Appendix 3

Social Analysis and Selective Inclusions in Rights-Based Approaches to Reproductive Health

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The endorsement of a reproductive rights agenda is the latest twist in an ongoing shift within population and development policy to move beyond the traditional targets of population policy to include other social categories - most obviously 'adolescents' and 'men' – and to transform provider-client relations. This paper examines this shift in terms of how international social policy about reproduction has responded to both the growing understandings of the implications of social relations for reproductive behaviour and to the increasingly orthodox call for rights-based approaches. We argue that this response does not adequately engage with the differentiated interests and needs of rights-bearers nor does it address the complex and ambiguous nature of power and autonomy in reproductive and sexual relations at either individual, community, societal or global levels.

Introduction

The endorsement of a reproductive rights agenda is the latest twist in an ongoing shift within population and development policy to move beyond the traditional targets of population policy. The progressive inclusions of different social categories within sexual and reproductive health has involved not only a broadening of client profiles – including most obviously 'adolescents' and 'men' alongside 'women of reproductive age' - but also a qualitative shift towards seeing clients as individual rights-bearers. These inclusions have had multiple drivers that include the need to address new epidemiological threat of HIV/AIDs, the limited impact of previous population policies, improved understandings of reproductive behaviours, new visions of global social development, and successful lobbying by women health advocates world-wide. The Cairo International Conference for Population and Development (ICPD) in 1994 embodies these inclusions in its vision for sexual and reproductive health (UN 1994) and its language has penetrated social policy in global institutions, donor agencies, national governments, and reproductive health service organisations. This paper critically reviews these inclusions, draws attention to their partial nature, identifies other selective exclusions, and considers their implications for reproductive and sexual health.

We are centrally concerned with how reproductive health policy has responded to both the growing understandings of the implications of social relations for reproductive behaviour and to the increasingly orthodox call for rights-based approaches. A growing literature drawing strongly on sociology, anthropology, politics and gender studies offers strongly contextualised and differentiated perspectives on reproduction (see for example, Greenhalgh 1995, McNicoll 1994, Bledsoe 1994, Petchesky and Judd 1998 and Harcourt 1997). These understandings engage closely with the way in which reproductive strategies are embedded in wider social relations and processes, exploring both the ambiguities of lived experiences and the iterative ways in which reproductive outcomes are shaped and given meaning. Attention to the politics of social policy, including reproductive health policy and service provision (such as Fraser 1989, Finkle and McIntosh 1994, and Sen et al 1994), and growing understanding of the dynamic and frequently problematic status of sexual and reproductive entitlements (see Pethcesky and Judd 1998) embodied within social practice and culture has deepened understandings of the complexities and subtleties of sexual and reproductive interests and the challenges of addressing them through intervention.

The emergence of a sophisticated literature concerned with the social relations of reproduction has the potential to complement the changing emphasis towards rights-based approaches within reproductive health policy. However, although "on the face of it, the rights agenda is now mainstream" (Jacobsen 2000:26), concern for reproductive rights has been interpreted most often as a call for improved quality of care plus an expansion of services to encompass 'comprehensive reproductive health' with a renewed push to meet 'unmet need' amongst a wider range of target individuals (see for example, DFID 2001:87 Box 12.4). The reorientation of the language of 'unmet need' from family planning to serve the 'new' reproductive health agenda betrays a continuity in which rights are seen largely in terms of needs (see Cox 1998:8-9). This interpretation reduces the social analytical content of reproductive health policy to an improved, but nevertheless simplistic and sometimes stereotypical, incorporation of select categories of social differentiation and factors out broader institutional challenges to reproductive rights.

Without utilising the concept of 'social exclusion', around which there is a growing literature (see for example, De Haan and Maxwell 1998), our use of the terms 'inclusion' and 'exclusion' in relation to population policy will resonate with some of these debates. These processes do not only mediate material access to services but also play a role in constructing meanings and identities as well as being a part of wider struggles about resources, power, culture, and social relations. Following Jackson (1999) and other feminist commentators on social policy (see Pascall 1997), inclusion *per se* is not necessarily a 'good thing' and attention needs to be paid to the terms of that inclusion as well as the possibility of multiple and partial inclusions/exclusions. Rights are a special form of 'needs talk' which despite their moral appeal to absolute standards derived from 'human nature', are social constructions that evolve over time and which bear specific ideological characteristics. The bureaucratic interpretation of needs as a series of administrable wants often depoliticises rights by 'enclaving' them within bounded arenas (Fraser 1989). Our focus here is on how, in social analytical terms, the challenge raised by reproductive rights is conceived, particularly on how reproductive health has revisioned the subjects and scope of its interventions and on the political implications of these partial inclusions and selective exclusions.

