behaviours and strategies informs official monitoring of reproductive rights.

Appendix A

Table 1: Objectives of Human Rights Indicators and Statistical Requirements (UNDP 2000:90-106)

Objective	Statistical Requirements
Asking whether states respect, protect and fulfill rights	1. Respect for rights • Data on rights violations 2. Protection of rights • Direct measurement of harmful activities • Measurement of state action to prevent or stop it 3. Fulfilling rights • Analysis of whether policy embodies rights principles • Analysis of whether action taken to ensure progress and effective remedies • Analysis of wether rights are being secured by building social norms, institutions, law and enabling economic environment
Ensuring that key principles of rights are met	• Data on non-discrimination (equitable treatment for all) – mainly disaggregation of statatics and indices. • Data on adequate progress (committing resources and effort to the priority of rights) – tracking changes in inputs and outcomes in relation to agreed benchmarks. • Data on true participation (enabling people to be involved in decisions that affect their wellbeing) including surveys of rights awareness, quantifying information made publically accessible and opportunities for public consultation. • Data on effective remedy (ensuring redress when rights are violated) by quantifying efficacy of judicial system.
Ensuring secure access	• Information on social norms • Informaiton on the quality and ethos of institutions (both institutions delivering on specific rights and institutions providing the framework for all rights, ie. judiciary, ombudsman, etc.) • Assessment of written law and its application • Assessment of the economic enabling environment both at macro and micro levels
Identifying critical non-state actors	• Assessing the actions (and non-actions) of a variety of actors including the state but moving beyond to include corporations, the international financial instituions, communities, NGOs, the media, parents, etc. as appropriate.

Table 2: Indicators for Human Rights International Accountability Index (UNDP 2000:107)

Dimension	Basis for Indicator
Accept: fundamental acknowledgement of international accountability	Ratification or accession to: • IC on civil and political rights (ICCPR) • IC on Economic, social and cultural rights (ICESR) • IC on elimination of all forms of racial discrimination (ICERD) • C on Elimination of all forms of discrimination against women (CEDAW) • C against torture and other cruel , inhuman or degrading treatment or punishment (CAT) • C on Rights of the child • The four Geneva conventions of 1949 Ratification of the individual complainst procedures for ICCPR, ICERD, CEDAW, CAT and the Geneva conventions
Cooperate: participation in established international procedures	• Submission fo reports due to treaty bodies in good time • Provision of requested information to special rapporteurs and thematic missions • Cooperation with monitoring missions • Cooperation with UN-sponsored election monitors • Cooperation with the International Committee of the Red Cross in relation to prison visits
Respond: Extent of adequate replies to requests	• Adequate response to recommedenations by treaty bodies • Adequate response to final views adopted in connection with communications procedures • Adeuqate response to recommendations by country rapporteurs and thematic missions

Table 3: UNDP's Political Freedom Index (UNDP 1992:31)

Cluster of Freedoms	Specific Freedoms
Personal security	• Arbitrary arrest and detention • Tortute or cruel treatment or punishment • Arbitrary killing • Disappearances
Rule of law	• Fair and public hearings • Competent independent and impartial tribunal • Legal counsel • Review of conviction • Failure to prosecute
Freedom of expression	• Restriction in law and practice • Media censorship • Media ownership • Freedom of speech
Political participation	• Political participation • Free and fair elections • Continuity of the democratic system • Community and local decision-making
Equality of opportunity	• Legal guarantees • Violence against, or harrasment of particular groups • Political participation • Economic participation

References

AbouZahr, C. and Vaughan, J.P. (2000) ‘Assessing the Burden of Sexual and Reproductive Ill-Health: Questions Regarding the use of Disability-Adjusted Life Years’ Bulletin of the World Health Organisation 78(5):655-666.

Bastian, H. (2000). "A Consumer Trip into the World of the DALY Calculations: An Alice-in-Wonderland Experience." Reproductive Health Matters **8**(15): 113-116.

Bhatia, J. and Cleland, J. (2000) ‘Methodological Issues in Community-Based Studies of Gyneacological Morbidity’ Studies in Family Planning 31(4):267-273.

Bruce, J. (1990). "Fundamental Elements of the Quality of Care: A Simple Framework." Studies in Family Planning **21**(2): 61-91.

Coliver, S. (1995). The Right to Information Necessary for Reproductive Health and Choice under International Law. In The Right to Know : Human Rights and Access to Reproductive Health Information. Edited by S. Coliver. London and Philadelphia, Article 19 and University of Pennsylvania Press**:** 38-82.

Cook, R. J. and B. M. Dickens (1999). "The FIGO Study Group on Women's Sexual and Reproductive Rights." International Journal of Gynecology & Obstetrics **67**(1): 55-61.

Cornwall, A. and J. Gaventa (2000). "From Users and Choosers to Makers and Shapers: Repositioning Participation in Social Policy." IDS Bulletin **31**(4): 50-62.

Correa, S. S. and R. L. Reichmann (1994). Population and Reproductive Rights: Feminist Perspectives from the South. London & New Jersey, Zed Books in association with DAWN.

