

**Implementing Reproductive Rights:
Population Debates and
Institutional Responses to the New Agenda**

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This paper briefly traces the evolution of population-development debates and discusses related changes in international population policy. The politics of the latest shift – the consensus around reproductive rights – are explored in more detail. The paper then reviews the way in which three very different organisations concerned with reproductive health policy have responded to the reproductive rights agenda. The organisations included were the Women's Global Network for Reproductive Rights (WGNRR), the International Federation of Family Planning Associations (IPPF) and the UK's Department for International Development (DFID). An informal interview with policy staff and secondary materials were used to describe how the WGNRR, IPPF and DFID respectively saw their roles with respect to establishing and promoting reproductive rights in developing countries.

Introduction

During the early years of implementing donor-sponsored population control programmes, heated debates between the developing and developed worlds occurred over the relationship of population and development. Since the late-1980s, however, the central concerns of the population-development discourse have been significantly reoriented towards reproductive health and rights. This paper traces the trajectory of the population-development debates and discusses changes and shifts in international population policy. We argue that population has never been a neutral issue, and the evolution of the population debates has reflected complicated relations in terms of ideology, power, resources, national interests, gender and the influences of social movements. The more recent shift of focus in the population debates has been closely associated with the increasing influences of feminist perspectives on the issue, an international rethinking of the meaning of development, and the international women's health movement. All this has contributed to the increased incorporation of a reproductive rights and health agenda into population and health programmes by different international policy forums.

A Brief History of the Population and Development Debates

Few issues in the world have ever caused so much heated academic and political debates as population and development. Perceptions of the relationships between population growth and economic development have inevitably surrounded Malthusian demographic theory, which, in its simple version, predicts a much faster rate of population increase than that of food production. In this perspective, the threat posed by the rapid population growth could only be mitigated by such natural or human disasters as war, famine and disease. Despite Malthus' later modification of this thesis, his earlier writings continued to exert influences on social and political thinking and practices during the 19th century and beyond.

Accordingly, the Malthusian school of thought informed and rationalised many Western-sponsored population control programmes in developing countries from the 1950s to the 1980s. This was a major source of the prolonged debates on the population and development issue both in academia and between the developed and developing worlds. Although there has been much diversity in views and policies within either of the “worlds”, a broad line can be drawn between the two with respect to

broadly shared political and economic interests at the global level. Northern donor governments led by the United States initiated population control programmes in Southern countries as a component of aid on the grounds that unchecked population growth was the major cause of poverty and underdevelopment experienced in the South. In contrast, many developing countries, rather than seeing poverty as associated with natural population growth, emphasised Western political domination, economic exploitation and the unfair world economic order as mainly responsible for developing countries' poverty and development problems (Gulhati & Bates, 1994).

This division was evidenced in the UN Population Conference held in Bucharest in 1974, when the international support for population control programmes in the South started to gain prominence. The developing countries' position was partially expressed by the Indian delegation's claim that "development is the best contraceptive" and the related perception that poverty and under-development functioned as the cause rather than effect of rapid population growth (Gulhati & Bates, 1994: 53). Similarly, the Chinese government strongly denied that population was a development issue under socialism, which it considered the best economic and social structure for development. Many other developing countries, e.g. the Group of 77, demanded redistribution of resources between the rich and poor countries on an international scale in their appeal for a new international economic order (Finkle & Crane, 1975; Hartmann, 1987; Ratcliffe, 1978).

Commentators pointed out that developing countries' suspicion of the donor-sponsored population programmes of the time was not groundless. The United States, which played a leading role in the international population policy making (e.g. funding), was ideologically driven in designing its aid packages (Gulhati, 1994). It was reported that behind the U.S. support for population programmes in the South were its strong Cold-War ideology against communism, its profound fear that high birth rates may facilitate the spread of communist influence, and thus threaten the power of the West. The U.S. aid policy, including its population control programmes, was often intended to expand the U.S. sphere of influence among Third World countries. As such, the U.S. international population policy-making was regarded as largely concerned about its own economic and political interests instead of the declared aims of reducing poverty and facilitating economic growth in the developing world. In practice, birth control programmes frequently tilted towards achieving population control goals through provision of contraceptives in the absence of demand in the developing countries concerned. The self-oriented motives of Western donor governments and the specific context of policy implementation were one of the reasons for the rejection of Western-promoted population control programmes by many developing countries during the 1950s to the early 1980s, and the allegation that population control was a form of genocide in the name of humanitarian aid by the West (see Furedi, 1997; Gulhati & Bates, 1994; Hartmann, 1987). Despite such rhetoric, international pressures and domestic problems, such as poverty and famine, led to the adoption of population control programmes by a number of developing countries, some of which tended to go extremes as exemplified in the India case, [Correa, 1994 #72].

By the 1984 International Conference on Population in Mexico City, however, positions of the Northern and Southern governments on the population issue shifted in opposite directions. Many developing countries started to recognise the problems related to rapid population growth and had

begun to introduce family planning programmes despite opposition and resistance from religious, political and social-cultural forces. On the other hand, the United States as a leading donor retreated from its earlier emphasis on the perceived urgency in checking rapid population growth. The so-called “Mexico City policy” stipulated that the U.S. would not support any NGOs or international agencies involved in abortion-related activities. Accordingly, the United States withdrew its funding for the International Planned Parenthood Federation (IPPF), the biggest NGO working in the area of family planning, for its abortion-related information and service provisions. Shortly afterwards, in 1986 the U.S. government further announced its decision to stop funding the activities of UNFPA, the largest multilateral agency specialising in population and development issues, on the grounds that the latter supported the Chinese official family planning programme. Analysts have argued that this reversal of the U.S. international population assistance policy was largely the working of its domestic politics [Dixon-Mueller 1993, Finkle 1985]. The Mexico City Conference took place while the U.S. presidential election was approaching. Thus, the U.S. government was ready to make compromise with a coalition of heterogeneous groups and constituencies of the New Right within the country, including religious pro-life, anti-abortion groups, conservative politicians and social forces. The working of the domestic politics in the U.S. international population policy-making, which significantly influenced the position of other Western donors as well, represented a typical case of the importance of interwoven international and national politics as well as economic and strategic interests in the design and formulation of population policies.¹

The Mexico City policy was reversed by the Clinton administration in 1993. Nevertheless, differences between the developing and developed worlds have not been completely removed. A recent point of debates, for example, is around population and environment relations. At the 1992 UN Conference on the Environment and Development in Rio, the U.S. government emphasised demographic factors as a major source of environmental degradation world-wide. In contrast, developing countries saw life-styles and excessive consumption, including energy consumption, in Western society as largely responsible for the “greenhouse effect” and other global environmental problems. The argument that “One birth in the United States is the ecological equivalent of 25 [births] in India” (Collins, 1992: 53) reflects the latter’s sentiment towards the current population debate, which is charged with international politics leading to negotiations over rights and obligations as it has always been.

