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After Cairo: Challenges to Women's Organizations

Gita Sen and Carmen Barroso

A decade ago, issues of reproductive health and sexuality were considered either irrelevant or a divisive by important sectors of the women's movement in many countries. Today these issues have galvanized the energies of a rapidly growing women's health movement that has become an active and respected player in policy-making at the international level. In countries as varied as Brazil and India, Nigeria and the Philippines, the same is true at the national level.

In these countries, the women's health movement usually includes grassroots organizations of all sizes and mandates as well as more formalized national networks with clearly articulated feminist agenda [1]. Reproductive health has entered the agenda of groups traditionally impervious to such concerns [2]. A recent essay by C. Garcia-Moreno and A. Claro documents the size and dynamism of the movement: 'The Women's Global Network for Reproductive Rights doubled from 800 members and newsletter subscribers in 1988 to 1.655 in 1992. Its membership spans 113 countries... 'The Latin American and Caribbean Women's Health Network, created in 1984 by approximately 30 groups and individuals, now has a contract list of 2,000... The International Women's Health Coalition, working with about groups in 1984, now has contact with over 2,000 individual, and groups in Southern countries. About 150 organizations in Asia include women's health in their agenda [3].

The emergence of reproductive health as a priority within the women's movement had a different history in each country. But in all of them it was the result of a complex process that involved both the internal dynamics of the women's movement and the role-played by other political actor's [4]. In this process, two factors were prominent: the growing awareness about the dramatic impact that poverty; powerlessness, and lack of access to information and health services were having on the Ivies of women; and the increasing mobilization of pro-natalist and anti-natalist forces, both of which may have profoundly

deleterious effects on the policies and allocation of resources to programs that affect women's access to the means of controlling their own reproduction.

The awareness within the women's movement about the devastating 'conditions of reproduction'" came about as a result of the growing participation of grass-roots women. These women brought the complex texture of their daily lives to a movement that in attempting to prioritize the issues that affected the majority of the world's women - who are poor - had been limited in many instances to the most obvious concerns of survival and livelihoods. The voices of grass-roots women gave life to statistics that were the staple of demographers but had nor really caught feminists' attention.

Five hundred thousand deaths due to maternity-related causes every year is a worldwide catastrophe. The dimensions of this scandal reach the unspeakable when we realize that the majority of these deaths are easily preventable. An estimated 100 million married women want to avoid a pregnancy and have no access to contraceptives. Uncounted millions more who are unmarried face the same problem every time they have a sexual encounter with a man. Many of them - married and unmarried - become the casualties reflected in the maternal mortality statistics when, in desperation, they resort to illegal abortion in unsafe conditions. Those who die are only a fraction of the enormous number of women (an estimated 20 million annually) who are victims of legal and health systems that, deny women the much needed services of safe abortion.

Grass-roots women also voiced their distress about the poor quality of services when they are available and reported cases of abuse and even coercion by service providers. They presented a wide range of concerns - of which the above examples are just the most common - making it possible for the women's movement to incorporate reproductive health and rights as an integral part of a broad agenda for structural change. The movement then developed its expertise in the area through the creation of self-help groups, alternative services that demonstrated the kind of attention women needed and a rich variety of educational materials that promoted health education using participatory methodologies.

The second factor that prompted the emergence of an integrated agenda of reproductive health and women's empowerment within the women's movement in many countries was the attempt to affect the way resources allocated to population policies were being used and the need to counteract the growing mobilization of anti women forces. In some countries, population policies

command a relatively large share of the portion of the national budgets devoted to social services. Data is very precarious, but estimates of total family planning expenditures in the Third World range from US$3.5 billion to US$7.1 billion, or from about 4 to 9 percent of the total government health and family planning expenditures. This average figure camouflages diversity across countries. In India, for instance, family planning makes up 15 percent and maternal and child health only 1 percent of total health expenditures. Foreign aid may account for up to one-quarter of resources spent on family planning, in the public sector. Population assistance in 1990 was estimated to be US$936 million, of which 60 percent is provided by bilateral donors, 36 percent by multilateral donors, and 4 percent by private foundations and NG0s. While the absolute amounts are pitiful when compared with military expenditures, for instance, they are quite large when viewed from the perspective of women whose share of national resources are even more paltry.