Dasgupta, P. (1990). "Well-being and the Extent of Its Realisation in Poor Countries." The Economic Journal **100, Supplement**: 1-32.

Doyal, L. and I. Gough (1991). A Theory of Human Need. Basingstoke, Macmillan Education.

Fraser, N. (1989). Unruly Practices: Power, Discourse and Gender in Contemporary Social Theory. Cambridge, Polity Press.

Freedman, L. P. and S. L. Isaacs (1993). "Human Rights and Reproductive Choice." Studies in Family Planning **24**(1): 18-30.

Freedom House (2000). Freedom in the World, Freedom House. **2001**.

Gasper, D. (1993). "Entitlements Analysis: Relating Concepts and Contexts." Development and Change **24**: 679-718.

Gasper, D. (1996). "Culture and Development Ethics: Needs, Women's Rights, and Western Theories." Development and Change **27**: 627-661.

Gore, C. (1993). "Entitlement Relations and "Unruly" Social Practices: A Comment on the Work of Amartya Sen." The Journal of Development Studies **29**(3): 429-460.

Graham, W.J. (1998) ‘Outcomes and Effectiveness in Reproductive Health” Social Science and Medicine 47 (12): 1925-1936.

Greenhalgh, S., Ed. (1995). Situating Fertility: Anthropology and Demographic Inquiry. Cambridge, Cambridge University Press.

Harcourt, W., Ed. (1997). Power, Reproduction and Gender: The Intergenerational Transfer of Knowledge. London, Zed Books.

Harcourt, W. (1999). "Reproductive Health and Rights and the Quest for Social Justice." Development **42**(1): 7-10.

Hawthorne, G., Richardson, J., and Day, N.A. (2001) ‘A Comparison of the Assessment of Quality of Life (AQoL) with Four Other Generic Utility Instruments’ Annals of Medicine 33(5):358-370.

Jackson, C. (1997). "Post Poverty, Gender and Development?" IDS Bulletin **28**(3): 145-155.

Jackson, C. (1998). "Women and Poverty or Gender and Well-Being." Journal of International Affairs **52**(1): 67-81.

Jackson, C. (1999). "Social Exclusion and Gender: Does One Size Fit All?" European Journal of Development Research **11**(1): 125-46.

Jacobson, J. L. (2000). "Transforming Family Planning Programmes: Towards a Framework for Advancing the Reproductive Rights Agenda." Reproductive Health Matters **8**(15): 21-32.

Jain, A. and J. Bruce (1994). A Reproductive Health Approach to the Objectives and Assessment of Family Planning Programmes. In Population Policies Reconsidered: Health, Empowerment and Rights. Edited by G. Sen, A. Germain and L. C. Chen. Boston, Harvard University Press.

Kabeer, N. (1999). "Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment." Development and Change **30**: 435-464.

Keysers, L. (1999). "The Politics of Inclusion and Exclusion: Fortress Europe and the Reproductive Rights Agenda." Development **42**(1): 18-24.

Khanna, J., Ed. (1999). Advancing Reproductive Health Through Human Rights and Laws. Progress in Human Reproduction Research. Geneva, UNDP/UNFPA/WHO/World Bank Special programme of Research, Development and Research Training in Human Reproduction (HRP).

Lane, S. D., J. M. Jok, et al. (1998). "Buying Safety: The Economics of Reproductive Risk and Abortion in Egypt." Social Science & Medicine **47**(8): 1089-1099.

Leach, M. (1999). "Environmental Entitlements: Dynamics and Institutions in Community-based Natural Resource Management." World Development **27**(2): 225-247.

Locke, C. (2001). The Rights Language? Reproduction, Wellbeing and Global Social Policy. Wellbeing, Rights and Reproduction Research Report I, Social Policy Research Programme, Norwich: UEA.

Locke, C. (forthcoming) Discursive Challenges: Reproductive Rights and Women’s Wellbeing in Developing Countries in F.Poland and G.Boswell (eds) Women’s Minds, Women’s Bodies: Interdisciplinary Perspectives, Basingstoke: Palgrove

Locke, C. and Okali, C. (1999) “Analysing Changing Gender Relations: Methodological Challenges for Gender Planning” Development in Practice 9(3):274-286.

Macfarlane, S., M. Racelis, et al. (2000). "Public Health in Developing Countries." The Lancet **356**(9232): 841-846.

Maine, D. et al (1997) Guidelines for Monitoring the Availability and Use of Obstetric Services. WHO, UNICEF and UNFPA.

McAlearney, A.S., Schweikhart, S.B., and Pathak, D.S. (1999) 'Quality-Adjusted life Years and other Health Indices: A Comparative Analysis' *Clinical Therapeutics* 21(9):1605-1629.

McNicoll, G. (1994). Institutional Analysis of Fertility. In Population, Economic Development, and the Environment. Edited by K. Lindahl-Kiessling and H. Landberg. Oxford, Oxford University Press**:** 199-230.

Mirsky, J. and Radlett, M. (eds) (2000) *No Paradise Yet: The World's Women Face the New Century*. London: PANOS/Zed.

