Population Policies Reconsidered

Health, Empowerment, and Rights

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Setting a New Agenda: Sexual and Reproductive Health and Rights

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As preparations for the 1994 International Conference on Population and Development (ICPD) gather momentum, debate is intensifying over the validity, objectives, scope, and accomplishments of population policies in Southern countries with high rates of population growth. A variety of groups with starkly different ideological positions have become involved in defining the problems to be addressed and appropriate solutions.

At one end of the spectrum are those who perceive rapid population growth in Southern countries as the most overwhelming threat to the future of the planet, economic growth, and national security.[1] At the other end of the spectrum are those who for religious or other reasons are opposed to induced abortion and to most or all contraceptives, sex education, and women's rights. Between the extremes are various other groups, including family planning "revisionists," who would improve current programs on the margins; feminist activists, human rights advocates, and progressive health and development professionals who seek to transform population policies and programs into reproductive and sexual health programs; and some population professionals who recognize the necessity both to improve the quality of services and to broaden population policies to encompass women's status and education, their access to material resources, and child health (see Bongaarts 1994; Bruce 1993; see Jain and Bruce; and Sen, in this volume).

These positions derive from four decades of experience with population policies and programs, and debates about them are fueled by varying concerns, perspectives, and interests. In regard to past experience, family planning programs have certainly made services available and have contributed to fertility decline (Mauldin and Ross 1991; Ross and Frankenberg 1993), but not yet sufficiently either to ensure that all who wish to regulate their fertility can do so safely and effectively or to achieve population stabilization. In addition, recent developments in the world pose severe obstacles to universal reproductive health and rights and to population stabilization. Since the early 1980s, the world community has faced severe economic crisis, which is translated into declining real wages, increasing unemployment, and deepening poverty in much of the South (see Anand in this volume). Structural adjustment policies, national government actions such as

disproportionate investments in the military and corruption, undermine fragile health, education, and other social services even as the populations in need are ever larger (Antrobus 1993; Due 1991; Elson 1990; Lele 1991; Sen 1991; Weil et al. 1990). The pandemics of Human Immunodeficiency Virus (HIV), AIDS and other sexually transmitted diseases (STDs) are devastating (amilies and communities, as well as placing overwhelming demands upon health systems. While poverty pushes more and more people onto fragile lands and into megacities without adequate shelter, clean water, sanitation, and jobs, some businesses and governments are promoting environmentally damaging approaches to development, and consumption in many Northern societies is placing unsustainable demands on natural resources around the globe. At the same time that Southern governments' social-sector budgets are under severe pressure, many industrialized countries are reducing their foreign assistance budgets, shifting allocations to the former U S S R and Eastern Europe, and increasing disaster and emergency aid.

These trends require reassessment of both population and development policies to ensure that they create conditions in which it makes sense for people to have fewer children, the so-called demand side of the population equation. Policies should also ensure that all persons have the means to do so safely and effectively, the "supply" side. To accomplish both, it is necessary to transform population policy, until now narrowly equated with family planning services, to address development and human rights concerns and to transform "family planning" into reproductive and sexual health services that advance health and rights, not simply the achievement of demographic objectives.

In this chapter, we briefly address this need to transform population and development policies. We propose three intetrelated investment strategies: women's reproductive and sexual health services, including but not limited to birth control; policies and programs to encourage men to take more responsibility for their *own* fertility, for prevention of STDs, and for the health and well-being of their sexual partners and the children they father; and policies and programs to address underlying issues of sexuality and gender relations, especially for children and young people.

Creating the Necessary Socioeconomic Conditions

Although the importance of the demand side of population growth has long been recognized (Davis 1967; Davis and Blake 1956; Dixon-Mueller 1993b), and many national population policies have been appropriately adjusted (see, for example, Ethiopia 1993), population resources have been invested primarily in family planning programs, rather than in creating the conditions that facilitate people's use of those programs. Substantially changed definitions of the problem to be addressed, along with new approaches to the solutions, are required. The well-being of *both* current and future generations must be at the center of such policies, which would emphasize *investments in* people of all ages — their health, education, livelihoods, living conditions, and human rights — *and* would prioritize gender equity and women's empowerment. Despite considerable lip service, the political will to bring about more equitable and sustainable development, especially gender equity, has been sorely lacking (see Anand in this volume).

Investments in human development, including the empowerment of women, and assurance of human rights are essential in their own right. They are also the most effective and humane ways to reduce the continuing demand for many children in most Southern countries. Together, they provide the "enabling conditions" essential for people to exercise their reproductive rights and choose "freely and responsibly" the number of children they have (see Correa and Petchesky in this volume). They may also go a long way to slowing down population momentum[2] by creating conditions that foster later marriage; delay of the first birth, longer intervals between births, and demand for smaller families; more equitable relationships and decisionmaking between women

and men; and more equitable parental responsibility for children.

It is increasingly clear that the narrow approach adopted to date, which emphasizes quantity of contraceptive methods provided, is inadequate both to meet people's needs and to achieve fertility change. What is required is systematic and persistent interaction between population professionals and agencies on the one hand, and finance, planning, and development agencies on the other. Over the years, population agencies have mounted various attempts to insert "population" and "women" into the development planning process. Little success has been documented, in part because only demographic objectives have been expressed. As Dahlgren (1993) has pointed out, those concerned with population need to work more actively to integrate their objectives and strategies into mainstream agencies. They can do the following:

M Persuade ministries of finance to increase investments in *human development,* broadly defined (health, education, water, sanitation, housing, social services).

- Promote investment in *primary health care* to develop a stronger infrastructure for all health ministry activities.

3 Work for legislation and implementing mechanisms to *empower women* in all spheres of social and political life (marriage, inheritance, and so forth) and require men's responsibility for their own sexual behavior and its consequences.