Traditionally these resources have funded programs inspired by demographic goals in which a woman's role was only that of an 'acceptor' of contraceptives. When the women's movement started to criticize the inadequate attention given to contraceptive safety, the poor quality of services that ignored women's multiple reproductive health needs, the limited range of contraceptives available, the preference for sterilization. and the barriers to safe abortion, the population policy makers initially saw women activists as irritants, to be silenced and ignored as much as possible.

However, during the last decade, population 'policies had to face a barrage of attacks coming from the opposite direction: the conservative forces that see the provision of contraceptive services as undermining their traditional control over women’s sexuality and reproduction. These attacks were more evident when the Catholic Church became very active in the International Conference on Population and Development (ICPD), held in 1994 in Cairo; with the Vatican enlisting the support of the Islamic fundamentalists. More covert maneuvering in that direction had been going on since at least 1984, in the previous international population conference held in Mexico City. It is important to note that the conservative forces are by no means restricted to Catholics and Muslims but encompass a broad range of religious and non-religious trends. Under fire from that side, and in search of new allies, the population policy makers re-examined their assessment of the women's criticisms and found some validity in them, opening the opportunity for a dialogue.

At the beginning, women activists were skeptical about the motives and possible consequences of these exchanges. Many feared the risk of co-optation and

doubted one possibility of radical policy changes. Others welcomed the challenge and felt that even incremental changes were worth the effort, given the immense immediate needs of women worldwide. Moreover, they believed that the decision not to participate in the shaping of population policies would mean leaving the control of power in the band of others. The tension persists, but as Garcia-Moreno and Claro point out, 'There is increasing recognition that dialogue with the establishment is a critical strategy for change."

Women's Impact on The International Conference on Population and Development [6]

The growing capacity of women's organizations and networks to act together as subjects and agents of change in international policy-making has been demonstrated recently at two major events: the first World Conference on Human Rights (WCHR), held in Vienna in 1993, and ICPD, mentioned above. At both conferences, women's organizations successfully strategize negotiated, and lobbied governments and agencies in order to achieve major gains. Women's rights were recognized as part of universal human rights in Vienna, While the substance and language of population policies were transformed from demographic imperatives to critical aspects of women's health and rights in Cairo.

ICPD was a major political marker for the international, women's movement. In the processes leading up to and at Cairo, women had to marshal arguments, evidence, and political support for a major policy transformation in the presence of two formidable sets of actors. The first was a population-policy establishment that has defined its mandate and received considerable public funds over four decades, largely on demographic grounds. Women have long been critical of the traditional population establishment, which has had control over resources and the directions of policies and programs (including reproductive technologies) but has been wedded too long to an approach that has subordinated women's reproductive and sexual health needs and rights to the control of numbers. For over a decade, many women's organizations and networks have also been critical of the directions of contraceptive research and development and of abuses within family planning programs. At the same time, women's health organizations strongly affirm women's rights to plan and manage their own fertility, to have access to decent health services, and to secure livelihoods and productive resources. An ongoing challenge for women's organizations has been to work our how to be effective in their critique of existing programs without falling into the game of those who criticize family planning programs from an entirely different perspective - one that denies women's rights.

The second set of actors at ICPD used religion as a weapon in their mission to keep women in their 'proper,' subordinate place. The attempt by these forces to wrap themselves in the mantle of cultural sovereignty and anti-imperialism came to the surface during ICPD. At a conceptual level and in open public debate, it is quite easy for women to address the challenge of fundamentalists, since the representation of culture in their discourse is so unabashedly patriarchal, as became obvious during the ICPD debates. But at the national level in many countries, it is the most dangerous and difficult force for women to contend with, since it unleashes political powers and processes that operate outside the realm of rational discourse.

The above actors are still present and vocal in the policy arena. The ability of women's organizations to prevail in their transformative agenda during ICPD does not, therefore, signal a final victory. There is an effort to obtain the resources needed by the Cairo agenda for reproductive and sexual health and rights, to shape programs and services to empower and strengthen women in different countries, and to ensure that women are present when critical decisions are being made. This is especially difficult as not everyone within the traditional population establishment full accepts the new directions. Even more difficult are the fundamentalists with whom there is little possibility of negotiation, since they appear intent on waging an all-out war on the world's women.