Partial Inclusions?

In contrast to many spheres of development, women's problem with population policy was not that they were 'left out' but that their bodies were the objects of sometimes aggressive attempts to reduce fertility. Inclusion in family planning services was, as has been well-documented, sometimes coercive, including forced compliance and gate-keeping access to economic opportunities, and often was demeaning or stigmatising (for instance, Hartmann 1987). There is now a wide literature on the inadequacies of client-provider relations and quality of care in family planning services (for example Gupta 1993). At the same time women were also targeted under maternal and child health initiatives in ways that reinforced their already heavy caring roles without tackling underlying problems. However, not all women were included in this way, and women, particularly very young women, engaging in sexual relations outside of marriage or established partnerships found themselves stigmatised by services or even completely excluded from them, as did men, boys, as well as older women and men, infertile couples, and other specific reproductive interest groups. These partial inclusions and selective exclusions make manifest the ways in which 'reproductive health' is implicated in the management of sexual and reproductive relations and the role of women and men within the social order (Maine et al 1994:204).

The traditional targets of population policy have been (married) women of reproductive age and the key distinctions drawn between them have revolved for the most part around age, age at first birth, and parity on the basis of biomedical assessments of risk and health. 'Good' outcomes remain defined as delaying, spacing and limiting births using modern contraceptives. To these characteristics deemed to be 'of interest' we can also add proxy indicators of women's status, typically their educational achievements or literacy and their employment status. Win-win theories hold that education and independent incomes improved women's status and thus their autonomy and contraceptive use. Indeed, the use of contraceptive rates as a proxy measure for women's status illustrates the unquestioned strength of the association between greater female autonomy and reduced fertility. Although women were always central to population policy, Greehalgh (1995:23) has commented that even today demography is "almost prefeminist in the implicit assumption and biases that inform its work (for example, that only women aged 15-49 are reproductively 'dynamic' and thus worth studying, that women and men occupy separate spheres, the former private, the latter public) and in the narrow range of women's characteristics considered demographically important".

Although some of these inclusions/exclusions and related constructions of target groups have been progressively challenged by new thinking and advocacy, the Cairo ICPD has not so far marked a sharp break with past policies and some troubling continuities remain within its broadened agenda. The Programme of Action (PoA) is significant in placing efforts to improve reproductive health at the centre of population policy and at embedding this vision within a rights-based understanding of reproductive health that puts women's empowerment firmly on the agenda. However, for many a rights-based approach to reproductive health simply means doing "family planning better" (Greene 2000:50). There is a fairly uncontroversial consensus over the need to work harder to eliminate "unmet need", to improve the quality of services, and to broaden services. There is also a widely shared emphasis on girl's education and on income generation/employment/credit for women. Greater priority

is given to the needs of adolescents, to the involvement of men, and to working on HIV/AIDS. These shifts represent changes of emphasis in population policy that have been growing in momentum since before Cairo. The PoA added strength and legitimacy and took the agenda another step along the road but it didn't transform population policies in the way that many women's health advocates envisaged. The dimensions of this which concern us here include the incomplete and selective incorporation of reproductive interest groups, and the enclaving of reproductive interests within a biomedical approach to reproductive health programming which fails to engage with social institutional constraints, and the limited engagement with the task of revisioning the client group as rights-bearers who might play a role in shaping policy as well as in determining their own needs.

