# FEMINIST THEORY READER

LOCAL AND GLOBAL PERSPECTIVES

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# 10.
# REPRODUCTIVE AND SEXUAL RIGHTS: A FEMINIST PERSPECTIVE

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In current debates about the impact of population policies on women, the concept of reproductive and sexual rights is both stronger and more contested than ever before. Those who take issue with this concept include religious fundamentalists, as well as opponents of human rights in general, who associate human rights with individualist traditions deriving from Western capitalism. Some feminists, too, are skeptical about the readiness with which advocates of fertility reduction programs, whose primary concern is neither women's health nor their empowerment, have adopted the language of reproductive rights to serve their own agendas. As a Southern and a Northern feminist who have written about and organized for women's reproductive health for many years, we are conscious of the tensions and multiple perspectives surrounding this conceptual territory. Our purpose in this chapter is not to impose a concept, but to explore a different way of thinking about it in order to advance the debate. We define the terrain of reproductive and sexual rights in terms of power and resources: power to make informed decisions about one's own fertility, childbearing, child rearing, gynecologic health, and sexual activity; and resources to carry out such decisions safely and effectively. This terrain necessarily involves some core notion of "bodily integrity," or "control over one's body." However, it also involves one's relationships to one's children, sexual partners, family members, community, caregivers, and society at large; in other words, the body exists in a socially mediated universe....

### Epistemological and Historical Premises

Contrary to many social critics, we are not convinced that reproductive and sexual rights (or human rights) are simply a "Western" concept. As Kamla Bhasin and Nighat Khan (1986) have argued with regard to feminism in South Asia, "an idea cannot be confined within national or geographic boundaries." Postcolonial writers and Southern governments have readily adopted, and adapted, the theories of Marx, Malthus, or Milton Friedman to suit their own purposes. Democracy movements in postcolonial societies easily invoke rights when it comes to voting, or forming political parties or trade unions. Why should concepts like "reproductive rights," "bodily integrity," and women's rights to sexual self-determination be any less adaptable?...



The term "reproductive rights" is of recent—and probably North American[1]—origin, but its roots in ideas of bodily integrity and sexual self-determination have a much older and culturally-broader genealogy. The idea that a woman in particular must be able "to decide whether, when, and how to have children" originated in the feminist–birth control movements that developed at least as early as the 1830s among the Owenite socialists in England and spread to many parts of the world over the course of a century (Chesler 1992; Gordon 1976; Huston 1992; Jayawardena 1993; Ramusack 1989; Weeks 1981). Leaders of these movements in Western countries, like Margaret Sanger in North America and Stella Browne in England, linked "the problem of birth control" not only with women's struggle for social and political emancipation, but also with their need to "own and control" their bodies and to obtain sexual knowledge and satisfaction (Sanger 1920). Their counterparts among women's rights advocates in nineteenth-century Europe and America and among the early–birth control pioneers in twentieth-century Asia, North Africa, and Latin America were more reticent about women's sexuality, emphasizing instead a negative right: that of women (married or single) to refuse unwanted sex or childbearing.

Underlying both the defensive and the affirmative versions of these early feminist prototypes of reproductive rights language were the same basic principles of *equality, personhood, and bodily integrity.* They held a common premise: in order for women to achieve equal status with men in society, they must be respected as full moral agents with projects and ends of their own; hence they alone must determine the uses—sexual, reproductive, or other—to which their bodies (and minds) are put.[2]

In the late 1970s and early 1980s, women's health movements emerged throughout Asia, Latin America, Europe and North America (DAWN 1993; Garcia-Moreno and Claro 1994). These movements aimed at achieving the ability of women, *both* as individuals *and* in their collective organizational forms and community identities, to determine their own reproductive and sexual lives in conditions of optimum health and economic and social well-being. They did not imagine women as atoms completely separate from larger social contexts; rather, they consciously linked the principle of "women's right to decide" about fertility and childbearing to "the social, economic and political conditions that make such decisions possible" (Women's Global Network for Reproductive Rights 1991).