Despite the division, by the time when the International Conference on Population and Development (ICPD) was held in Cairo in 1994, greater consensus over the population and development issue seemed to have been achieved. International population policies have gradually moved away from a single-minded focus on fertility reduction towards increased emphasis on sexual and reproductive

¹ It should be noted that the phenomenon has not been observed in Western contexts alone. The Cold War situation as well as the internal political and economic systems influenced many developing nations with respect to their perceptions and positions on the population issue. For instance, both Russia’s influence and orthodox Marxism shaped the economic and political structure and the population policy of China, the biggest and most populous developing country in the world, from the 1950s till the late 1970s. In consequence, the term family planning was turned into a taboo following severe political persecutions of scholars and politicians who advocated family planning in the late 1950s. Abortion was strictly restricted and sterilisation forbidden by the state. This policy led to a net increase of 220 million people within 12 years from 672 million in 1962 to 892 million in 1973 (Ma, 1996: 265; Tien, 1973), forcing the post-Mao Chinese government to adopt the much criticised radical family planning programme since the early 1980s on the grounds of a perceived population explosion and welfare crisis for the nation.

health, rights and empowerment of women. As such, the Cairo agreement is regarded as a turning point in the international population debates and population policy. This historical shift of focus has largely been due to the gradual incorporation of a gender perspective since the mid-1980s, the intensive lobbying by feminists prior to and at the ICPD, the growing influence of the international women's health movement, as well as mounting international concerns over the grave threat of HIV/AIDS to human well-being (Correa, 1994). In the next section, we analyse the major factors that have contributed to the policy reorientation leading to the Cairo agreement and a rights-based approach to sexuality and reproduction.

International Women's Health Movement – A New Actor with an Alternative Agenda

The main challenge to international population programmes has come from women's health movement, which gained momentum during the late 1970s and the early 1980s. Originating from second-wave feminist campaigns for women's health and rights regarding sexuality and reproduction in the Western context, the women's health movement and the politics surrounding reproductive health and rights have gradually expanded to include women from the Third World. This was partly attributable to increasing communication, exchanges and solidarity among women in the North and South following the UN Decade for the Advancement of Women from 1975-1985, which called for international attention to gender issues in development and women's status world-wide. Alongside this has been growing awareness of the fundamental problems associated with international population policies in terms of the rationale, focus and implementation in developing countries. The joint involvement of feminist academics, women professionals working within and outside the population establishments and women activist groups in both the North and South have helped broaden the scope of the population debates to include human development issues, particularly women's health, wellbeing and rights.

Feminist Critiques of the International Population Policy

Initially, feminist critiques of the international population policy reflected earlier developing countries' concerns over the ideology and motivation of Western governments' promotion of population control in the Third World. Feminists have been critical of the assumption of a linear relationship between rapid population growth and poverty and underdevelopment. Instead, they have stressed the importance of social justice and redistribution of resources both nationally and internationally. The gender perspective brought by feminists into the population debates has pointed to the major neglected areas by the mainstream international population institutions: the low priority given to women's reproductive needs, health, rights as well as broader economic and social policies necessary for creating an enabling environment (see Correa & Reichmann, 1994; Dixon-Mueller, 1993; Hartmann, 1987).

It is true that international population programmes from the 1950s to the 1980s facilitated a decline in fertility in many developing countries through disseminating family planning information, popularising related measures and providing contraceptives. In addition, subsidised services of family planning introduced through population programmes made it possible for poor people to gain access to such services (Potts & Rosenfield, 1990). However, many feminists felt uneasy with the principles and

practices of the international population control paradigm. Ethical issues and potential abuses of birth control programmes and technologies particularly caused alarm among feminists, who pointed out that international population thinking and policy-making had put the incidental (the much debatable causal relationship between rapid population growth and widespread poverty) before the fundamental (women's health, rights and empowerment) [Correa, 1994 #87].² Such a guiding principle led to policy practices where quantitative targets overrode quality of services, family planning was provided with a narrow focus on married women in childbearing age alone to the neglect of the diverse health needs of women at different life stages. Dissatisfactions with the demographically oriented family planning programmes were expressed among diverse groups, including clients of the services, health professionals, feminist scholars and even some family planning service providers.

Parallel to the prevailing development thinking of the time, which defined and evaluated development by a simple index of economic growth, population control programmes tended to view fertility reduction as the most effective approach to poverty elimination and development. Women, in this perspective, were deemed as "excessive child-bearers", and thus the principal programme target. In other words, women were treated as programme objects and perceived as means for reaching demographic goals (Dixon-Mueller, 1993; Germain, Nowrojee, & Pyne, 1994; Hartmann, 1987). Against this trend, feminists pointed out the dangers of the instrumentalist approach: possibilities of normalising coercive birth control programmes; ethical issues concerning contraceptive safety and the dumping of the Northern out-of-use contraceptives in the Southern market; the eugenic overtones in certain population programmes, which had the connotation of earlier Western anti-poor, racist and even genocide policies and practices (e.g. the Nazi sterilisation laws and gas chambers); and the low priority given to quality of services compared with the overwhelming imperative placed on quantities. The population control policy was also criticised for its top-down approach, and hence its insensitivity to cultural traditions, economic realities and the failure to meet the needs of clients, especially women and their families. This is deemed as being associated with the different aspirations, priorities and goals of men, women, families, nations, as well as the population establishments in reproduction-related issues (see Bok, 1994; Correa & Reichmann, 1994; Dixon-Mueller, 1993; Hartmann, 1987). Feminist critiques of the population programmes have, therefore, re-emphasised the notion of individual rights, particularly women's rights to determine their own sexuality and reproduction. This position is typically expressed in the following definition of reproductive rights as "women's right to decide whether, when and how to have children – regardless of nationality, class, race, age, religion, disability, sexuality or marital status – in the social, economic and political conditions that make such decisions." (Correa & Reichmann, 1994: 61)

Rethinking the Meaning of Development

The questioning and criticism of the population control programmes' instrumentalism and narrow focus can also be traced to the new development thinking since the 1980s. The conventional perception

² See also Women's Declaration on Population Policies initiated by over 20 women's organisations world-wide. The full text is carried in [Germain, 1994 #84: 31-34]. The Declaration, created in preparation for the 1994 ICPD, was an effective feminist lobbying tool used for the incorporation of reproductive rights and health onto the ICPD agenda.

of development as equivalent to GDP growth, income and wealth has been challenged by such influential moral philosophers as Amartya Sen. Sen, in his examinations of poverty and deprivation in the development context, reinterprets development from a perspective of intrinsic value of human wellbeing. Sen perceives wellbeing as closely related to an individual's capabilities and functionings (rather than mere possession of commodities and wealth), which refer to a person's potentials and the realisation of these potentials respectively (Sen, 1985a; 1987). At the community and society level, wellbeing is seen as going beyond the conventional utilitarian understanding of the standard of living to include broader notions of human development and social welfare.