The continued narrow focus on reproduction is accompanied by ambivalence over non-reproductive sex and sexual self-determination, de-links concerns of social reproduction and empowerment from reproductive health policy, and side-steps critical issues of power. These deficiencies are evident in the partial inclusion of adolescent reproductive health and the particular way in which adolescents and their health needs are constructed. Although the reproductive health needs of adolescents are receiving considerably more attention, these approaches are mainly not rights-based, work with homogenised understandings of adolescence (Gage 2000) and circumvent important aspects of power that are critical to improving wellbeing. The Cairo PoA notably fails to articulate reproductive rights for adolescents, instead emphasising the need for "appropriate" services "suitable for that age group" with "proper regard for parental guidance and responsibilities" (PoA 7.44 – 7.47). These strategies do not engage with growing understandings about the realities of sexual and reproductive relations for younger men and women or draw up a vision of an appropriate enabling environment in which they can take control over their sexuality and reproduction (see for example Hawkins and Meshasha 1994 and Gage 2000). Although female genital mutilation (FGM) and gender violence, including sexual abuse, receive attention they are constructed as a separate front of activity thus obscuring the lines of power that impact on adolescent reproductive self-determination and health.

Without denying the many arguments that early marriages are often arranged, place untimely burdens of childbirth, social reproduction and work on adolescents, and can close down opportunities and perpetuate powerlessness, it can be observed that adolescent reproductive health needs are overwhelmingly constructed around the perceived 'problem' of teenage pregnancy (see PoA 7.44). In many developing countries these perspectives also incorporate overtones of religion and ethnocentrism in contexts where, until recently, low age at marriage and early childbearing was the approved social behaviour. Young married, and often unmarried, mothers have usually been able to access reproductive health services, while unmarried young women without children have been excluded in many contexts. Today, changing social norms means that almost everywhere the age at which young women and men get married has been rising, and in some contexts the age at first intercourse has been declining, and this gives rise to a growing and differentiated set of sexual and reproductive interests and needs for teenagers. For example, Reysoo describes "a new adolescent life stage" emerging in Morocco where sexual relations outside of marriage are illegal and age at marriage is rising: double-standards permit men sexual relations before marriage but demand virginity in young women (1999). Gage (2000) calls for an approach that disaggregates adolescents in terms of their life stage and relevant circumstances (out-of-school, unemployed, living on the street, not-sexually active and so on), rather than defining adolescents using broad age ranges.

Whilst research has drawn attention to the importance of power relations in adolescent reproductive-decision making, policy approaches have been slow to engage with the implications for action. Poor adolescent girls may rely on sexual strategies for their economic survival and educational advancement and these relationships often contain large power imbalances and the implicit or actual threat of male violence. Policy responses have tended to see the solution narrowly in terms of improving the flow of resources to these women and improving interpersonal skills to negotiate sex and condom use (Gage 2000). Efforts at empowerment need to address the reality that adolescents are under the authority of adults who have vested interests in their reproductive and sexual behaviours by focusing much more on the context of the family, community, peer groups and the larger social system, particularly given the complicity of parents in determining the timing of young women's entry into marriage and childbearing (Gage 2000:194, Dubey and Dubey 1999). Although teenage pregnancy has recently been seen broadly in terms of social exclusion within the UK debate (Social Exclusion Unit 1999), the political will has not been there to defend their rights to a full range of reproductive health services for teenagers or to effectively transform sex education to address their concerns and interests (Guardian 2000).

Men's prominence within reproductive health policy has also improved, and there is agreement about the need to "address the ways in which men view and influence women's reproduction, as well as the ways in which men view their own reproductive lives and responsibilities" (Freedman and Isaacs 1993:19). However, woman-centred approaches have constructed men in particular ways: as uninformed, irresponsible, blocking women's contraceptive use, promiscuous and as under-investing in their children (Greene and Biddlecom 2000). International family planning efforts have integrated male methods into their programmes and used public health campaigns to seek male support for female contraceptive use by encouraging 'responsible' fatherhood (Ali 2000:122). There have been few positive experiences in addressing men's sexual and reproductive health needs and "few programmes have taken the plunge to initiate work that erodes the gender inequities inhibiting reproductive health" (Greene 2000: 56). Initiatives have been fragmented and have often been based upon stereotypical assumptions or in some instances reinforced gender inequalities. The latter was the case in Zimbabwe where a public health campaign aiming to involve men in contraceptive use by appealing to their sense of power using sports metaphors reinforced men's perception that they should be in sole control over contraceptive decision-making rather than working together with their partners (Barroso and Jacobsen 2000:362).