Increasingly, as women of color in Northern societies and women from Southern countries have taken leadership in developing the meanings of sexual and reproductive rights for women, these meanings have expanded. They have come to encompass both a broader range of issues than fertility regulation (including, for example, maternal and infant mortality, infertility, unwanted sterilization, malnutrition of girls and women, female genital mutilation, sexual violence, and sexually transmitted diseases); and a better understanding of the structural conditions that constrain reproductive and sexual decisions (such as reductions in social sector expenditures resulting from structural adjustment programs; lack of transportation, water, sanitation, and child care; illiteracy; and poverty). In other words,

the concept of sexual and reproductive *rights* is being enlarged to address the *social needs* that erode reproductive and sexual choice for the majority of the world's women, who are poor (Desai 1994; Petchesky and Weiner 1990).

In the past decade, the integral tie between reproductive rights and women's sexual self- determination, including the right to sexual pleasure, has gained recognition not only in the North, but in Latin America, Africa, and Asia.[3] As the Women's Resource and Research Center (WRRC) in the Philippines states in its Institutional Framework and Strategies on Reproductive Rights (Fabros 1991), "self-determination and pleasure in sexuality is one of the primary meanings of the idea of 'control over one's body' and a principal reason for access to safe abortion and birth control." Anchoring the possibility of women's *individual* right to health, well-being, and "self-determined sexual lives" to the *social* changes necessary to eliminate poverty and empower women, this framework dissolves the boundary between sexuality, human rights, and development. It thus opens a wider lens not only on reproductive and sexual rights, but on rights in general.

### Rights Discourse: Rethinking Rights as Individual and Social

The discourse of (human) rights has come under heavy assault in recent years, from, among others, feminist, Marxist, and postmodernist sources (Olsen 1984; Tushnet 1984; Unger 1983)....

While these criticisms are theoretically compelling, they offer no alternative discourse for social movements to make collective political claims. Whatever its theoretical weaknesses, the polemical power of rights language as an expression of aspirations for justice across widely different cultures and political-economic conditions cannot easily be dismissed (Heller 1992). In practice, then, the language of rights remains indispensable but needs radical redefinition. Feminist theorists and activists have figured prominently in efforts to shed the abstract universality, formalism, individualism and antagonism encumbering rights language (Bunch 1990; Crenshaw 1991; Friedman 1992; Nedelsky 1989; Petchesky 1994; Schneider 1991; Williams 1991). Allying themselves with worldwide struggles for democratization among indigenous peoples, ethnic minorities, sexual minorities, immigrant groups, and oppressed majorities—all of whom invoke the language of "human rights"—they seek to recast rights discourse in a more inclusive "referential universe" (Williams 1991). The purpose is to transform the classical liberal rights model in order: (1) to emphasize the *social*, not just individual, nature of rights, thus shifting the major burden of correlative duties from individuals to public agencies; (2) to acknowledge the *communal* (relational) *contexts* in which individuals act to exercise or pursue their rights; (3) to foreground the *substantive* basis of rights in human needs and a redistribution of resources; and (4) to recognize the bearers of rights in their self-defined, multiple identities, including their gender, class, sexual orientation, race, and ethnicty....

Feminist writings and actions in defense of women's human rights build on these critiques to challenge the customary reluctance of states and international



agencies to intervene in traditionally defined "family matters." Through vigorous international campaigns leading up to and beyond the United Nations Human Rights Conference in Vienna in 1993, they have called for national and international sanctions against gender-based violations of human rights, and they have shown how such violations occur most frequently in the supposedly private realms of family, reproduction, and sexuality (for example, through endemic violence against women). Inaction by public authorities in response to such violations—whether at the hand of state officials, nongovernmental organizations (NGOs), or spouses—constitutes, they argue, a form of acquiescence (Bunch 1990; Cook 1993b; Copelon 1994; Freedman and Isaacs 1993; Heise 1992).

By prying open the "citadel of privacy," feminist legal and political theory offers a wedge with which to challenge the claims of "tradition" and "local culture" used to defeat domestic application of international human rights norms (see Boland, Rao, and Zeidenstein, 1994). Feminist deconstructions of the public-private division also point to a model of reproductive and sexual behavior that is socially contextualized[.]...

A social model of human behavior does not assume that individuals make decisions in a vacuum or that "choices" are equally "free" for everyone. Group identities that are complex and "intersectional" (across gender, class, ethnicity, religion, age, nationality) pull women's decisions in multiple directions. Moreover, because of existing social inequalities, the resources and range of options women have at their disposal differ greatly, affecting their ability to exercise their rights (Crenshaw 1991; Eisenstein 1994; Williams 1991).