ICPD has been crucial for women's organizations, not only in resting their ability and resolve vis-a-vis powerful external agents. Equally important was the ability and of organizations and networks with widely differing histories and experiences to work together for a common agenda.

Both prior to and during ICPD there were sections of the women's sections of the women's movement that were reluctant to address reproductive health and rights, and some continue to question the gains of Cairo. This reluctance does not stem from a fundamental disagreement about their substantive importance. Rather, it reflects a fear that other pressing issues (the problems of macroeconomic policies, especially structural adjustment, or the poor quality of primary health services, for example) will be neglected. For some groups, there is a fear of being co-opted by powerful economic and political forces and seeing the sharpness of their critique of existing systems diluted. And some fear being misunderstood and misinterpreted by their political constituencies. 'The fears are legitimate, and women's organizations worked to address them prior to ICPD. Women's strategies became increasingly sophisticated and careful during the

two years leading up to the Cairo conference. These strategies have had four aspects.

1. To clarify positions and bottom-line non-negotiable. It is necessary to affirm reproductive health and rights in the context of equitable development strategies and to be critical of past population policies and programs, including technologies, without throwing the baby out with the bath water. Soon after the United Nations Conference on Environment and Development (UNCED, Rio de Janeiro, 1992), there was an early attempt by a number of women's organizations and networks to define a bottom line. This endeavor ran into criticism as being unclear about the broader development context. A clearer statement, one that affirmed common ground across a range of women's organizations while acknowledging the existence of differences, was negotiated at the "Reproductive Health and Justice: Cairo 1994" meeting, which brought together members of over 200 organizations in Rio de Janeiro in 1994.

2. To acknowledge the multiple roles of women's organizations at this juncture. North South and ideological divisions (as well as personality clashes and ego any problems) have been as present in the international women's movement as in any other social movements. Furthermore, global politics is itself in flux. Some of this is strongly positive, since spaces are opening up for new methods of citizen action, as well as ways of linking international and national politics. Women have had to learn, sometimes painfully, how to move between positions of pure opposition and positions of negotiate with those in power. How to negotiate without compromising on fundamental positions and with transparency and accountability and how to criticize with a degree of responsibility and without holier-than-thou posturing have been difficult lessons, but many women's organizations are learning them. As a result, women were able to be extraordinarily effective in their advocacy both during the third Preparatory Committee meeting for the Cairo conference (Prep Com IIIY and under the logistically more challenging conditions of ICPD itself.

3. To increase information flow, communication, and planning. Advocacy networks exchanged a great deal of information sometimes faster than governments, during the process leading up to ICPD. Their ability to mobilize women's energies during the negotiations for the draft of the Program of Action during PreCorn III was critical. Women were thereby able to influence the draft to make it stronger in terms of the right to development, reproductive health and rights, and resources. New skills of working together across national boundaries under intense pressure, of negotiating and lobbying with governments and

international agencies, and of working inside delegations and in the corridors have been learned.

4. To produce carefully researched materials that could be the basis of the new paradigm. A wealth of new material has begun to be published, and new research agendas as well as new material for popular communication [7] are being defined.

These strategies, developed during the preparations for the ICPD, have had to be reshaped to respond to the post-Cairo scenario in a flexible manner.

Implementation and Accountability After Cairo: India As An Illustration

India was one of the first countries in the world to implement an official family planning program in the early 1950s. Since that time, the program has expanded and gained considerable experience. After a brief and unhappy experiment with coercive sterilization in the mid-1970s, the program changed its name to "family welfare", became more low-key in its advertising campaigns, and attempted to forge stronger links among birth control services, safe motherhood, and primary health care. Despite these attempts, the Indian program continues to be criticized by women's organizations on a number of grounds.

First, the program operates under a vertical, bureaucratic chain of command and is funded and monitored directly by the central government, although state departments of health and family welfare do the actual implementation. This excessively top-down structure has all the problems of insensitivity to people's needs, inflexibility, and weak accountability that are the usual hallmarks of such structures.