Research into men's reproductive lives is a small but growing field (see Bledsoe et al 2000 for a valuable contribution), and as far as we are aware, little progress has been made in differentiating male reproductive interests within health policy. Barroso and Jacobsen say that "the growing interest in increasing male participation in reproductive health and family planning must be broadened to address the structural and cultural factors working against men's support of women's empowerment" (2000:367). They see this as including the development of an "enabling environment" in which men can develop their nurturing capabilities and share responsibilities for child care, contraception and reproduction in general. In order to do this we need to understand much more about the "co-operation and sharing between the sexes [which] already exists simultaneously with male practices and rhetoric

that seek to generate power and authority" (Ali 2000:120) as well as tackling broader societal constraints, including, for instance, the paternity rights of workers.

Barroso and Jacobsen (2000) highlight the construction of different 'core groups' for HIV/AIDS prevention strategies. Commercial sex workers (CSWs) have been seen as high-frequency transmitters of HIV and other STDs and have been seen as objects of strategies, largely designed to get CSWs to negotiate condom use with their clients, to prevent the spread of disease. They say: "CSWs have been treated as a 'separate' group of women, and development discourse and programmes have in practice paid little attention to the broader social and economic context of their lives and their subordination (Gorna 1996; Asthana and Oostvogels 1996)" (2000:358). Heterosexual women who were not CSWs "were largely invisible" in HIV/AIDs policies until recently despite the fact that they represent the majority of HIV positive women (Maine and Freedman 1994). It is now recognised that monogamous women are at risk from their partners and that their economic dependency on male partners can increase their risk of infection if the partnership falls apart (De Zoysa 1996 and Elias and Heise 1994 cited Barosso and Jacobsen 2000). Kemp's study of STDs in West Africa went further and concluded that understanding of sexual behaviours needed "to investigate the terms of the sexual contract within a cultural context" (1992:76) echoing Bledsoe's warning that "women in West Africa were "interpreting [official AIDS advice] through their own cultural categories or attempting to stretch their options to avoid the constraints posed by AIDS dangers and policy directives" (1989 cited Kemp 1992:76). Whilst prevention programmes attempt to encourage condom practice within marriage, the development of microbicides for women that allow conception whilst protecting against HIV/AIDs is given marginal importance despite a concerted campaign by feminist health activists (Maine and Freedman 1994, CHANGE 2001). International guidelines on HIV/AIDs and human rights have focussed primarily on the rights of people living with HIV/AIDs but also on the rights of groups vulnerable to HIV/AIDs (UN 1998). Whilst rights to life-prolonging drugs have at times been back grounded (see FCO 2000 and UN 1998), this position has changed in response to an active and highly successful international campaign addressing multinationals and international patents laws (see Guardian 2001).

Alternative statements of reproductive rights, such as Correa and Reichmann's (1994) feminist perspectives from the south, put questions of social justice more firmly on the agenda than Cairo. Complex understandings of reproductive behaviour draw attention to the socially and culturally embedded nature of inequalities confirming the centrality of social and institutional factors in realising greater reproductive health and freedom for all. Whilst the PoA urges freedom from discrimination of all kinds, the lines of difference to which it gives prominence exhibit continuities from older population policies. Although disabled and indigenous groups are mentioned (UN 1994: Chapter VI), poverty is largely dealt with in respect of questions of economic and population growth (UN 1994: Chapter III) and the categories of social differentiation that are most used include girl children/adolescents versus boys, women versus men and women with early, low parity, well-space births as opposed to women with high parity, closely space births. The difference in these ways of looking at inequalities implicitly reflect different understandings of the challenges to be met by reproductive health policy.

This difference of emphasis is perhaps best illustrated by the interpretation of empowerment within the official reproductive rights agenda. Despite considerable rhetorical emphasis on supporting empowerment, financial allocations are weak and remain focused on girl's education, and women's employment and income-generation (Barroso and Jacobsen 2000:353). The contribution of these programmes to transforming underlying gender inequalities is highly questionable and more radical interpretations of empowerment and reproduction suggest different focii for research and policy that include issues such as unwanted sex and unsafe sex (Presser and Sen 2000). The contradication between the routine inclusion of empowerment in official reproductive rights agendas and the continuing controversy over women's reproductive and sexual self-determination (Keysers 2000) is emblematic of the implications of the accommodations made to secure consensus around the final PoA at the Cairo ICPD.

Selective Exclusions?