How does this interactive, socially-embedded model of personal decision making apply to the realm of sexual and reproductive rights? Qualitative data across a variety of cultural and historical settings suggest that the extent to which reproductive and sexual decisions are "freely" made eludes easy classification; but "free" or "voluntary," whatever its meaning, is not the same as isolated or individualistic. In each concrete case we must weigh the multiple social, economic, and cultural factors that come to bear on a woman's decision and constitute its local meaning. Women's decisions about whether or not to bring a pregnancy to term are most frequently made in consultation with, under the constraint of, and sometimes in resistance against networks of significant others—mothers, mothers-in-law, sisters, other kin, neighbors; sometimes husbands or male partners, sometimes not (Adams and Castle 1994; Ezeh 1993; Gilligan 1982; Jeffery, Jeffery, and Lyon 1989; Khattab 1992; Petchesky 1990)....

Here we confront the nagging problem, always a dilemma for feminist advocates, of how to critique the kinds and range of choices available to women without denigrating the decisions women do make for themselves, even under severe social and economic constraints.[4] The debate concerning sterilization prevalence rates in Brazil provides a striking illustration. In a context of rapid fertility decline, female sterilization has become a "preferred" method in Brazil, used by 44 percent of current contraceptors. In some regions, the sterilization rate reaches more than 64 percent, as in the case of the Northeast, and the average age of sterilization has rap-

idly declined since the early 1980s (15 percent of sterilized women in the Northeast are under 25 years of age). A complex mix of factors explains this trend: concerns about the side effects or effectiveness of reversible contraception, failure of the public health system to provide adequate information about and access to other methods, severe economic conditions, women's employment patterns, and cultural and religious norms making sterilization less "sinful" than abortion (Correa 1993; Lopez 1993; Petchesky 1979).

In their analysis of the sterilization trends, Brazilian feminists are caught between the urgent need to denounce the inequities in sterilization rates—particularly among black women—and the evidence of research findings that many women have consciously chosen and paid for the procedure and are satisfied with their decision. On the one hand, this is a clear example of the "constrained choices" that result from circumstances of gender, poverty, and racism; the very notion that women in such conditions are exercising their "reproductive rights" strains the meaning of the term (Lopez 1993). On the other hand, the call for criminal sanctions against sterilization by some groups in Brazil seems a denial of women's moral agency in their search for reproductive self-determination.

We need to develop analytical frameworks that respect the integrity of women's reproductive and sexual decisions, however constrained, while also condemning social, economic, and cultural conditions that may force women to "choose" one course over another. Such conditions prevail in a range of situations, curtailing reproductive choices and creating dilemmas for women's health activists. Women desperate for employment may knowingly expose themselves to reproductively hazardous chemicals or other toxins in the workplace. Women hedged in by economic dependence and the cultural preference for sons may "choose" abortion as a means of sex selection. Where female genital mutilation is a traditional practice, women must "choose" for their young daughters between severe health risk and sexual loss on the one hand, and unmarriageable pariah status on the other.

For reproductive decisions to be in any real sense "free," rather than compelled by circumstance or desperation, requires the presence of certain *enabling conditions*. These conditions constitute the foundation of reproductive and sexual rights and are what feminists mean when they speak of women's "empowerment." They include material and infrastructural factors, such as reliable transportation, child care, financial subsidies, or income supports, as well as comprehensive health services that are accessible, humane, and well staffed. The absence of adequate transportation alone can be a significant contributor to higher maternal mortality and failure to use contraceptives (see Asian and Pacific Women's Resource Collection Network 1990; and McCarthy and Maine 1992). They also include cultural and political factors, such as access to education, earnings, self-esteem, and the channels of decisionmaking. Where women have no education, training, or status outside that which comes from bearing sons, childbearing may remain their best option (Morsy 1994; Pearce 1994; Ravindran 1993).

Such enabling conditions, or social rights, are integral to reproductive and sexual rights and directly entail the responsibility of states and mediating institutions



(for example, population and development agencies) for their implementation. Rights involve not only *personal liberties* (domains where governments should leave people alone), but also *social entitlements* (domains where affirmative public action is required to ensure that rights are attainable by everyone). They thus necessarily imply public responsibilities and a renewed emphasis on the linkages between personal well-being and social good, including the good of public support for gender equality in all domains of life.

This is not meant to suggest a mystical "harmony of interests" between individual women and public authorities, nor to deny that conflicts between "private" and "public" interests will continue to exist.... These realities prompt us to rethink the relationship between the state and civil society, and to map out an ethical framework for reproductive and sexual rights in the space where the social and the individual intersect.