3 Persuade education ministries ro adopt policies that not only eliminate *the gender gap* in education, but also include *sexuality and gender education* in the curricula, foster equitable gender relationships, prevent violence against girls, and eliminate sex role stereotypes from textbooks.

- Support concerned ministries and agencies to provide credit, training, and other essential inputs for women to earn *decent livelihoods.*

3 *Involve women's advocates* in all levels of decisionmaking.

Such efforts are, *of course,* important in their own right. If they are adopted at the ICPD in 1994, and carried forward into the Summit on Social Development and the UN International Conference on Women and Development in 1995, the population community will indeed have made a significant contribution toward human security and development for current and future generations. Not only these demand-promoting actions, but also the supply side — namely, the provision of reproductive and sexual health services, rather than contraception alone—should receive priority.

Providing Services

To date, family planning programs have assisted millions of women (and couples) to prevent unwanted fertility. Nonetheless, an estimated 100 million married women of reproductive age still have no *access* to services and about 170 million married women will be added to the potential user pool in the 1990s (Merrick 1994). Uncounted millions more are excluded from services because they are "too young" or unmarried, or they are poorly served (Dixon-Mueller and Germain 1992); most men are not included in family planning services. As many as 38 million abortions occur annually in Southern countries, an estimated 20 million of them clandestine, a stark testament to the lengths to which women go to prevent an unwanted birth (Germain 1989). In too many cases, subtle or explicit coercion of one sort or another has been used to "persuade" or force individuals to use contraceptives, be sterilized or have abortions (see Boland, Rao, and Zeidenstein in this volume). Despite national and international outcry, such practices persist, and may even increase as growingpopulations challenge governments to provide social services, jobs, and security.

If we are to achieve truly voluntary fertility control that respects human rights and advances health, our agenda must include not only improved quality of family planning services, but also expanded approaches that encompass the

multiple dimensions of sexual and reproductive health for both women and men — sexuality and gender education, STD prevention and treatment, safe abortion, pregnancy and deliver}' services, postpartum and gynecologic care, and child health. We must enable men to take responsibility for their own behavior, and we must provide services and information to children and young people *before* they are sexually active, as well as in the crucial teenage years of sexual exploration and development. The primary objectives of services should be to assure a healthy and satisfying sexual and reproductive life. This agenda is described in the Women's Declaration on Population Policies (see Box 1; also Correa and Petchesky in this volume).

Policies and programs must, among other precautions, tailor interventions to suit particular situations (for example, not all health infrastructures are strong enough to ensure safe, nonabusive provision of long-acting hormonal contraceptives). While encouraging men to take responsibility for their *own* behavior, they must also assure women's control over their bodies (see Boland, Rao, and Zeidenstein; and Correa and Petchesky, in this volume). Given that women bear the primary burdens of reproduction and STDs,[3] that resources and political will to provide reproductive and sexual health sendees are limited, and that policy-development, institution building, and attitudinal changes cannot be immediately achieved, it is essential that representatives of the women to be served are included in all levels and aspects of decisionmaking. Three priority areas for program investment and development are described below: women's health services, programs for men, and education on sexuality and gender.

Women S Sexual and Reproductive Health Seivices

The objectives should extend beyond simply fertility control and include the following:

K Enabling women to manage their own *fertility safely* and effectively by conceiving when they desire to, terminating unwanted pregnancies, and carrying wanted pregnancies to term.

- Promoting a healthy, satisfying sexual life, free of disease, violence, disability, fear, unnecessary pain, or death associated with reproduction and sexuality.

E Enabling women to bear and raise healthy children as and when they desire to do so.

To achieve these objectives, changes are needed in the definition of who is to be served; in how services are to be provided, especially the balance between quantity and quality of care; in what services are provided; and in *measures to monitor* and evaluate programs. Basically, we need to improve the quality and extend the reach of birth control services, as well as provide other, closely related reproductive and sexual health services to all who need them.

Contraceptive Services

In regard to family planning, debate persists on whether unmarried persons should be included in the population to be served, whether the primary focus should continue to be women, whether persons younger and older than reproductive age should be included, and whether persons,, who are sterile (whether voluntarily or not) should be considered clients (Dixon-Mueller and Germain 1992). Constraints on financial and human resources, along with religious or other beliefs, are often cited as absolute barriers to broadening program scope. A reordering of program and budgetary priorities, however, would contribute substantially to ensuring that all persons, regardless of gender, age, or fertility status, are reached with a wider range *of sen'ices.*

We would give much higher priority than has heretofore been given to improving the quality- of services. As regards family planning, Bruce (1990) conceptualized the primary elements of quality of care to include choice among methods, information on technical competence, client-provider relations, continuity of use, and constellation of services. More recently, the International Planned Parenthood Federation (Huezo and Briggs 1992) has formulated a document, "Rights of the Client," to be posted in all of its clinics. Systematic

B O X

Women's Declaration on Population Policies

(In Preparation for the 1994 International Conference on Population and Development)

Introduction

In September 1992, women's health advocates representing women's networks in Asia, Africa, Latin America, the Caribbean, the U.S. and Western Europe met to discuss how women's voices might best be heard during preparations for the 1994 Conference on Population and Development and in the conference itself. The group suggested that a strong positive statement from women around the world would make a unique contribution to reshaping the population agenda to better ensure reproductive health and rights.

The group drafted a "Women's Declaration on Population Policies," which was teviewcd, modified and finalized by over 100 women's organizations across the globe.

The Declaration is now being circulated by the initiators to women's health advocates, other women's groups and women health professionals, outside and inside government, for their signatures. In addition, the initiators invite othet networks, organizations, governments, and individuals, including men, to endorse the Declaration.