The official framing of reproductive rights has been pursued in a manner that effectively "enclaves" (Fraser 1989) concerns around reproduction and addresses them to an audience of reproductive health policy-makers and service-providers. This process not only influences the nature of inclusions in population policies but also selectively excludes some interests and concerns from this agenda.

Prominent amongst those raised by social analysis, as well as activists, are: the way that enabling conditions including macroeconomic policy, unequal international relations and fundamentalism, have been left off the agenda; the way certain kinds of rights talk has occluded social differences thus de-centred objectives concerned with social justice; and the reductionism of an approach that sees social institutional and cultural dynamics as undesirable traditions obstructing more modern/individuated reproductive behaviour.

Despite the endorsement of reproductive rights, official social policy related to reproduction continues to neglect "enabling conditions and the absence of institutional and political environments that promote and protect rights" (Jacobsen 2000:26) including poverty, globalisation, privatisation, fundamentalism, political movements, lack of transparency and accountability of government, donors and reproductive health services. These go to the heart of international power relations around reproduction and have concrete implications for the capacity of 'better' reproductive health to contribute to improved wellbeing and freedom. Although the World Summit on Social Development (WSSD) established two international development targets reflecting reproductive health concerns (UN 1995), the International Conference on Population and Development at Cairo was notably out of tune with its 'social integrationist' perspective (Anon 1995:10-19) and was firmly embedded within a neoliberal economic agenda for health sector reform (Petchesky 2000). Ollila et al (2000:87) argue that despite rhetorical prominence given to reproductive rights at Cairo "the increased emphasis on the general market agenda was more important…as was evident in the greater stress on cost-recovery mechanisms and non-governmental agencies". This neoliberal agenda is widely seen as inimical to expanding the realisation of reproductive rights both directly, in terms of its residualisation of social services and the consequences of shifting of caring burdens back to the household and exacerbating inequalities in health-seeking behaviours, and indirectly through undermining livelihoods, social security and creating conditions of vulnerability which lead to ill-being, powerlessness and the greater commodification of women and sex (Barroso and Jacobsen 2000:358).

Keysers puts the view of many feminist observers succinctly when she says that "the broad concerns of women's health were narrowed down to reproductive health only and to a de-politicised plea for more choice in contraceptive means" (2000:21). Southern women's groups have been instrumental in broadening international women's health advocates' understandings about reproductive health, and in particular the importance of embedding reproductive behaviour within material interests. However, livelihoods, and even concerns relating to social reproduction and parenting were marginalised in the Cairo PoA. Although reproductive health targets are now more prominent in international social policy, concern for reproductive rights has not penetrated important arenas. For example, the development of voluntary codes of conduct is now a significant component of emerging mechanisms for the global regulation of capital, but as Pearson and Seyfang (2001) point out none make specific reference to the known violations of reproductive rights that occur within export processing factories. These include including loss of employment following pregnancy, enforced contraception and pregnancy testing, and restrictions of toilet breaks.

Control over the population agenda and responsibility for delineating and monitoring reproductive rights are disproportionately influenced by western powers. The continuing inequality between north-south in international policy arenas has given rise to calls from international women's health advocates for reforms of the international financial institutions and international organisations. The role of the Roman Catholic Holy See within the UN has come under repeated criticism and was again highlighted at Cairo after Islamic Fundamentalist groups and the Holy See attempted a strategic alliance against abortion and perceived threats to religious and family values. Although supposedly set within an international human rights framework and therefore universal in outlook, the reproductive rights agenda remains one addressed from the North to the South in many important respects. Keysers notes that "the reformulated population agenda… still tends to keep attention and funding narrowly focused on fertility management in the economic South" (1999:20). In the US, a major player financially and politically, support for rights approaches to population has been weak and traditional support for family planning efforts continues to be motivated by perceived threats to the environment, the global economy, and international security (Jacobsen 2000). Keysers argues that in these ways population policy categorises populations into the 'wanted' and the unwanted', "the 'us' and 'them' "(2000:20), and that scrutiny of developed/donor country population policies, including immigration policies, is overdue.