Moran, M. (1991). The Frontiers of Social Citizenship: The Case of Health Care Entitlements. In The Frontiers of Citizenship. Edited by U. Vogel and M. Moran. Basingstoke and London, Macmillan**:** 32-57.

Newman, K. and J. F. Helzner (1999). "IPPF Charter on Sexual and Reproductive Rights." Journal of Women's Health & Gender-based Medicine **8**(4): 459-463.

Nussbaum, M. C. and J. Glover, Eds. (1995). Women, Culture, and Development: A Study of Human Capabilities. Oxford, Clarendon Press.

Nygaard, E. (2000). "Is It Feasible or Desirable to Measure the Burdens of Disease as a Single Number?" Reproductive Health Matters **8**(15): 117-125.

Obermeyer, C. M. (1995). "A Cross-Cultural Perspective on Reproductive Rights." Human Rights Quarterly **17**: 366-381.

Petchesky, R. P. (2000). Reproductive and Sexual Rights. Geneva, UNRISD.

Petchesky, R. P. and K. Judd, Eds. (1998). Negotiating Reproductive Rights : Women's Perspectives across Countries and Cultures. London, Zed Books.

Pillai, V. K. and G.-z. Wang (1999). Women's Reproductive Rights in Developing Countries. Brookfield, USA, Singapore and Sydney, Ashgate.

Presser, H. B. and G. Sen, Eds. (2000). Women's Empowerment and Demographic Processes: Moving Beyond Cairo. Oxford, Oxford University Press.

Ram, K. (1994) 'Medical Management and Giving Birth: Responses of Coastal Women in Tamil Nadu', Reproductive Health Matters, 4:20-26.

Ramirez, F. O. and E. H. McEneaney (1997). "From Women's Suffrage to Reproductive Rights? Cross-national Considerations." International Journal of Comparative Sociology **38**(1-2): 6-24.

Razavi, S. (1999). "Gendered Poverty and Well-being: Introduction." Development and Change **30**: 409-433.

Reysoo, F. (1999) 'Gender, Reproductive Rights and health in Morocco: Traps for Unmarried Mothers', Development, 42(1): 63-66.

Sadana, R. (2000) 'Measuring Reproductive Health: Review of Community-Based Approaches to Assessing Morbidity' Bulletin of the World Health Organisation 78(5):640-654.

Sawalha, l. (1999) 'Barriers of Silence: Reproductive Rights for Women in Jordan' Development 42(1):41-46.

Scott, S. (1999). Gendered Institutions and Entitlements to Land: An Analysis of Vulnerability in Vietnamese Decollectivisation. In Joint Northwest Regional Consortium on Southeast Asian Studies -- Canadian Council for Southeast Asian Studies (NWRCSEAS-CCSEAS) Conference. University of British Columbia.

Sen, A. (1990a). Gender and Cooperative Conflicts. In Persistent Inequalities: Women and World Development. Edited by I. Tinker. New York and Oxford, Oxford University Press**:** 123-149.

Sen, G., A. Germain, et al., (Eds.) (1994). Population Policies Reconsidered: Health, Empowerment, and Rights. Boston, Harvard University Press.

Sen, G. and R. C. Snow, (Eds.) (1994). Power and Decision: The Social Control of Reproduction. Harvard Series on Population and International Health. Boston, Massachusetts, Harvard University Press.

Sloan, N.L., Amoaaaful, E., Arthur, P., Winikoff, B., Ajei, S. (2001) 'Validity of Women's Self-Reported Obstetric Complaints in Rural Ghana' Journal of Health, Population and Nutrition 19(2): 45-51.

UN (United Nations) (1994). Programme of Action of the International Conference on Population and Development, UN Doc A/Conf.171/13, Geneva: UN.

UN (United Nations) (1999). Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development.

UNDP (United Nations Development Programme) (1992) Human Development Report. Oxford University Press, New York.

UNDP (United Nations Development Programme) (1997) Human Development Report. Oxford University Press, New York.

UNDP (United Nations Development Programme) (1998) Human Development Report. Oxford University Press, New York.

UNDP (United Nations Development Programme) (1999) Human Development Report. Oxford University Press, New York.

UNDP (United Nations Development Programme) (2000) Human Development Report. Oxford University Press, New York.

WHO (World Health Organisation) (1997). Monitoring Reproductive Health: Selecting a Short List of National and Global Indicators. Geneva, WHO`.

WHO (World Health Organisation) (1997). Reproductive Health Indicators for Global Monitoring: REport of an Interagency Technical Meeting. Geneva, WHO.

WHO, W. H. O. (1998). DALYs and Reproductive Health: Report of an Informal Consutaltion, World Health Organisation.

Wellings, K., and Cleland, J. (2001) 'Surveys on Sexual Health: Recent Developments and Future Directions' Secually Transmitted Infections 77(4): 238-241.

World Bank (1993) Investing in Health. 1993 World Development Report. Washington: World Bank.

World Bank (1996). Measuring the Achievements and Costs of Reproductive Health Programs. Washington, World Bank, Population Council.

Yamin, A. and D. Maine (1999). "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations." Human Rights Quarterly **21**(3): 565-607.