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Women's Declaration on Population Policies

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Preamble

Just, humane and effective development policies based on principles of social justice promote the well-being of all people. Population policies designed and implemented under this objective need to address a wide range of conditions that affect the reproductive health and rights of women and men. These include unequal distribution of material and social resources among individuals and groups, based on gender, age, race, religion, social class, rural-urban residence, nationality and other social criteria; changing patterns of sexual and family relationships; political and economic policies that restrict girls' and women's access to health services and methods of fertility regulation; and ideologies, laws and practices that deny women's basic rights.

While there is considerable regional and national diversity, each of these conditions reflects not only biological differences between males and females, but also discrimination against girls and women, and power imbalances between women and men. Each of these conditions affects, and is aiTected by, the ability and willingness of governments to ensure health and education, to generate employment, and to protect basic human rights for all. Governments' ability and willingness are currently jeopardized by the global economic crisis, structural adjustment progtams, and trends toward privatization, among other factors.

To assure the well-being of all people, and especially of women, population policies and programs must be framed within and implemented as a part of broader development strategies that will redress the unequal distribution of resources and power between and within countries, between racial and ethnic groups, and between women and men.

Population policies and programs of most countries and international agencies have been driven more by demographic goals than by quality of life goals. Population size and growth have often been blamed inappropriately as the exclusive or primary causes of problems such as global environmental degradation and poverty. Fertility control programs have prevailed as solutions when poverty and inequity are root causes that need to be addressed. Population policies and programs have typically targeted low income countries and groups, often reflecting racial and class biases.

Women's fertility has been the primary object of both pro-natalist and antl-natalist population policies. Women's behavior rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programs.

As women involved directly in the organization of services, research and advocacy, we focus this declaration on women's reproductive health and rights. We call for a fundamental revision in the design, structure and implementation of population policies, to foster the empowerment and well-being of all women. Women's empowerment is legitimate and critically important in its own right, not merely as a means to address population issues. Population policies that are responsive to women's needs and rights must be giuunded in the following internationally accepted, but too often ignored, ethical principles.

Fundamental jEthical Principles

1. Women can and do make responsible decisions for rhemseJves, their families, their communities, and, increasingly, for the state of the world. Women must be subjects, not objects, of any development policy, and especially of population policies.

2. Women have the right to determine when, whether, why, with whom, and how to express their sexuality. Population policies must be based on the principle of respect for the sexual and bodily integrity of girls and women.

3. Women have the individual right and the social responsibility to decide whether, how, and when to have children and how many to have; no woman can be compelled to bear a child or be prevented from doing *so* against her will. All women, regardless of age, marital status, or other social conditions have a right to information and services necessary to exercise rheir reproductive *eights and* responsibilities.

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4. Men als^have a personal and social responsibility for their own sexual behavior and fertility and for the effects of that behavior on their partners and their children's health and well-being.

5. Sexual and social relationships between women and men must be governed by principles of equity, non-coercion, and mutual respect and responsibility. Violence against girls and women, their subjugation or exploitation, and other harmful practices such as genital mutilation or unnecessary medical procedures, violare basic human rights. Such practices also impede effective, health- and rights-oriented population programs.

6. The fundamental sexual and reproductive rights of women cannot be subordinated, against a woman's will, to the intetests of partners, family members, ethnic groups, religious institutions, health providers, researchers, policy makers, the state or any other actors.

7. Women committed to promoting women's reproductive health and rights, and linked to the women to be served, must be included as policy makers and program implemenrors in all aspects of decision-making including definition of ethical standards, technology development and distribution, services, and information dissemination.

To assure the centraliry of women's well-being, population policies and programs need to honor these principles at national and international levels.

Minimum Program Requirements

In the design and implementation of population policies and programs, policy makers in international and national agencies should:

1. Seek to reduce and eliminate pervasive inequalities in all aspects of sexual, social and economic life by:

- providing universal access to information, education and discussion on sexuality, gender roles, reproduction and birth control, in school and outside;
- changing sex-role and gender stereotypes in mass media and other public communications to support more egalitarian and respectful relationships;
- enacting and enforcing laws that protect women ***from sexual and*** gender-based violence, abuse, or coercion;
- implementing policies that encourage and support parenting and household maintenance by men;
- prioritizing women's education, job training, paid employment, access to credit, and the right to own land and other property in social and economic policies, and through equal rights legislation;
- prioritizing investment in basic health services, sanitation, and clean water.

2. Support women's organizations that ate committed to women's reproductive health and rights and linked to the women to be served, especially women disadvantaged by class, race, ethnicity or other factors, to:

- patticipate in designing, implementing and monitoring policies and programs for comprehensive reproductive health and rights;
- work with communities on service delivery, education and advocacy.

3. Assure personally and locally appropriate, affordable, good quality, comprehensive reproductive and sexual health services for women of all ages, provided on a voluntary basis without incentives or disincentives, including but not limited to:

- legislation to allow safe access to all appropriate means of birth control;
- balanced attention to all aspects of sexual and reproductive health, including pregnancy, delivery and postpartum care; safe and legal abortion services; safe choices among contraceprive methods including barrier methods; information, prevention and treatment of STDs, AIDS, infertility, and other gynecological problems; child care services; and policies to support men's parenting and household tesponsibilities;
- nondirective counselling to enable women to make free, fully informed choices among birth control methods as well as other health services;
- discussion and information on sexuality, gender roles and power relationships, reproductive health and rights;
- management information systems that follow the woman or man, not simply the contraceptive method or service;

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Women's Declaration on Population Policies
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- **Training** to enable all staff *to* be gender ***sensitive,*** respectful service providers, along with procedures to evaluate and reward performance on the **basis** of the quality of care provided, not simply the quantity of services;
- program evaluation and funding criteria that utilize the standards defined here to eliminate unsafe or coercive practices, as well as sexist, classist or racist bias;
- inclusion of reproductive health as a central component of all public health programs, including population programs, recognizing that women require information and services not just in the reproductive ages but before and after;
- research into what services women want, how to maintain women's integrity, and how to promote their overall health and well-being.