Official reproductive rights talk has curiously occluded key processes of social exclusion despite the traditional association of rights discourse with concerns of social justice. Reproductive rights have been constructed in international social policy in ways that divert attention from concerns around social structural inequalities, power, entitlements and freedom. Considerable research has shown that reproductive experiences are differentiated not only in terms of sex, age, and parity, but can also be differentiated in terms of gender, life-stage, social identity, wealth, ethnic group, caste, location, political affiliation and other lines of inequality (see Greenhalgh 1995). For example, Lane et al (1998) looking at the 'economics of abortion safety' in Egypt confirm that reproductive rights are differentiated by poverty (1089). Ram (1996) shows how class and caste shape women's experiences of medical institutions around childbirth in Tamil Nadu and Reysoo (1999) describes how a complex series of life stages structures women's sexuality in Morocco. Reproductive health policy has been slow to engage with these differences in interpreting the needs of different reproductive and sexual health interest groups and this reluctance is manifest in the continuing disengagement with questions about wellbeing, and narrow approaches to entitlements and sexual and reproductive freedoms. International monitoring of reproductive rights is poorly developed and focussed on assessing reproductive health. Traditional population indicators such as total fertility rates and contraceptive prevalence rates remain pre-eminent in WHO guidelines for global monitoring despite review in the light of Cairo (WHO 1997). As Graham says "concerted research effort is needed if those activities related to wellbeing, rather than to ill-health, which were endorsed in the Cairo ICPD are to be tracked for progress" (1998:1926).

It has been widely acknowledged that although human rights discourses have been utilised worldwide by social movements making claims for greater wellbeing and freedom (Petchesky 2000, Ferguson 1999) they are rooted in Western liberalism and its vision of the individual. For example, the PoA bestows reproductive rights on "couples and individuals" (UN 1994: Para 7.3) thus side-stepping thorny questions about power struggles between "couples" and alienating such struggles from the relational context of child-bearing and processes of family-formation in developing countries (see Ali 2000, Harcourt 1997). Although it is rarely acknowledged in rights debates, sexual and reproductive strategies within developed countries are also relational to varying degrees and varying ways: everyday occurrences include subtle and not so subtle pressures from partners, parents and in-laws including to begin child-bearing once married, to avoid child-bearing outside marriage, to select particular types of marriage partner, or to have a certain number of children and to nurture them in specific ways. These interests within developed countries may sometimes have less economic content but have strong emotional, cultural and sometimes religious significance and undoubtedly have a real impact on sexual and reproductive experiences.

Ali (2000:126) follows Chakrabarty (1994) in arguing that the modernisation project of population policy "to regulate reproductive sexual relations of the conjugal couple without hindrance or competition from other kin, affine and community members" is closely linked to the creation of the 'responsible citizen' but diverges widely from men's and women's lived experiences of reproductive health policy. He notes that "men themselves give meaning to the language and practice of fertility control as it enters their household and affects their notions of their bodies , fertility and sexualities" Ali (2000:129). In contrast, culture in population thinking is seen as divorced from broader social, political and economic forces as a traditionalism or fatalism that obstructs 'modern' reproductive decision-making (and contraceptive use) (Greenhalgh 1995:7). The cultural construction of contraceptive and reproductive technologies, the ways in which they are used, and the implications for meanings around sexual and reproductive relations needs to be seen as important information about how sexual and reproductive health impacts on wellbeing (see Russell 1996, Graham 1998, Sadana 2000).

Although the international human rights framework theoretically makes room for the local interpretation of what fundamental rights mean in specific contexts, there has in reality been almost no attention to considering what reproductive rights might look like in different places. The International Reproductive Rights Action Group (IRRAG) have conducted sensitive research into the cross-cultural meanings of reproductive rights that confirm an ethical core of agreement over fundamental rights whilst demonstrating local variation in expression (Petchesky and Judd 1998). Freedman and Isaacs (1993:18) stress that we "need to examine much more closely what we really mean by an individual human right to reproductive choice, freedom, or autonomy in a world as demographically complex and culturally diverse as ours". However, the international reproductive rights agenda is ambivalent and inconsistent in relation to local social practice and culture. For example, international statements that

condemn female genital mutilation, which is normative for particular ethnic groups, as "harmful 'traditional' practice" (WHO 1997:1) suggests that the good and bad parts of culture can simply be retained and weeded out respectively. Despite the rhetoric that justifies the rejection of 'harmful traditional practices', official reproductive rights discourse pays almost no attention to 'beneficial traditional practices'. Nevertheless, research has shown that 'traditional' social relations can perform important reproductive and sexual health functions which may be marginalised by the pace of contemporary changes leaving an important vacuum. For example, Kinuthia-Njenga (1999) argues that breakdown in social and family traditions is leading to poor sexual and reproductive health for poor women at different life stages in Nairobi's slums. Similarly, Harcourt notes that in Ghana "modernity has disrupted traditional knowledge-transfer of reproductive health and sexual behaviour, so that grandparents, once so important in educating young people at puberty, are no longer consulted, and birthing rituals involving the whole family are now abandoned" (1997:3).