In connection with this interpretation of wellbeing are Sen's notions of entitlement and extended entitlement, which are adopted to analyse such human ill-fares as famine and hunger, as well as intra-household gender relations (Sen, 1985b; 1990a; 1990b). It is generally understood that entitlement refers to "the legitimate effective command over alternative commodity bundles or resources: the legally sanctioned and economically operative rights of access to resources" (Scott, 1999: 2). The notion of extended entitlements takes us further beyond the formal legal and market relations to look at the role of informal institutions, such as socially accepted rules, customary laws and arrangements, norms and values, in determining gendered individuals' entitlements to commodity and relational goods as well as resources. The entitlements approach as such directs attention to both formal and informal institutions that determine individual men's and women's rights to the necessary goods, which fundamentally affect their capabilities and wellbeing (see Leach, 1999). Since the 1980s, this new understanding of development as associated with human wellbeing has drawn more attention to issues of social development, justice and gender equity, given the considerable gaps in wellbeing outcomes among people of different social positions and between men and women (see Anand, 1994; Saith & Harriss-White, 1999).

The International Women's Health Movement

Sen's capabilities and entitlements approach has led to a rethinking of not only the meaning of development, but also the very ends of the population programmes. Parallel to as well as influenced by this theoretical advancement in development thinking is the emergence of an alternative approach to reproduction and sexuality based on individual, particularly women's rights and wellbeing. The shift of emphasis from population control to a women-centred, rights-based approach promoting reproductive health has also resulted from social movements, particularly women's health movement starting from the late 1970s and early 1980s.

Contrary to the population control paradigm, the international women's health movement has regarded women as subjects, and treated women's wellbeing (e.g. sexual and reproductive health and rights, as well as women's empowerment) as of intrinsic value, for its own sake rather than as means to attain demographic goals. This central tenet has led to the movement's emphasis on issues relevant to women's health, needs and the creation of an enabling environment for women, including both micro and macro policies and processes as the basis for female empowering conditions. It is recognised that great diversity exists within the international women's health movement in terms of strategies and priorities owing to the wide range of political, religious, socio-economic and cultural contexts, as well

as the relevant (context-dependent) issues. Nonetheless, a common cause has linked individual women and women's organisations involved in the movement throughout the world, that is, the struggle for women's rights to make decisions on matters concerning their own bodies, to gain access to quality health services and wellbeing, as well as to lead a meaningful and fulfilled reproductive and sexual life (see Dixon-Mueller & Germain, 1993; Doyal, 1996).

The principal feature of the movement is identified as individuals, groups and movements, which share similar concerns, communicating through journals and regional and international networks, meeting on a regular basis to discuss and plan actions and strategies, and launching regional and international campaigns on issues regarding women's reproduction and sexuality (Garcia-Moreno & Claro, 1994). The movement has also been characterised by grass-roots activities such as organised demands for meeting the basic reproductive health needs of women and their families, including food, clean water, fuel, as well as basic hygiene, sanitation, transportation and housing facilities (Doyal, 1996). Leading organisations and forums active in the movement, particularly in the area of reproductive rights and health, include, among others, the Amsterdam-based Women's Global Network for Reproductive Rights (WNGRR), the New York-based International Women's Health Coalition (IWHC), the Caribbean Women's Health Network, the Woman and Health Network for East and Southeast Asia, and the Development Alternatives with Women for a New Era (DAWN). Originated from second-wave feminist campaigns for reproductive rights in the face of religious pro-life negation of and conservative political and social opposition to women's abortion rights in the North, the international women's health movement has extended to Southern countries and regions. Since the mid-1980s, it has grown into a global political force exerting substantial influences. The movement has advanced from voicing critiques at the margin towards swaying policies with alternative, women-centred agendas at major international conferences, international conventions, and different policy forums at local, national, regional and global levels.

Taking Reproductive Health and Rights on Board

Diverse actors, players and stakeholders are involved in the area of population and reproductive health, including, among others, national governments, academics and research institutions, activist groups, national and international NGOs, and multilateral/bilateral agencies. In this section, we analyse how reproductive rights have been interpreted and incorporated into the agendas of three distinct policy forums. These are Women's Global Network for Reproductive Rights (WGNRR), which is largely an activist network advocating women's health and rights; the International Planned Parenthood Federation (IPPF), the largest NGO in the world providing family planning and reproductive health information and services; and the British government Department for International Development (DFID), which is a major bilateral agency and significant player in the area. The analysis is based on discussions with policy personnel of the organisations concerned and data and information, including internal documents, collected therein during July and September 2000. We hope that such an analysis, though not sufficient to fully reflect the wide diversity of the actors and players in the field, will nonetheless provide insights into the ways in which reproductive rights and health have been interpreted and brought onto the agendas of various organisations and institutions prior to and following the international agreement reached in Cairo.

Women's Global Network for Reproductive Rights (WGNRR)³

WGNRR is an autonomous international network consisting of locally active individuals and groups, who are connected to one another in solidarity on issues related to reproductive rights and health. These individuals and groups are from all walks of life, including suppliers and providers of reproductive health services; academics and professionals; journalists and other media personnel; trade unionists, politicians and civil servants; human rights activists; feminists and reproductive rights activists (WGNRR, 1995). The Network's co-ordination office is based in Amsterdam and functions to facilitate this linkage and exchange of information and ideas. Historically, WGNRR originated from a feminist/socialist activist group called International Campaign for Abortion Rights founded in 1977 and based in London. The Campaign focused on women's control over their own bodies from the perspective of individual rights and choice. As part of the second-wave feminist movement, the Campaign fought for women's abortion rights in the Western context, where abortion was still illegal in many countries and clandestine operations were only accessible for those with better means.

With the influence of some Latin American women living in Europe, the Campaign soon expanded to include issues of women's rights to safe contraception and against forced sterilisation. A new name – International Contraception, Abortion and Sterilisation Campaign (ICASC) – was adopted to reflect this broadened scope of themes and activities. In 1984, ICASC organised The 4th International Women and Health Meeting (IWHM) convened in Amsterdam, which was devoted to issues related to reproductive rights, including contraception, abortion, sterilisation and population control. Although still dominated by Western feminist experiences, the meeting incorporated onto its agenda other issues that were more relevant to women in developing countries, including infertility, safe motherhood, birth spacing, breast feeding as well as Islam and women. As such it drew women's involvement from countries in Asia, Africa and Latin America. As a main actor in the women's health movement, especially through organising The 4th IWHM, ICASC widened its linkages and contacts with women of varied cultural and socio-economic background and from countries and regions at different stages of development. To reflect this diverse and cosmopolitan nature, the name ICASC was again changed into Women's Global Network for Reproductive Rights (WGNRR) with its co-ordinating office moved from London to Amsterdam due to practical considerations.⁴ "Think globally, act locally" has since then become the motto of the Network (WGNRR, 1990: 6; see also WGNRR, 1993a).