4. Develop and provide die widest possible range of appropriate contraceptives to meet women's multiple needs throughout their lives:

- give priority to the development of women-controlled methods that protect against sexually transmitted infections, as well as pregnancy, in order to redress the current imbalances in contraceptive technology research, development and deliver}';
- ensure availability and promote universal use of good quality condoms;
- ensure that technology research is respectful of women's right to full information and free choice, and is not concentrated among low income or otherwise disadvantaged women, or particular racial groups.

5. Ensure sufficient financial resources to meet the goals outlined above. Expand public funding for health, clean water and sanitation, and maternity care, as well as birth control. Establish better collaboration and coordination among U N , donors, governments and other agencies in order to use resources most effectively for women's health.

6. Design and promote policies for wider social, political and economic transformation that will allow women to negotiate and manage their own sexuality and health, make their own life choices, and participate fully in all levels of government and society.

Necessary Conditions

In order for women to control their sexuality and reproductive health, and to exercise their reproductive rights, the following actions are priorities:

1. Women Decision Makers

Using participatory processes, fill at least 50 percenr of decision-making positions in all ***relevant*** agencies with women who agree with the principles described here, who have demonstrated commitment to advancing women's rights, and who are linked to the women to be served, taking into account income, ethnicity and race.

2. Financial Resources

As present expenditure levels are totally inadequate, multiply at least four-fold the money available to implement the program requirements listed in this Declaration.

3. Women's Health Movement

Allocate a minimum of 20 percent of available resources for women's health and reproductive rights organizations to strengthen their activities and work toward the goals specified in this declaration.

4. Accountability Mechanisms

Support women's rights and health advocacy groups, and other nongovernmental mechanisms, mandated by and accountable to women, at national and international levels, to:

- investigate and seek redress for abuses or infringements of women's and men's reproductive rights;
- analyze the allocation of resources to reproductive health and rights, and pursue revisions where necessary;
- identify inadequacies or gaps in policies, programs, information and ***services and recommend*** improvements;
- document and publicize progress.

Meeting these priority conditions will ensure women's reproductive health and their fundamental right to decide whether, when and how many children to have. Such commitment will also ensure just, humane and effective development and population policies that will attract a broad base of political support.

implementation of these guidelines has not yet been achieved. In fact, clinics are still struggling to define specific standards of care, and to establish measures to monitor and evaluate the quality of services. While the terminology of quality of care has gained currency, the concepts often have significantly different meanings for women's health advocares and for family planning policy lakers (see Table 1).

In debates about quality of care in family banning services, it is commonly argued that the best is the enemy of the good." Some say that he pursuit of quality for a few would jeopardize ccess for the many and, in extreme cases, would et up "medical barriers" to access (see, most ecently, Shelton, Angle, and Jacobstein 1992). n fact, good-quality care need not be expensive see box on page 246; also Kay and Kabir 1988). The motivation of staff and revisions in the lllocations of human, not only financial, re-*lources* can improve basic program management md logistics systems and, more importantly, the technical quality and interpersonal quality of services (see Aitken and Reichenbach in this volume). It is not acceptable, nor is it effective, for services to be of such poor quality that women "accept" methods for which they have cleat contraindications (Hardy et al. 1991); are exposed to high risk of infection or injury, such as uterine perforation during IUD insertion; are given no or insufficient information to use the method effectively, or are sterilized without consent (Khattab 1992); are not counseled adequately regarding side effects and not enabled to switch methods freely; or are persuaded to use a particular method because of the provider's incompetence or preferences (Dixon-Mueller and Germain 1992 and 1993). Clients should be treared with dignity, not disrespect, and with eating about the social and emotional consequences that may result from a decision to practice birth control.

Such shortcomings, which all too commonly occur, can be solved with commitment to improved training and supervision of staff. Critical

T A B L E

Interpretations of Quality of Care Concepts

Concept	Women's health advocates	Family planning policy makers
Information	Education Advantages and disadvantages of methods	Motivation Advantages of methods methods
Scope of services	Sexual and reproductive health	Contraception; sometimes abortion
Counseling	Client-provider dialogue	Persuasion
Choices	All methods Provide safe abortion	"Modern" methods Prevent abortion
Outcome measures	Contraceptive continuation Client satisfaction	Method continuation Long-acting methods
Follow-up	Provide information, routine care, support for switching methods	Manage complications

Source: Marcelo and Germain 1994.

to this effort are new program statistics and evaluation measures that follow each client to assure proper treatment and positive outcomes; skilled staff to assist clients with emotional or social, not just physical, consequences of birth control; program managers who are alert to quality control problems; and reward systems for staff and programs based on how well they serve people, not on how many contraceptives they dispense (see Jain and Bruce in this volume).

Three other *essential* elements of good-quality birth control services are often resisted, but are of equal priority: safe abortion services; STD prevention, diagnosis, and *treatment; and* improved technologies.

Safe Abortion Services

Women are demonstrating with their lives and their health that abortion is, for them, a method of family planning (Dixon-Mueller 1993a). It is impractical, as well as unethical, not to provide safe abortion ***services.*** *The ideal* is, of course, to both remove legal restrictions and assure provision of safe services to all who need them. Even where abortion is illegal, however, or where political and social factors are serious obstacles, *governments and other agencies* in a number of countries have found means to provide this critical service for women's health.