Second, the performance of all the different levels of service providers is evaluated on the basis of their ability to meet annual contraceptive method-specific targets. Heavy emphasis on such targets, as well as the use of monetary and other incentives and disincentives, have become emblematic of the program. Between January and March, which is the end of each financial year, there is a desperate scramble in most states to fulfill their targets. Sterilization camps occur largely during this period, and the numbers game becomes paramount. The use of incentives and disincentives within the family planning program has also distorted the incentive structure for village-level workers (such as auxiliary

nurse-midwives who are the actual providers of services) away from safe motherhood and toward contraception.

Third, as a result, the quality of services provided under the program is poor, and services rarely meet the criteria [8] that have now come to be generally accepted as appropriate quality indicators in family planning programs. Indeed, minimal criteria of hygiene and sanitation, as well as pain management, are often breached.

Fourth, although the Indian program started out emphasizing condoms and vasectomy and even provided diaphragms in its early years, female sterilization now accounts for over 90 percent of the services provided. This excessive emphasis on an irreversible method makes service provision a one-time affair. It becomes only too easy for service providers to ignore women's health needs, including prior check-ups and follow-up care, let alone broader reproductive and general health needs. Consequently, women have few options and little ability to plan their reproductive lives healthfully and effectively.

Fifth, women's organizations in India have been especially concerned about the conditions under which some of the newer hormonal contraceptives are being tested and introduced into the country. Formally the system of clinical testing and approval is an elaborate one, but many feel that it lacks both transparency and accountability in practice. Women's health activists are also very concerned about the potential long-term effects of hormonal contraceptives on Indian women, the majority of whom are underweight and malnourished and suffer from iron-deficiency anemia, as well as a high incidence of reproductive tract infections.

Although abortion laws have been liberalized since the early 1970s, the actual services provided by the public system are poor in both quality and coverage. Most Indian women seeking abortions are married and have two or more living, children but are forced to take recourse to illegal, expensive, and unsafe services.

Along with some health organizations, social scientists, and demographers in India, women’s organizations have been critical of the government's family planning program for at least two decades. Although some gains have been made (largely through the courts), These criticisms have not been able to effect any significant changes in the program’s functioning. Indeed, in recent years it has appeared to many that the bureaucracy has become increasingly impervious to criticism. In the year prior to ICPD, a number of women’s organizations

decided to work together to attempt to reopen the dialogue Their purpose was to use the opportunities provided by a global conference to make an impact on the national program. To do this, it was necessary to start a process of dialogue before the conference and it during the conference, so as to be in a position to raise issues of implementation and accountability in the period after.

Accordingly, a series of meetings were held before ICPD [9] in which women's organizations began to agree on common positions and to show the government that they had both knowledge of and access to key actors in the international arena. The government in turn responded by continuing the process of information sharing and discussion during the conference itself. (The senior Indian civil servant at the conference met with almost 70 NGO representatives in daily briefing sessions.) It also drew upon the advice of NGO representatives at pivotal moments during the official ICPD debates. Further, it was agreed that the dialogue would continue after the conference.

In the months following Cairo, many organizations at multiple levels have been exploring, methods of ensuring implementation. Some of the organizations that have been engaged in this process have come together to form a network, Health Watch, one of whose principal objectives is to ensure implementation of the ICPD program. Health Watch is now in the process of expanding its membership beyond the initiators. At this stage, it has defined its priorities as

- The replacement of method-specific contraceptive targets, incentives, and disincentives in the family planning program by a system of monitoring and performance evaluation that would be more consonant with the ICPD program of action.

- Expansion of services to better meet people's reproductive health needs and improve service quality;

- Increasing resource allocation for primary health care; and

- Regular dialogue among NG0s and between NG0s and government.

Clearly, the post-ICPD process of implementation and accountability has a long way to go in India. The way forward will depend on the willingness of government to live up to its international agreements; the tenacity, patience, and

skill of the organizations of civil society; and the support of key international agencies. Some positive pointers can be seen. Agencies such as the United Nations Population Fund appear to be seriously reorienting their approaches and are far more open to NG0s than they have been in the past, both at the international and at the country level. Partly as a result of all the NGO efforts, state governments in the country have recently been mandated for the first time to experiment without targets in one or two districts in each state. How successful this experiment will be will depend on the extent to which network members and other NG0s are able to work with state governments to replace the target-based system with a more comprehensive, need-sensitive, and high-quality program.