As a forerunner in promoting women's reproductive rights locally, regionally and internationally, WGNRR has actively participated in and significantly contributed to the international debates on the notion of reproductive rights and appropriate strategies to realise such rights. An example of this is its organisation of the International Conference on Reinforcing Reproductive Rights held in India in May 1993. At the Conference, women representatives from five different regions (Africa, Asia, the Pacific, Latin America and Europe and North America) both within and outside the Network were invited to

³ Discussions in this section are based on informal interviews and conversations with WGNRR's policy staff and the Network's Newsletters from 1980 – 2000.

⁴ These included the availability of funding and co-ordination staff, as well as the lack of enthusiasm among members with the idea of a co-ordinating office based in a different Western European country by rotation.

present their interpretations and reflections on the concept of reproductive rights. Critiques of the notion, in particular by women from the South, such as South Asia and Africa, raised the question of whether the “rights”/“choice” discourse had much relevance to women’s real lives in underdeveloped countries, where women were often preoccupied with the more imminent needs of physical survival for themselves and their families. Frequently, instead of freedom to choose, many poor women were left with limited choice by the structures of society where they lived. Socio-economic, political, cultural, and religious factors, as well as the prevailing gender and reproductive norms affect women’s decisions in this respect as well. Furthermore, given the great heterogeneity of women even at the local level in terms of ethnicity, class, religion, culture, etc., and the diversified perceptions of reproductive needs, questions regarding whether the notion of reproductive rights had any universal content arose (WGNRR, 1993b).

It was also argued that formal rights, whose realisation is frequently dependent on resources and power in relation to private property, tended to be translated into social and political privilege for upper and middle class women alone. It may mean little for the poor and disadvantaged if the socio-economic conditions were not changed. It was suggested that instead of focusing on individuals’ rights to choose, in developing countries, health and the right – in the sense of entitlement – to health make more sense to women living in poverty, and thus should be encompassed in the notion of reproductive rights. Based on this awareness, WGNRR has been paying more and more attention to issues of basic needs and sexual and reproductive health of women and children. These include clean water, fuel and food supply, housing, infectious diseases, STDs and HIV/AIDS, unsafe abortion, sexual abuse and violence, as well as the lack of basic health services, including sexual and reproductive health services (WGNRR, 1993b).

Discussions on the concept of reproductive rights at the 1993 Conference covered a wide range of issues, such as legal rights, sexuality, choice and self-determination, reproductive health, as well as fertility and population control policies. The debates and dialogues between women from the North and the South around reproductive rights resulted in a basic consensus that despite the problems with the notion (e.g. lack of clarity, its abstract individualism and universality, as well as the enormous gap between legal rights and reality), the polemical power of rights for social movements to make collective claims for substantive issues of economic and social justice across social strata and cultural differences cannot be denied or replaced (WGNRR, 1993b). This recognition, combined with concerns over the everyday experiences of women in the Third World, has led WGNRR to reconstruct rather than abandon the concept of reproductive rights, which involves integrating feminist analysis of rights into its understanding and practices.⁵ The interpretation of reproductive rights has gradually gone beyond a legal perspective in relation to fertility alone (e.g. legal abortion) to include all aspects of reproductive health and sexuality, such as access to reproductive health services and quality of care.

⁵ Feminist debates on the notion of rights have pointed to several important shifts away from the classical liberal thinking focusing entirely on the individual. These include: 1) greater emphasis on the social nature of rights, thus holding public agencies rather than individuals accountable for protecting and realising such rights; 2) acknowledgement of the relational contexts in which individuals act to exercise or pursue their rights; 3) highlighting the substantive basis of rights in human needs, whose satisfaction calls for equity, social justice and redistribution of resources; 4) recognition of the rights’ bearers’ self-defined, multiple identities based on gender, ethnicity, sexual orientation and social positions [see Correa, 1994 #87].

Questioning the dominant international population and development policies, and campaigning for the creation of enabling conditions, which may empower women, are also deemed as important elements of the international struggle for women's reproductive rights (WGNRR, 1993b). To WGNRR, the notion of reproductive rights has two related but distinct dimensions. One is the conceptualisation of such rights, which defines it as a universal principle of women's self-determination in matters related to their sexuality and reproduction. The other is strategic approaches to the realisation of such rights, which are not globally homogenous, but locally or regionally developed in accord with the specific conditions and contexts (see WGNRR Newsletter 1993, No. 43: Part 2, No. 44). Such an interpretation has enabled WGNRR to transcend the dualism of universal claims versus context-dependent strategies and to adopt an integrated approach to women's reproductive health issues.

The earlier focus of WGNRR on abortion rights has gradually extended to include examinations and critiques of the international development, population and health policies, as well as a wide range of relevant issues such as women's sexual and reproductive needs at different life stages, prevention and treatment of HIV/AIDS and other STDs, and sexual violence, such as female genital mutilation (FGM), rape and sexual harassment. WGNRR's active involvement in the international women's health movement together with its broadened vision has contributed to a gradual expansion of the Network over the past couple of decades. From a relatively small (composed of 10-odd women activist groups), European-centred feminist organisation fighting for abortion rights, it has developed to a global network linking over 1,700 women individuals and groups committed to women's reproductive rights and health in more than 150 countries world-wide (WGNRR, 2000).

Representing a movement fighting for women's reproductive and sexual rights and health, WGNRR has initiated solidarity actions and organised international campaigns. The most important international campaign is the Campaign against Maternal Mortality and Morbidity (MMM) started in May 1988 in accord with a decision made at The 5th IWHM held in Costa Rica in 1987. An International Day of Action for Women's Health on May 28 has since then been designated with each year having a specific theme relevant to sexual and reproductive health (The major themes selected by far include teenage pregnancy, access to safe and legal abortion, women and poverty, women's rights to quality health care, health for all, and women and HIV/AIDS) (see WGNRR's Newsletter, various issues from 1987 – 2000). This campaign has functioned to raise awareness, advocate women's rights and extend political influence of the international women's health movement through concerted actions at the local, national and international level. Activities carried out around the Action Day disseminate information on maternal health in its broad sense, and call for international and national attention to the root causes of maternal mortality and morbidity, as well as for the development of social policy to meet women's sexual and reproductive health needs.