STD Prevention, Diagnosis, and Treatment

In the face of the STD and HIV pandemics, it is mandatory that all programs that serve sexually active people offer information and services for the prevention and control of STDs, including HIV, to all clients. In fact, many family planning services have often given low priority to condom introduction and distribution, although condoms are currently the only means, other than abstinence, to reduce exposure to disease (Liskin, Wharton, and Blackburn 1990). Few, if any, family planning programs in Southern countries, as far as we are aware, systematically screen and treat clients *for STD* infection. Yet, contraceptive safety is compromised by these diseases; STDs are the major cause of infertility; and the presumed clients of family planning services, married women of reproductive age, have virtually no *access* to specialized STD services (Dixon-Mueller and Wasserheit 1991; Elias 1991; Elias, Leonard, and Thompson 1993; Germain et al. 1992).

Improved Technologies

The third *necessary* change in the birth control dimension of reproductive and sexual health has to do with technology and the ways in which research and development priorities are determined. As described by Fathalla (in this volume), a major reorientation of research priorities and process is needed to pursue critical technological gaps: woman-controlled methods that will protect against infection, with or without protection against pregnancy; abortifacients; and male methods. Simpler, less-expensive diagnostic techniques and treatments for conventional STDs are urgently needed (Wasserheit and Holmes 1992). Substantial changes are also needed in the research process to ensure that the women to be served are fully represented at all stages, and that introductory trials are *conducted* in such a way as to ensure that service delivery systems are strong enough to protect and follow up on clients' safety and well-being (see Garcia-Moreno and Claro in this volume; Spicehandler and Simmons **1993;** WHO/HRP and IWHC 1991).

Other Reproductive Health Services

In addition to these essential investments to transform family planning services into truly voluntary and safe birth *control services,* investments must be made in *broader reproductive and sexual health services for women* (see Aitken and Reichenbach in this volume). In 1987, the International Women's Health Coalition defined and promored a reproductive health approach to meet women's needs by encouraging enhanced collaboration among disparate vertical programs for family planning, maternal and child health, and STD control (Germain and Ordway 1989). Since then, many in population and related health fields have adopted the language and the concept of reproductive health. But until now, "repro-

ductive health" has been at best understood and implemented as a combination of conventional contraceptive services, child survival interventions, and pregnancy care (see box on page 246; also Si Mujer 1992). Recently, some agencies — notably, the Fotd Foundation, the John D. and Catherine T. MacArthur Foundation, IPPF, the Population Council, and the Wotld Bank — have begun to incorporate "sexuality," "sexual health," or STDs into theit agendas (Ford Foundation 1991; IPPF 1993; Population Council 1989; Senanayake 1992). Such programs represent a significant advance over narrower approaches and serve well those whom they recognize as their clients.

Most programs, however, have approached women as means to the ends of fertility control and child health. They have concentrated on married, fertile women in their reproductive years, and have left many girls and women seriously underserved or unserved. Although family planning has been combined with maternal and child health (for example, Coeytaux 1989; Otsea 1992), such programs have had very little interaction with AIDS and STD programs until quite tecently (see, for example, Berer and Ray 1993; World Health Otganization 1993). Debates ovet integtated vs. vertical approaches continue unresolved, leaving most women with no option but to travel to and wait at multiple clinics on multiple days (see Aitken and Reichenbach in this volume).

By the time girls and young women reach family planning and maternal and child health services, they are, in many countries, severely anemic, malnourished and stunted, pregnant, or infecred with STDs. Child health programs have as yet invested little in ending discriminatory and abusive treatment *of girls* by families, communities, and health services. Unmarried, but sexually active *young* people who do not have children are generally excluded from services; when served, they may be treated punitively (see Hawkins and Meshesha in this volume). Services for childbearing women remain woefully inadequate in preventing death and treating morbidity (see, for example, Btady and Winikoff 1992). At the other end of the age spectrum, preventive health services have generally had no ***interest in women*** who are sterile or beyond reproductive age even though they remain sexually active. At the same time, tertiary health services see increasing numbers of older women with pteventable cancers; STDs, including HIV and AIDS; and the effects of menopause, some of which may be inappropriately treated as illness.

Thus, we propose that policies and programs seek to meet the *sexual* and reproductive health needs of girls and women of all ages throughout their life cycles, regardless of whether their sexual relations have a reproductive purpose. Services would include the following:

- Fully voluntary birth control for individuals (a full range of contraceptive methods and safe abortion).
- ***M*** Services related to pregnancy (prenatal and postnatal care, safe delivery, nutrition, child health).
- * *STD* prevention, screening, diagnosis, and treatment.
- Gynecologic care (screening for breast and cervical cancer).
- Sexuality and gender information, education, counseling.
- Health counseling and education in all services.
- Referral systems for other health problems.

How this agenda is accomplished, short- and longer-range priorities, and specific investments will, of course, need to be adjusted for particular settings (see Box 2 on next page). What is important is an overall strategic vision against which specific plans can be made, implemented, and monitored (see box on page 50). Certainly, these services, and the agencies that fund and administer them, should no longer be driven solely or primarily by demographic concerns.

B O X 2

Meeting Women's Sexual and Reproductive Health Needs in Sierra Leone

> My friend said, [The clinic] is so good, I cannot explain. Go ahead and you will see for yourself. As soon as 1 enter, the place feels like a clinic. It is tidy, neat and clean...There is no waste of time, you are constantly cared for.
>
> ***—Primary school teacher, age 31, on her first visit to the Marie Stopes clinic***

For the average Sierra Leonean, life is a constant struggle for survival. The public sector is able to provide only minimal social services. The majority ***of women learn*** about womanhood and reproduction only through initiation ceremonies for traditional secret societies. As a result, Sierra Leone has one of the world's highest child mortality rates (150-200 per 1000 births), and one of Africa's highest maternal mortality rates (estimated at 2,500 per 100,000 births). The average woman bears 6-7 children during her lifetime.