Even more challenging for reproductive rights is the hidden and taboo nature of some social practices associated with reproductive and sexual health. Petchesky and Judd describe what they call a "sense of entitlement" which cannot be equated with normative morality but which is grounded in the ways that women act to secure what they perceive to be their own and their children's needs (1998:14). Breaking the "zones of silence" around these social practices raises ethical questions but may be important for extending reproductive and sexual entitlements (Harcourt 1997, Sawalha 1999). For example, the resistance to abortion rights effectively fails to recognise that women everywhere for many centuries have sought to terminate unwanted pregnancies. Although abortion is a pervasive social practice, in many contexts it is neither legal nor socially legitimated, and as such it is not acknowledged as a part of local culture making it a politically controversial area for service provision. In these contexts, abortion remains unsafe jeopardising women's lives and risking social exclusion and even imprisonment. Today, new technologies such as 'menstrual regulation' are opening up the possibilities of expanding safe access to abortion in conservative contexts but the emphasis of official reproductive rights discourse remains on expanding services to deal with the complications of unsafe abortion where it is illegal.

Despite broad rhetorical support for rights-based approaches to reproductive and sexual health, this has rarely been conceived in terms of expanding sexual and reproductive freedoms. Whilst wanting to support the expansion of comprehensive reproductive health services, it is important to recognise that research and activists point to other lines of action that some argue are more critical for expanding freedoms (Pillai and Wang 1999). Although there is scope for legal reforms, for legal literacy, for greater accountability and consultation over social policy, for supporting the development of reproductive rights organisations and related strategies aimed at changing social and gender norms and practices, the rights element of this agenda has been largely conceived of in terms of improving client rights. Reproductive health policy needs to go beyond respecting the 'rights of the client' in order to focus on strengthening entitlements to sexual and reproductive freedoms and care through informal and formal social institutions. As Cornwall and Gaventa point out, a rights-based approach also means refiguring clients as rights-bearers who have a role in making and shaping policy and services (2000). Reproductive and sexual empowerment has a collective dimension and support for greater accountability nationally and internationally needs to take stock of the fact that everyday entitlements to sexual and reproductive rights can only be improved by transformation of social values. Advocacy of self-articulated priorities by different sexual and reproductive interest groups has an important role to play in legal, policy and social change.

Future Challenges?

We have argued that reproductive health policy has responded to increasingly sophisticated social analysis of reproductive behaviour and to the consensus around reproductive rights by constructing needs in ways that extend rather than transform policy-making. This response does not adequately engage with the differentiated interests and needs of rights-bearers not does it address the complex and ambiguous nature of power and autonomy in reproductive and sexual relations at either individual, community, societal or global levels. The selective inclusions and partial exclusions are not simply oversights but bear the mark of older political and professional interests that continue to shape the population agenda. The identification of social categories 'in need' of reproductive rights remains largely informed by biomedical perspectives and the motivation of overcoming constraints to programme success. The underlying motivation of inducing lower fertility remains influential and has encouraged instrumentalist interpretations of the empowerment agenda. The perspective on culture is

ethnocentric focusing on 'obstacles' and 'harmful' practices in the south and denying the social context of reproduction in developed countries. The 'project' is defined as extending and improving comprehensive reproductive health services thus back-grounding social change and political action around sexual and reproductive norms and entitlements. The challenge for the future can not therefore be seen technically as one of improving the social analytical content of policy but must also be seen politically as one of transforming the way reproductive rights, needs and policy are defined, interpreted and addressed. Social analysis can inform and support this process but the business of creating forces that can use the consensus over rights to articulate the claims of disadvantaged groups for sexual and reproductive freedoms and wellbeing is a much broader undertaking.

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