WGNRR's activities in conjunction with the International Women's Health Meetings, e.g. regular participation in and organisation of the meetings, has rendered it one of the most active organisations in the women's health movement. For the past couple of decades, the development of the movement has gone hand in hand with the expansion of the Network, both of which have exerted growing influences over national, regional and international policy processes with respect to population and development, gender, women's empowerment, and reproductive rights and health. WGNRR has persevered in its

campaigning, advocacy and lobbying activities for sexual and reproductive rights through organisation of workshops before, and active involvement in the various NGO forums in connection with important UN conferences, such as the 1994 ICPD in Cairo and the 1995 FWCW in Beijing. One example was the collaboration between WGNRR and other women's organisations including Boston Women's Health Book Collective (USA) and the Committee on Women, Population and the Environment (USA) in setting up a series of workshops entitled "From Malthus to Cairo: What's Next?" The workshops stimulated discussions and debates on population, development, environment and reproductive rights and health, and attracted good attendance (WGNRR, 1994a; WGNRR, 1994b; WGNRR, 1994c). It is widely held that the ICPD Programme of Action, which marked a new international consensus on the issue of reproductive rights and health, was the result of intensive negotiations and lobbying by feminist groups and the international women's health movement, including WGNRR (see Rosenberg, 1998). Whilst WGNRR engaged with the ICPD's NGO forum, it was according to Petchesky (2000) one amongst a number of feminist groups who remained distrustful of the official conference and even the Women's Caucus. She says: "These groups charged that the whole ICPD process was an exercise in co-option; that it used the language of reproductive health and rights to legitimate old-style population control with a feminist face; and that, given the population establishment's historical record, any population policy can never be compatible with feminist goals and values" (2000:22)

Networking, solidarity, information dissemination and exchange, and training have constituted other important aspects of WGNRR's strategy to promote women's reproductive rights and health. A call for solidarity and concerted action to support a national women's organisation or an individual would be issued by WGNRR when the organisation or individual is faced with legal or political obstacles to protecting or realising reproductive rights and health. A follow-up report on the particular solidarity action would be carried in a later issue of the Newsletter. For instance, when a Brazilian women's organisation, The National Feminist Network for Reproductive Rights and Health of Brazil, launched its campaign to stop a constitutional amendment, which was to further restrict women's (limited) rights to abortion, WGNRR issued its call for solidarity with the Brazilian women. The repercussions produced by women world-wide provided solidarity and support for Brazilian women fighting to defend their own rights. Their persistent struggles and lobbying efforts led to the final dismissal of the amendment (WGNRR, 1996).

A major networking vehicle is the WGNRR Newsletter. Established in 1980, it is currently published three times a year in English and Spanish. Over the years, it has linked women throughout the world by co-ordinating collective actions, providing a forum for women to exchange and disseminate information, express opinions and engage in discussions and debates on issues related to sexual and reproductive rights and health. In addition, it has represented women's voices in the international arena in an attempt to influence policy making in international agencies and donor governments. Since 1997, WGNRR has introduced a new initiative called African Net-worker Programme, which is intended to strengthen the reproductive rights movement within the region through capacity building for women's groups working on sexual and reproductive rights and health. Under the Programme, a couple of women representatives from African women's organisations have been invited to work in the Amsterdam-based co-ordination office for a few months each year to exchange ideas and experiences,

receive further training and expand linkages and networks. Since its introduction, the Programme has been well received by women in both the co-ordination office and Africa, and women from Nigeria, Kenya, Ghana, Namibia, Mali, Rwanda, Cameroon, etc. have been invited (WGNRR, 1998).

The major strategies and activities of WGNRR to promote sexual and reproductive rights can be summarised as follows:

- Active participation in the discussions and debates on the meaning and scope of reproductive rights, and contributing significantly to research and development of national, regional and global strategies to promote reproductive rights and health;
- Influencing international population and development policy-making through preparing relevant documents, organising and participating in workshops and NGO forums in connection with the UN conferences in the field of reproductive rights, health and women's empowerment, e.g. the 1994 ICPD in Cairo and the 1995 FWCW in Beijing;
- Engagement in regional and global networking, alliance, solidarity and capacity building for reproductive rights and health through dissemination and exchange of information, ideas and experiences via regular publication of Newsletters, organisation of and participation in workshops and conferences;
- Representing women's voices and concerns in the UN and other international conferences through active involvement in the international women's health movement, as well as organisation of and participation in the IWHMs and other related activities;
- Campaigning for women's reproductive rights and health nationally and globally to raise awareness, advocate women's rights and extend political influence of the international women's health movement.

4.2 International Planned Parenthood Federation (IPPF)⁶

The International Planned Parenthood Federation (IPPF) is an international NGO and the largest voluntary organisation in the world working on family planning and sexual and reproductive health with its headquarters based in London. Founded in India by women birth control pioneers in 1952, IPPF represented an autonomous movement, which came into being many years before international population institutions were involved and started dominating the scene. It is an independent organisation initially concentrating on work in relation to family planning. In the early 1950s, family planning promoted by IPPF was faced with strong oppositions from conservative social and religious forces as well as obstacles placed by political and legal institutions in different societies (Correa & Reichmann, 1994). Nowadays IPPF has worked on a global scale through its extensive links with

⁶ Analysis in this section is based on informal discussions with IPPF staff, its publication *Planned Parenthood Challenges*, 1994-1997, electronic materials (www.ippf.org) and other IPPF's formal publications and internal documents, such as IPPF annual reports, IPPF news bulletins and IPPF Vision 2000 Strategic Plan.

national voluntary, autonomous Family Planning Associations (FPAs) in about 180 countries. Its membership has grown from an initial small group of eight to more than 150 throughout the world in the late 1990s ((IPPF), 1999a: 1).⁷

IPPF has operated at three organisational levels: the FPAs at the local and national level; the Regional Office at the regional level; and the Central Office/Headquarters at the international level. As a voluntary organisation, it has been funded by donation ((IPPF), 1999b). From a single focus on family planning in its early days, IPPF and its member FPAs have greatly expanded the scope of activities during the past few decades to include information and service provisions, education and training, standard setting, as well as lobbying in a wider field of family planning, gender equality and women's empowerment guided by the broad notion of sexual and reproductive health. It has increasingly been involved in meeting developing countries' needs, and the bulk of its funds now are allocated to support local and national services and programmes in the Third World, including countries currently under transition (see (IPPF), 1998a; (IPPF), 1999a).⁸ IPPF's close linkages with local volunteers, indigenous groups and communities have enabled it to adopt a contextualised approach to the identification and satisfaction of local needs, particularly the needs of the most disadvantaged individuals, groups and communities.

The policy foci of IPPF on family planning have reflected the international debates on birth control, population and development, gender and empowerment of women, as well as reproductive and sexual health and rights. In the 1980s, the demographic, quantitative paradigm of population control with its ethical problems and potential abuse was challenged by an alternative approach proposed by women professionals working inside mainstream population institutions. This is the quality of care framework systematically put forward by Bruce (1990) in Population Council, who also drew from Scrimshaw's earlier work on family planning services (Scrimshaw, 1972). This framework assesses quality of family planning services by using several key indicators, such as the range of contraceptive choice, provision of full information on different methods and their effectiveness as well as possible side effects, providers' professional competence, their attitudes towards clients and the constellation of services. In other words, the quality of care framework implicitly stresses the rights of service users, especially female users as subjects, in contrast to the top-down approach of population control, which treated women as objects and means for attaining demographic targets. IPPF, as a service provider, quickly incorporated the framework by working out 10 basic rights of the client, including the rights to safety, information, access, choice, privacy, confidentiality, dignity, comfort, continuity and opinion (Huezo & Briggs, 1992). The Rights of Clients have functioned as a code of conduct for IPPF-supported family planning clinics and services, which have been increasingly oriented towards women-centred, health-focused programmes.