Since 1988, the Marie Stopes Society of Sierra Leone (MSSL) has overcome social and economic barriers to provide high-quality reproductive and sexual health services, including contraception, diagnosis and treatment of STDs, Pap smears, prenatal care, services for women with unwanted pregnancies, simple operative procedures, and counseling for menopausal women. ***General*** health and nuttition services are also provided, especially for children under age five and malnourished pregnanr women. Special care is given to counseling and follow-up to reassure clients and ensure their concerns are met, even by the pharmacist:

> I make sure I explain the use of all medications I dispense and confirm that the client absorbed [the information]. It does not take that much time, really.
>
> ***—Nurse I pharmacist at the Aberdeen clinic***

Staff" training includes, not only technical skills, but also continuing orientation to the goals and ethics of MSSL, to ensure high quality client care and staff harmony despite escalating hardships. Every day, new solutions have to be found to endlessly vexing problems, such as assuring adequate supplies and maintaining accounting procedures in the face of fluctuating exchange rates, inflation, and lack of computerization.

Nonetheless, the rewards are worth the hardships. By the end of 1991, MSSL boasted two main clinics that provide a full range of services (including operating theaters for menstrual regulation and minor gynecologic procedures), and eight satellite clinics. By August 1991, MSSL clinics were seeing about 4,000 clients per month. Most are low-income, petty traders in their middle or late twenties.

Donor contributions are still required, primarily to purchase supplies and spare parts from abroad. Local currency, raised chiefly from clinic charges, is used to pay for staff salaries, other operating costs, and local supplies. The fees MSSL charges clients are minimal, within a range most clients are able to afford. In some cases, fees are waived for clients unable to pay.

MSSL's goal is to fulfill the reproductive and sexual health needs of women throughout their life ***cycles.*** Currently, MSSL youth programs include awareness campaigns through radio; talks and videos in schools; a network of youth clubs; and workshops, plays, and singing groups. MSSL advises young people to postpone sexual activity until they feel they are ready. If they are already sexually active, MSSL encourages them to use their clinic's contraceptive and STD information and service.

Although MSSL's primary purpose is to create a space for women, it is very aware that women's lives are closely tied to both their children and their male partners. Thus, it has welcomed men and encouraged them to be involved in the welfare of their partners and children. Employment-based clinics provide regular seminars for male workers on family planning and responsible parenthood. Staff explain to the men all the services that are offered to women and children, and what they are for. As a result, men's interest and participation has increased significantly, and a clinic providing STD and contraceptive services for men opened in 1994.

Source: Adapted from Toubia 1994, with permission.

Men's Responsibility and Behavior

Generally, population policies in Southern countries, concerned international agencies, and demographers have focused on women, since it is they who bear children.'' While it is essential that women have *access* to services with which to control their health and fertility, it is entitely inappropriate lor policy to allow, even enable, men to abdicate their responsibility for theit own fertility, prevention of STDs, and the well-being of their sexual partners and the children they father. Men remain fertile longer than women and continue sexual activity into their older years, often with multiple partners. As a result, evidence from some countries shows that many men actually have higher fertility than their wives, and much or this excess occurs after age 45 (Bruce 1993).

Although vasectomy is significantly cheaper and safer than female sterilization procedures, tubal ligation is nearly three times as frequent as vasectomy in Southern countries. The only othet male conttaceptive method, the condom, has more often than not been offered as a last choice for women who cannot or will not use modem, more "effective" contraceptives. In any case, many men tefuse to use condoms at all, or consistently, or with their regular partners, leaving their partners at risk of STDs (Rosenberg and Gollub 1992; Stein 1993). In genetal, men have not been welcomed or encouraged to patticipate in family planning services designed for women. Separate programs for men have generally been of much smaller scale and focused on vasectomy.

It is thus not surprising that contraceptive use data show that in "less-developed" regions of the world, methods that tequire men's initiative and cooperation (vasectomy, condom, rhythm, and withdrawal) account for only 26 percent of contraceptive use. (In "more-developed" regions, these methods account for 57 percent of use.) Even taking into account the likelihood of undetestimation, the gteat discrepancy between the female and male burdens of responsibility fot contraception is stark (see Table 2 on page 226; Mauldin and Segal 1988; Ross and Frankenberg 1993).

Refusing to use conttaceptives themselves, many men also resist their partners' desire to use a method (Liskin, Wharton, and Blackburn 1990; Ruminjo et al. 1991). At the same time, in many cases they abdicate responsibility for their children to the woman or women who bore them (Bruce 1989; Bruce and Lloyd 1992). In Costa Rica, where over 80 percent of first births are to adolescent women, a 16-year-old girl described how her boyfriend reacted when she told him she was pregnant: "He told me he didn't want to hear anything about babies because he wasn't interested. He said it probably wasn't his baby anyway. And then he left." (Castillo 1993)

Because theit objective has been fertility control, vasectomy services have missed an extremely important opportunity to work with men on other aspects *of sexual* health (see, for example, Lynan et al. 1993). Programs could provide information, screening, and treatment for STDs; promote continued condom use beyond the initial period following vasectomy; and provide counseling and educational activities to promote healthy sexuality and equitable gender relations (Liskin, Benoit, and Blackburn 1992). Box 3 (on the next page) desctibes two projects that demonstrate not only how to move from a simple vasectomy clinic to a men's reproductive health program, but also that men can become interested in such services (Rogow 1990; see also Mtsogolo 1992).

Overall, substantially greater investments are needed in vasectomy services and condom promotion, as well as STD control and broader reproductive health services for men. Across regions, men have sometimes shown mote interest in family planning than is usually assumed by service providers and policy makers (Hawkins 1992; Liskin, Benoit, and Blackburn 1992; Liskin, Wharton, and Blackburn 1990). It seems that men often prefer separate service facilities from women and, sometimes, male providers (Rogow 1990; Mtsogolo 1992), but experimentation is needed to determine suitable approaches in each country.