Changes For the Future

The process of engagement between states and civil society that ICPD represents has created a number of challenges for women's organizations. These include both immediate needs related to holding governments and agencies accountable for implementing the Cairo agenda and ongoing strategies to strengthen the capacity of the women's movement to engage in the next phase.

The most important immediate challenge is to mobilize resources and gain political clout to affect policies at national and international levels without losing a critical stance. To do this well, women's organizations will have to further develop their capacity to construct and articulate policies and programs that will support women's health and rights. Many organizations already have considerable ability to do this at both national and international levels; their knowledge and experience, particularly in empowering women to demand and access health services & and in providing more holistic health care, are invaluable and need to be brought center stage. This is the necessary antidote to temptations within the population establishment to go back to business as usual under the new rubric of reproductive health or to exclude women's organizations, the main stakeholders of the Cairo agenda, from the implementation stage of the policy debate.

The longer-term, more strategic challenge for women's organizations is to come to terms with access to power at the policy level. After two decades of experience criticizing existing political, economic, legal, and cultural systems and the practices of those who wield power within those systems, women themselves are now poised to access power. Access to power for those who have previously been powerless can be both heady and intimidating. For the women's movement,

the diversity and heterogeneity that are the source of its strength and richness also add to the complexity of this challenge. Three types of activities are essential for the movement to build on its achievements to date. The first is to strengthen the movement by establishing a constructive dialogue within its diverse constituencies, building bridges across different cultures and classes and responding more meaningfully to the concerns of the younger generation. The second is to develop a conceptual framework that offers a comprehensive critique of current culture and macro-economic trends and policies and provides an inspiring and realistic vision of an equitable society free from poverty, violence, and gender discrimination. The third is to permeate different levels of civil society in order to achieve a transformation of values by establishing a presence in the media and in education systems.

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Notes

[1] Examples of national networks are the Brazilian Feminist Network on Health and Reproductive Rights, created in 1991 which incorporates more than 50 regional groups has a representative on the National Health Council, a board advising the president of the country: and the Women's Health Organization of Nigeria, a group of NGOs aimed at strengthening the capacity of Nigerians, particularly women's groups at the grass-roots level, to respond collectively to their identified health needs.

[2] For instance, the first Latin American and Caribbean conference on rural women scheduled for late 1995 in northeastern Brazil (one of the poorest regions of the world), has planned sessions on self-help and sexuality.

[3] C. Garcia-Moreno and A. Claro, "Challenges from the Women's Health Movement: Women's Rights versus Population Control," in G. Sen, A. Germain, and L. Chen (eds.), Population Policies Reconsidered Health, Empowerment, and Rights. Cambridge, MA: Harvard University Press, 1994, pp. 47-61.

[4] For detailed accounts of the interplay between feminists, the left the Catholic Church and the State in Brazil, see C. Barroso, "The Women's Movement, the State and Health Policies in Brazil," in G. L. Nijeholt (ed.), Towards Women's Strategies for the 1990's: Challenging Government and the State. The Hague: Mamillan and Institute of Social Studies, The Hague, 1991, pp. 51-70. See also J. Pitanguy, "Feminist Politics and Reproductive Rights: The Case of Brazil," in G. Sen and R. C. Snow (eds.), Power and Decision: The Social Control of Reproduction. Cambridge, MA: Harvard University Press, 1994.

[5] J. Zeitlin, R. Govindaraj and L. Chen "Financing Reproductive and Sexual Health Services" in G. Sen, A. Germain, and L. Chen (eds.), Population Policies Reconsidered: Health, Empowerment, and Rights, Cambridge, MA: Harvard University Press, 1994, pp. 235-48.

[6] This section draws upon G. Sen, "The World Program of Action, A New Paragdigm for Population Policy." Environment 37 (1) (Jan/Feb 1994), pp. 10-15, 34-37.

[7] An example is the summary of the DAWN platform document (Correa, 1994) which is already available in English, French, Spanish, Portuguese, and Arabic.

[8] J. Bruce, "Fundamental Elements of the Quality of Care: A simple Framework." Studies in Family Planning 21 (2) (1990), pp. 61-91.

[9] UNFPA and the Ford Foundation jointly supported a number of these consultations.