On the occasion of the Federation's 40th founding anniversary in 1992, IPPF produced a *Vision 2000 Strategic Plan* to guide its work up to the year 2000 and beyond. The *Strategic Plan* set out three main

⁷ The eight founding members are: UK, USA, Holland, Sweden, West Germany, India, Singapore and Hong Kong.

⁸ For the major funding sources of the Federation, see the IPPF Annual Report 1997-1998: 24; 1999: 24.

goals with six imminent challenges perceived by IPPF. The goals are: those of advancing human rights regarding sexual and reproductive health, of responding to unmet needs for family planning and sexual and reproductive health services, and of operating a democratic Federation, securing funding and maintaining accountability. The six challenges are identified as sexual and reproductive health, empowerment of women, unsafe abortion, youth, family planning and quality of care ((IPPF), 1999b). The fact that there has been considerable overlap between IPPF's strategic plan *Vision 2000* and the 1994 ICPD's Programme of Action suggests an unprecedented influence of NGOs, including IPPF, on the direction and outcome of the Cairo conference. IPPF's active role in influencing international policies on population and development is reflected as well in its involvement in the 1999 Cairo + 5 UN Special Session through co-ordinating with UNFPA and other UN organisations, and participating in the Cairo + 5 preparatory activities. These include, among other things, participation in the Hague Youth and NGO Forum in February 1999, in UNFPA Roundtables and Technical Meetings in June-July 1999, to influence discussions and actions on key issues such as adolescent sexuality, reproductive rights, unsafe abortion and the unmet needs for family planning and reproductive health services ((IPPF), 1998e; (IPPF), 1998f).

Following the 1994 Cairo agreement, international discourse on population and development has shifted further towards sexual and reproductive rights and health. Concerns over sexuality and fertility have increasingly been examined from a human rights perspective on the basis of the important international human rights conventions and treaties. These include, among others, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the UN Convention on the Elimination of All Forms of Discrimination against Women, and the UN Convention on the Rights of the Child. A key assertion of these is the 1993 Vienna World Conference on Human Rights, which proclaimed that women's rights are human rights.

Shortly after the Cairo agreement, IPPF produced a Charter on Sexual and Reproductive Rights in 1996. The Charter has been designed as a tool to increase the capacity of FPAs and other NGOs to engage themselves in human rights advocacy and promotion in relation to sexual and reproductive health and well-being ((IPPF), ND). The Charter has stipulated 12 basic rights, including right to life; right to liberty and security of the person; right to equality and to be free from all forms of discrimination; right to privacy; right to freedom of thought; right to information and education; right to choose whether or not to marry and to found a family; right to decide whether or when to have children; right to healthcare; right to the benefits of scientific progress; right of freedom of assembly and political participation; right to be free from torture and inhuman or degrading treatment ((IPPF), 1996; see also Newman & Helzner, 1999). The Charter, grounded in and linking reproductive rights to major international human rights instruments as mentioned above, calls for the nation states which have signed the human rights treaties to respect, protect and fulfil the reproductive rights designated therein ((IPPF), ND). Guided by the Charter, the national FPAs have committed to the removal of political, legal and administrative barriers to the provision of sexual and reproductive health care services. For instance, in Colombia, the FPA introduces legal advice clinics into family planning centres, which provide information in terms of women's rights, sex education for adolescents and legal help for women suffering from domestic violence. The Palestinian FPA offers legal counselling service in

several of its clinics, advising women on issues such as inheritance, marriage contracts and child custody. In Hungary, the FPA has held discussions with the government based on the IPPF Charter on new legislation concerning access to health care from a human rights perspective ((IPPF), 1998b).

In practice, IPPF has tried to implement these rights more broadly through placing greater emphasis on sexual and reproductive health services, basic needs programmes, other health-related activities (e.g. treatment of genealogical ailments and STDs in hospitals and clinics), as well as training, information and education on sexual and reproductive health. For instance, priorities have been given to integrating family planning into basic needs satisfaction, including primary health care, such as safe motherhood, maternal and child health (e.g. pre-natal and post-natal care, immunisation programmes, infant survival and child nutrition, contagious disease prevention, etc.), and the supply of food, clean water and sanitation facilities. It is recognised that the notion of sexual and reproductive health is much more broader than mere family planning services. Thus, in contrast to a population control programme's narrow focus on providing mainly contraceptives for women in childbearing age alone, IPPF's perception of the relations between family planning and sexual and reproductive rights and wellbeing has led to its adoption of a comprehensive life-cycle approach to meet diversified health needs of women in different life stages and reproductive conditions (e.g. the young, the unmarried, women in menopause, and those who have had sterilisation, or cannot conceive).⁹

It is recognised that women bear the largest burden of social reproduction, and as a group they often lack decision-making power in matters concerning sexuality and reproduction. In addition, young people's sexual and reproductive rights and health needs tend to be neglected. This has rendered youth especially vulnerable to the HIV/AIDS pandemic. Women and youth have, therefore, been prioritised in IPPF's activities to promote reproductive and sexual health and rights. In 1996, the IPPF South Asia Regional Office and BBC collaborated to introduce a series of regional radio programmes on sex education for women and the young called "Sexwise". The series covered issues ranging from hygiene, puberty, contraception, sexual coercion versus mutual respect in sexual relations, safe sex and HIV/AIDS prevention to specific individuals' sexual and social concerns such as sexual pleasure, sex orientation, etc. Both the broadcast programmes and their accompanying booklets were produced in nine languages, gaining millions of audience. The success of the initiative of "Sexwise" led to the expansion of the project beyond the South Asian Region. In 1999, the programme took off in other regions and countries, including Albania, Bulgaria, Cyprus, Greece, Hungary, Kazakhstan, Poland, Romania, Russia, Turkey and Uzbekistan. By the end of 1999, 100 radio programmes were produced in more than 10 languages, 187,000 booklets were printed and distributed in different countries involved in the project, 50,000 page impressions were created in the "Sexwise" website and the audience size, excluding Central Asia, reached 18.9 million ((IPPF), 1999a: 22).

In addition, committed to promoting young people's rights to sexual and reproductive health information, education and services, IPPF has formed a Youth Committee to tailor its services to meet the specific needs of youth. The Youth Committee has helped introduce special clinics, centres or

⁹ See ((IPPF), 1999a: 2-3) for a detailed breakdown of services provided in clinics supported by IPPF and its national FPAs.

projects for young people, which offer youth-friendly sex education, counselling and services, in countries including Ethiopia, Uganda, Russia, India, Iran, Peru, Brazil and Palestine ((IPPF), 1998c). In relation to women's empowerment, which is deemed unachievable without the support and active participation of men, IPPF has paid attention to men's role in sexuality and reproduction. This is reflected partly in the shift supported by IPPF in the provision of sexual and reproductive health services, i.e. from delivering services geared only towards women to services that also involve men. Through its male participation schemes, IPPF has attempted to influence men, especially young men, in terms of sexual and reproductive health, gender equality, and their sexual and reproductive responsibilities. For instance, in countries such as Sierra Leone, India and Trinidad and Tobago, national FPAs have set up male clinics providing family planning services, counselling, information on the prevention of STDs and HIV/AIDS, as well as other sexual and reproductive health education, knowledge and information ((IPPF), 1998d). Another example is the Brazilian FPA BEMFAM's project in 1999 "Men – Participation, Health and Prevention". In this project, BEMFAM organised small discussion groups involving men to address the issue of male resistance to condom use in sexual intercourse through analysing traditional sexual stereotypes, gender roles and ideas of masculinity. The project helped to educate men and promote safe sex via condom use ((IPPF), 1999a: 15).