More profound changes will also be needed, however, to increase use of vasectomy and

condoms, to ensure men's tespect for their partners' contraceptive choices, and to motivate men to take tesponsibility for sexual health and the children they father (see, for example, Savara and Sridhar 1992). Socialization practices and other social institutions that condone or promote severe imbalances of power and other inequities between women and men, along with exploit-

B O X 3

Meeting Male Reproductive Health Needs in Latin America

Not much is known about how men view their reproductive and sexual lives. Limited available evidence suggests that they are highly concerned with achieving effective and satisfying sexual function and treating STDs. But what moves men to be concerned about unwanted pregnancy?

A combination of male ***attitudes and*** provider bias has meant that men are both a neglected and a poorly prepared ***constituency for*** family planning and reproductive health care. Frequently, pride makes men reluctant to ask about reproduction, sexuality, and conttaception. Men seldom learn about contraception from health professionals, who themselves have little information.

The experiences of PRO-PATER in Brazil and Profamilia's Clfnica para el Hombre in Colombia may help answer the question "How can men's interests be better understood and addressed by reproductive health programs?" The former is a reproductive health service for men only; the latter, a clinic created as an adjunct to a long-standing program for women.

Pro-Pater

This clinic was conceived in 1981 as a "space for men to participate more fully in family planning" through vasectomy, which is almost unknown in Brazil (even though 27 percent of all women aged 15-49 in union **have been sterilized).** The clinic now also provides counseling, screening and treatment for sexual dysfunction and infertil**ity.** It does not provide condoms, nor is it willing to sell them — an important shortcoming given the prevalence of STDs, including HIV, in Sao Paulo. Clinic staff do treat clients with STDs (except AIDS), but do not publicly promote this service, as STD clinics generally have a poor reputation. In the future, PRO-PATER may form adolescent groups ***focusing on*** birth control and sexuality.

PRO-PAl'ER's **Technical** competence is measured by its low complication and failure rates. The adequacy of the program's counseling is evident from client satisfaction at the initial visit and during follow-up visits, and the virtual absence of requests for vasectomy reversal.

Clinica para el Hombre

To meet the needs of a wide range of clients, this clinic in Colombia combines vasectomy services with testing and treatment of urological problems, sexual problems, infertility, and STDs; general physical examinations; condom distribution; and family planning education. Initially, the clinic faced substantial cultutal resistance, staffing problems, and a small case load; but after thtee years, it was 92 percent financially self-sufficient, had expanded to five cities, and was serving 750 new clients each month. By 1990, the clinic was seeing more than 500 men for follow-up and selling well over 2,000 condoms. Clinic staff also provide care for the female partners of STD and infertility clients.

The clinic is a training resource for orher institutions in Colombia and elsewhere in Latin America. The key to its success: careful determination of what is most important to clients, a very attractive facility, individualized care, a wide range of services, low-cost vasectomy, and Saturday hours.

The Future

For rhe time being, to ***increase male contraceptive,*** use we must make the best of the two available methods. This can be done by increasing general acceptance of these methods, improving access to them, and putting greater emphasis on the quality of care provided. Over the longer term, it is essential that new choices for men be developed, whether better condoms or entirely new approaches. Increasingly, the issue is, not lack of demand, but appropriate supply and technology.

Source: Adapted from Rogow 1990, with permission.

ative, abusive, and unhealthful sexuality, need to be changed (Aral, Mosher, and Caces 1992; see also Correa and Pecchesky in this volume). The greatest hope for such changes lies with young people, who, with support, can challenge gender role ***stereotypes*** as they participate in social life, explore their sexuality, and build relationships with each other (S. Nowrojee 1993b).

Sexuality and Gender Relations

Until the advent of HIV and AIDS, and even since then, the family planning field, especially government programs, has generally ignored the fact that reproduction takes place through sexual relations, which are conditioned by broader gender relations. A review of the conventional demographic and family planning literature illustrates that the population field has neglected sexuality, gender roles, and relationships, focusing instead largely on outcomes, such as contraceptive efficacy, unwanted pregnancy, and, more recently, infection (Dixon-Mueller 1993c). Similarly, health and education policies and programs in most countries have rarely dealt with sexuality and have understood very little about how gender relations affect achievement of their goals. Overall, population and health policies and programs continue to be rooted in and reinforce existing gender relations and traditional constructions of sexuality, rather than transforming them. Examples include public campaigns on child health that feature only mothers, family planning education materials or condom packaging that use aggressive images, and STD or HIV campaigns that portray women as vectors of infection.

Socialization into sexuality and gender roles begins early in the family and community, and is reinforced by basic social institutions, the mass media, and other factors (Miedzian 1993; Obura 1991). Political, economic, legal, and cultural subordination of women generally means they are easily subject to violence and unable to protect themselves from risk beginning at a very young age (Fullilove et al. 1990; Handwerker 1994; Heise with Pitanguy and Germain 1994; Worth 1989). Confusing double standards exist for male and female sexual behavior, under which boys are expected to be sexually aggressive and girls to be both chaste and sexually appealing (Ekwempu 1991; ECOS 1992; S. Nowrojee 1993a; Winn 1992). While women are expected to be submissive, they are also held responsible for sexual interaction. They are the ones expelled from school for pregnancy, or publicly shamed for "loose" behavior. This is well illustrated by boys in India, who identified "good" girls as those who ignored boys when they whistled at them, and "bad" girls as those who "turned and smiled" (Bhende 1992; Savara and Sridhar 1992). Even extreme behavior by boys is rarely questioned — and is sometimes condoned. From Kenya to the United States, boys who rape have been publicly exonerated by parents who say "boys will be boys" (Gross 1993; Perlez 1991), or school officials who say "they meant no harm" (V. Nowrojee 1993).