The actions and measures taken by IPPF to promote sexual and reproductive rights and health can be summarised as:

- Influencing international conferences and agreements on issues regarding sexual and reproductive rights and health, including family planning, through lobbying and advocacy to ensure that women's rights to sexual and reproductive health services, and their sexual and reproductive well-being remain a priority in international population and development policies;
- Representing the voices of the disadvantaged individuals, groups and communities (women, youth, ethnic minorities, poor people, etc.) in terms of their rights, needs and interests through active NGO participation and civil society involvement in policy processes, and providing services that are sensitive to their specific needs;
- Promoting reproductive health and rights through information and service provision in collaboration with international and national NGOs, the private sector and nation states;
- Working with media (television, radio, newspapers, internet technology) to increase international media awareness of the key issues involved in population and development policies and practices, as well as to facilitate dissemination of information and knowledge, and education on sexual and reproductive rights, health and gender equality;
- Formulating medium- to long-term strategic plans to promote sexual and reproductive rights and health, and setting standards and code of practice in service provision and delivery to define reproductive rights and guarantee quality of care;

- Encouraging the empowerment of women and girls through education, guidance, improved services, as well as male participation initiatives;
- Giving special priority to young people in terms of their sexual and reproductive rights, health and needs through introducing youth schemes and programmes, particularly in the face of the HIV/AIDS threat.

Department for International Development of the UK Government (DFID)¹⁰

The UK government is one of the leading donors and players in the international development arena. It has been actively involved in the negotiation processes and signing of the major international agreements, conventions and covenants on rights, including human rights, economic, cultural and social rights, and children's and women's rights. One of the most significant policy documents of DFID's following the 1994 ICPD in Cairo is the White Paper on International Development published upon Labour Party's assumption of power in November 1997. The White Paper has laid out policies of the UK government in response to the Cairo agreements. It views elimination of world poverty as the biggest challenge faced by the international community for the forthcoming new century. As such, it stipulates that Britain's international development assistance efforts under the Labour government give priorities to sustainable livelihoods strategies, human development, particularly gender equality and reproductive health, and environmental protection. Such efforts are perceived as being able to produce more effective and fruitful outcomes if genuine partnerships can be built with national governments, multilateral and bilateral agencies, the private sector and other civil society actors (DFID, 1997).

The blueprint for international development and aid outlined in the White Paper has been backed especially by a rights-based approach to development elaborated in more recent DFID's documents and strategy papers setting development targets on important issues such as poverty, gender and health (see DFID, 2000a; 2000b; Ferguson, 1999; Häusermann, 1998). A rights-based approach has been interpreted as increased participation/inclusion of the poor in development and decision-making processes which have affected their lives so that the voices of the poor and the disadvantaged can be heard and their perspectives incorporated in development efforts and plans. Broadly speaking, participation, inclusion and institutional capacity building are seen as major channels for empowerment of poor people, who, through such processes, are expected to become active agents rather than mere passive objects of the programmes and decisions produced on behalf of them. A rights-based approach also calls for the accountability of institutions and governments to guarantee, protect and promote the rights of citizens, particularly of the poor and disadvantaged ((FCO) & DFID, 1999; DFID, 2000b; Ferguson, 1999).

The DFID's rights-based approach to development has incorporated the new development thinking as elaborated in the work of Amartya Sen and others by emphasising human development and making people the central purpose of development. Social exclusion/inclusion, and health and well-being,

¹⁰ Sources of this section include discussions with DFID's specialists in social development and health and population, electronic materials from the DFID's website (www.dfid.gov.uk), DFID's formal publications and its internal documents.

which are notions closely related to economic and social rights, have stood out in the DFID's discourse on a rights-based approach. This may show that DFID's understanding of a rights-based approach within the broad human rights framework includes both civil and political rights and economic and social rights. The recently formulated and published strategies, documents and the latest White Paper on international development have further defined the notion of rights and connected rights with social policies in the wider context of globalisation (DFID, 2000b; DFID, 2000c; Ferguson, 1999). In the sphere of reproductive rights and health, DFID's interpretation of such rights has been interacted with and influenced by agreements and consensus reached in several important international conferences (e.g. the 1994 ICPD in Cairo, the 1995 FWCW in Beijing), as well as the framework of human rights established by the UN in its various declarations. The perception by DFID of a close link of such rights to poverty reduction and basic needs satisfaction is demonstrated in the fact that two of the DFID's international development targets have focused on sexual and reproductive rights, i.e. lowering maternal mortality by 75 percent and access to sexual and reproductive health services for all by 2015 ((FCO) & DFID, 1999: 17).

Discussions with DFID policy staff indicate that DFID has taken the reproductive rights approach as a sort of an umbrella covering and capturing all the relevant issues and their complexity on its political agenda of tackling poverty and gender inequality. Reproductive rights are frequently interpreted from perspectives of individual choice. Strategically, the approach is intended to work as a lobby instrument in order to hold discussions and negotiations with national governments and international agencies on how to promote reproductive rights. It is also to open up space for grassroots and civil society's efforts to promote, defend and fight for individual and groups' rights based on ethnicity, gender, class, etc. In practice, reproductive rights tend to be perceived as the rights to sexual and reproductive health and services, with priorities being granted to improving primary health care, reducing child mortality, promoting safe motherhood, access to family planning and other reproductive health services, e.g. contraception and abortion, quality of care, combating HIV/AIDS, as well as meeting basic needs, e.g. safe drinking water and sanitation ((FCO) & DFID, 1999; DFID, 2000d; DFID, 2000f).

To some extent, reproductive health programmes have been emphasised in a new framework called sector-wide approaches (SWAPs) on the DFID's reproductive rights and health agenda. The SWAPs have been designed to address problems of fragmentation and ineffectiveness in the international development aid arena witnessed in the earlier prevailing practice of project aid, which was operating outside the ministerial structures of national governments. It is understood that implementation of the sexual and reproductive health agenda within the broad human rights and development framework requires concerted actions both sector-wide and cross all sectors. Thus, the more recently adopted SWAPs have advocated a practice by which international donors contribute to the funding of the entire health sector. The funding is then allocated and managed by the aid-receiving government in accord with its perceived priorities and needs. Clearly, the new approach is in line with the DFID White Paper's focus on building longer-term partnerships with both national governments and other international donors. It also reflects DFID's interpretation of reproductive rights as a lobbying instrument to influence policies at the national level: in SWAPs, dialogues and negotiations occur at the level of overall policy and the institutional and financial framework, within which sexual and

reproductive health services are provided. It is recognised that the prerequisite for effectively adopting SWAPs is the existence of a relatively efficient and equitable indigenous health care system. The stress by DFID on the health sector reforms, including health care financing, can be understood as part of its attempts to achieve greater efficiency and sustainability of sexual and reproductive health programmes in the new initiative of SWAPs (see Allison, 2000; DFID, 2000f).

DFID's efforts and actions to promote sexual and reproductive rights in its overall international development plans are represented in the following strategies:

- Lobbying UN conferences on sexual and reproductive rights and health, particularly for women. One example of this strategy is DFID's role in the UN Beijing Plus Five Special Session, which took place in New York in June 2000 to review and assess the implementation of the Programme for Action (PFA) reached at the Fourth UN World Conference on Women. At the Special Session, DFID advocated the use of explicit language in the final document to link gender equality and poverty eradication, reproductive and sexual health (including HIV/AIDS), and specific indicators of progress in programme implementation and assessment. It also suggested the inclusion of clear affirmation of women's sexual rights and strong objection of sexual violence. Such efforts of DFID combined with those of other international agencies have resulted in the inclusion in the final document of explicit languages on sexual rights, sexuality and abortion – the first time that a UN document has clearly expressed its position on such sensitive, controversial issues ((FCO), 2000).
- Advocating and supporting health sector reforms in an attempt to ensure the establishment of a sound institutional base, which encompasses the public, private and informal sectors and is accessible and beneficial to poor people. The goal is deemed achievable through building long-term partnerships with both developing country governments and international agencies. DFID has currently established long-term partnership relations with more than 20 countries in Sub-Saharan Africa, South and Central Asia, Latin America and East Europe. It has also supported and increased its funding for international agencies and NGOs working in the field of sexual and reproductive rights and health, including UNFPA, WHO, UNAIDS and IPPF ((FCO) & DFID, 1999; Allison, 2000; DFID, 2000g).
- Revising priorities of service provision. In addition to the above-mentioned priorities of lowering child mortality and maternal mortality, safe abortion, meeting contraceptive needs and widening contraceptive choice (including emergency contraception and female condoms), DFID has, in recent years, granted special priority to the tasks of tackling HIV/AIDS. It has significantly increased its financial support for actions on HIV/AIDS in developing countries, especially in Sub-Saharan Africa. As young people and women are identified as the most vulnerable groups in the face of the HIV/AIDS epidemic, DFID has been particularly active in financing programmes that contribute to the reduction of vulnerability of women and the young through raising awareness, disseminating knowledge and information, fighting discrimination (e.g. protecting the rights of poor people in terms of access to information, knowledge and preventative measures and those of the infected with respect to confidentiality, employment,

education, sexual orientation, health care services, and most of all their rights to life) and supporting scientific research to find effective vaccines. For instance, in India, DFID has supported HIV/AIDS prevention work among commercial sex workers in the Sonagachi red light district. DFID's efforts have helped keep the HIV infection rate of this group in the area at a lower level compared with the HIV prevalence rate of other cities ((FCO), 2000; see also (FCO) & DFID, 1999; DFID, 2000h).

- Commitment to gender equality and women's empowerment. DFID recognises the importance of the gender issue in promoting and guaranteeing sexual and reproductive rights. It has taken effective measures to ensure the inclusion of gender perspectives in all its bilateral and multilateral development activities. More specifically, DFID has increased its support for the UN Development Fund for Women (UNIFEM) and its attempt to strengthen UN's capacity to promote women's rights as well as a rights-based approach to development. The financial support for UNIFEM is provided through greater funding for its Trust Fund on Violence against Women and other programmes that have worked on building capacity and leadership of women's organisations as well as strengthening linkages between women's organisations, national governments and the UN system. DFID's actions on mainstreaming gender issues as a vital approach to promoting rights is also demonstrated in its funding for a Gender Advisor post in the Office for Democratic Institutions and Human Rights (ODIHR), the Organisation for Security and Co-operation in Europe ((FCO), 2000; (FCO) & DFID, 1998; (FCO) & DFID, 1999).
- Bringing social development expertise into population and health work to produce better co-ordination and promote sexual and reproductive rights. Two DFID's departments, i.e. Social Development Department and Health and Population Department, have been involved in the area of reproductive rights and health. Interpretation and analyses of a rights-based approach usually fall into the responsibilities of the former, evidenced, among other things, in several DFID documents stipulating its development strategies regarding rights. The latter, in contrast, is more concerned with practical issues, including setting priorities for DFID's international assistance in health, implementing DFID's policies on population and reproductive health, and working in partnership with national governments, multilateral agencies, the private sector and civil society. It seems that the two departments used to work rather separately. Our discussions with DFID policy staff suggest that, increasingly, there are more exchanges and co-ordination between the two departments. There have been regular departmental interactions, particularly during the policy implementation process at the country level. A more integrated approach has been adopted in most DFID's health, including reproductive health, programmes for the past few years. For instance, a reproductive health project will be undertaken by several advisers, i.e. the main population and reproductive health specialist, a social development adviser, a gender specialist, etc. The so-called "procedural check" through guidance and technical notes used in appraisal and development of programmes is also applied to ensure that new development ideas and relevant issues identified are appropriately considered and incorporated.

Conclusions

The contrasting histories, structures and objectives of the organisations studied above are reflected in the varying ways in which they have approached reproductive rights. All have been involved in renegotiating population and development policy at the international level but from different perspectives: the WGNRR as an advocacy network offering probably the most radical position, IPPF representing the largest INGO provider of reproductive health services, and DFID as a bilateral donor agency. The greatest space for negotiation about what reproductive rights mean in different circumstances has been within the network structure of WGNRR, although unsurprisingly WGNRR is undoubtedly the most woman-focused of the organisations with strong feminist politics. IPPF has invested considerable effort in facilitating discussions between members from different countries about client rights and have also developed a Charter on Sexual and Reproductive Rights that is intended to assist partner organisations to broaden their advocacy efforts. Reproductive rights have only been really prominent within DFID approaches more recently since the Labour government came to power in the UK in 1997.

All three organisations recognise the need to reorder service priorities. IPPF has probably been most involved in bringing men into reproductive health and has paid special attention to the needs of young people. DFID has been involved in inserting concerns about rights, including reproductive rights, into sector wide approaches, particularly relating to health, but also in relation to other areas and in doing so by linking these concerns with issues around poverty and social exclusion. As a broad based donor agency with a formal role in international policy making, DFID has the most scope to tackle directly other dimensions of reproductive rights that lie outside the traditional population policy arena: these dimensions include most significantly gender empowerment, governance and accountability, international debt as well as the conventional sectors of government action. However, IPPF and its partners despite their focus on service provision have engaged in a surprisingly broad range of activities and WGNRR's lobbying also situates reproductive rights concerns within wider inequalities. In conclusion, these organisations have variously played important roles in shaping and interpreting reproductive rights in practice.

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