Women's reproductive and sexual well-being, self-perceptions, and self-esteem are directly and indirectly affected by rape, battery, homicide, incest, psychological abuse, genital mutilation, trafficking of women and children, dowry related murder, and forced sterilization and forced abortion (Adekunle and Ladipo 1992; Dawit 1994; Edemikpong 1990; Ghadially 1991; Maggwa and Ngugi 1992; Pyne 1992; Toubia 1993). The 1993 *World Development Report* indicates that "women ages 15 to 44 lose more Discounted Healthy Years of Life (DHYLs) to rape and domestic violence than they do to breast cancer, cervical cancer, obstructed labor, heart disease, AIDS, respiratory infections, motor vehicle accidents, or war" (World Bank 1993).

Other beliefs and practices regarding women's bodies and sexuality also have important health consequences. Beliefs that women should not know about sexuality can tesult in high risk of STDs, unwanted pregnancy, and inability or reluctance to seek health care. For example, STD symptoms are often believed by women to be normal, not problems to be treated. A rural Indian woman said, "Like every tree has flowers, every woman has white discharge" (Bang and Bang 1992; Dixon-Mueller

and Wasserheit 1991; Pyne 1992; Ramasubban 1994). Widespread beliefs that menstrual blood and normal vaginal discharge are dirt)', shameful, or distasteful to the sexual partner lead to poot menstrual hygiene ot vaginal cleansing, which increase the risk of vaginal infection and reduce women's sexual pleasure (Dixon-Mueller and Wasserheit 1991; Intetnational Center for Research on Women 1994; Ramasubban 1990; Sabatier 1993; Wambua 1992).

Finally, gender differentials in access to health care put gitls and women in unnecessary jeopardy. Women, more than men, have to overcome economic and cultural barriers to seeking and receiving information and care. Social constructions of "proper" female behavior and sexuality deter women from using STD clinics for fear of being regarded as promiscuous or defiled (Dixon-Mueller and Germain 1993; Elias and Heise 1993). Single women and adolescents may not approach family planning services, for fear of being seen as sexually active or being refused service. Even medical research has been discriminatory, giving little attention to breast and cervical cancer; using only male subjects for research on heart disease; and, until recently, excluding female-specific symptoms such as cervical cancer or vaginal candidiasis from the case definition of AIDS (Corea 1992; Hamblin and Reid 1991; Reid 1992).

Clearly, social consttuctions of sexuality' and gender relations are major deterrents to sexual and reproductive health and rights. They are genetally considered "politically sensitive," which has prevented necessary policy and program development in most countries, although the World Health Organization developed guidelines as early as 1975 (WHO 1975). When the state does intervene, mechanisms must be carefully designed to protect basic tights, including privacy and bodily integrity'. Perhaps the most urgent investment needed is in young people, who are being severely injured, and even dying, as a result of societies' unwillingness to invest in sexuality and gender education and services for both unmarried and married young people.

A narrow message of abstinence and dire warnings about the consequences of poorly managed sexuality' is not the answet. Sexuality' is a basic dimension of human life, and young people, especially under contemporary conditions, experiment in many societies. The message needs to be one of mutual caring and respect, with full knowledge of negative consequences and how to prevent them. A number of innovative efforts have been launched to engage young people in dialogue with each othet and with adults on theit perceived needs, and to provide them necessary information and services (Francis and O'Neill 1992; see also Hawkins and Meshesha in this volume). Sweden is one country that has adopted a transforming approach to sex education that recognizes sexuality as good and lovemaking as something people should know how to do well. Many other cultures have, or used to have, social institutions to support young people in sexual initiation. Much could be done simply by recovering, re-creating, or building on those ttaditions.

As experimentation proceeds with programs to support young people in their exploration of their sexuality' and their gender roles, we must provide the opportunities for education and work that will encourage and enable them to delay marriage and childbeating. We must also work with other major social institutions, especially the mass media, to promote more equitable and positive images of gender relations and sexuality.

Conclusion

Our proposed *approach is twofold. First,* transform population policies to help achieve human development equity and human rights. *Second,* put sexuality' and gender relations at the center of reproductive and sexual health and rights policies and programs to empower women, to ensure theit health, and to motivate men to take responsibility for their own behavior. The outcome should be mutually caring, respectful, and pleasurable sexual relationships, and a solid foundation for teproductive and sexual health and rights, as well as for human development and rights overall.

This is a sweeping agenda, which reflects especially women's perceived needs and experiences and recognizes that fundamental social and policy changes are needed. Significant changes are already occurring on a small scale in many countries and even at the level of international diplomatic debate. Women's empowerment, reproductive health, sexuality and many of the other issues are being actively and broadly discussed. What is still needed is the political will to reallocate resources to this agenda, imaginative strategies to use those resources well in the particular circumstances of each country, and the inclusion of representatives of women, who have most at stake, in all levels of decisionmaking.

Notes

1 Some of these also acknowledge that Northern overconsumption is an equal, if not greater, threat, but believe that interventions to restrict consumption are more difficult than population control and therefore urge pursuit of the latter (see, for example, McNamara 1991).

2 Despite falling fertility rates, the number of couples in the reproductive ages has doubled since I960, and the number of births continues to rise, a phenomenon referred to as "population momentum." Because of the young age structure of Southern populations, the momentum factor will be pronounced in the next 20 years (Merrick 1994).

3 For example, the rate of transmission of STDs from men to women is higher than from women to men. Women suffer much worse consequences than men, including increased risk of ectopic pregnancy and pregnancy wastage, and pelvic inflammatory disease (Dixon-MuellL-r and Wasserheit 1991; Germain et a!, (eds.) 1992).

4 An important exception was India, which put very strong emphasis on vasectomy in the national population program until the early 1970s.

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