## The Ethical Content of Reproductive and Sexual Rights

We propose that the grounds of reproductive and sexual rights for women consist of four ethical principles: *bodily integrity, personhood, equality,* and *diversity.* Each of these principles can be violated through acts of invasion or abuse—by government officials, clinicians and other providers, male partners, family members, and so on or through acts of omission, neglect, or discrimination by public (national or international) authorities. Each also raises dilemmas and contradictions that can be resolved only under radically different social arrangements from those now prevailing in most of the world.

### *Bodily Integrity*

Perhaps more than the other three principles, the principle of bodily integrity, or the right to security in and control over one's body, lies at the core of reproductive and sexual freedom. As suggested in our introduction, this principle is embedded in the historical development of ideas of the self and citizenship in Western political culture. Yet it also transcends any one culture or region, insofar as some version of it informs all opposition to slavery and other involuntary servitude, torture, rape, and every form of illegitimate assault and violence. As the Declaration of the International Women's Year Conference in Mexico City put it in 1975, "the human body, whether that of women or men, is inviolable and respect for it is a fundamental element of human dignity and freedom" (quoted in Freedman and Isaacs 1993).

To affirm the right of women to "control over" or "ownership of" their bodies does not mean that women's bodies are mere things, separate from themselves or isolated from social networks and communities. Rather, it connotes the body as an integral part of one's self, whose health and wellness (including sexual pleasure) are a necessary basis for active participation in social life. Bodily integrity, then, is not just an individual but a social right, since without it women cannot function as responsible community members (Freedman and Isaacs 1993; Petchesky 1990, 1994). Yet in its specific applications, the bodily integrity principle reminds us that

while reproductive and sexual rights are necessarily social, they are also irreducibly *personal.* While they can never be realized without attention to economic development, political empowerment, and cultural diversity, ultimately their site is individual women's bodies (DAWN 1993; Petchesky 1990).

Bodily integrity includes both "a woman's right *not to be alienated from her sexual and reproductive capacity* (e.g., through coerced sex or marriage,... [genital mutilation], denial of access to birth control, sterilization without informed consent, prohibitions on homosexuality) and... her right to the *integrity of her physical person* (e.g., freedom from sexual violence, from false imprisonment in the home, from unsafe contraceptive methods, from unwanted pregnancies or coerced childbearing, from unwanted medical interventions)" (Dixon-Mueller 1993)....

But bodily integrity also implies *affirmative* rights to enjoy the full potential of one's body—for health, procreation, and sexuality. Each of these raises a host of complex questions we can only touch upon here. In regard to health, the very term "integrity" connotes *wholeness*—treating the body and its present needs as a unity, not as piecemeal mechanical functions or fragments....

The question of whether there is a "fundamental right to procreate" based in one's biological reproductive capacity is clearly more complicated than whether one has a right, as a matter of bodily integrity, to prevent or terminate a pregnancy. Yet we can recognize that childbearing has consequences for others besides an individual woman, man, or lineage without subscribing to the claim that women have a duty to society (or the planet!) to abstain from reproducing. Such a duty could begin to exist only when all women are provided sufficient resources for their well-being, viable work alternatives, and a cultural climate of affirmation outside of childbearing so that they no longer depend on children for survival and dignity (Berer 1990; Freedman and Isaacs 1993). And even then, antinatalist policies that depend on coercion or discriminate against or target particular groups would be unacceptable.

Our hesitancy about a "right to procreate" is not based on any simple correlation between population growth, environmental degradation, and women's fertility,... rather, it comes from apprehensions about how patriarchal kinship systems throughout history have used such claims to confine and subordinate women, who alone have bodies that can be impregnated. Procreative rights are, however, an important part of reproductive and sexual rights. They include the right to participate in the basic human practice of raising and nurturing children; the right to bring wanted pregnancies to term in conditions of safety, decency, and good health, and to raise one's children in such conditions; and the right of gay and lesbian families to bear, foster, or adopt children in the same dignity as other families. They also include a transformation in the prevailing gender division of labor so that men are assigned as much responsibility for children's care as women.

Finally, what shall we say of the body's capacity for sexual pleasure and the right to express it in diverse and nonstigmatized ways? If the bodily integrity principle implies such a right, as we believe, its expression surely becomes more complicated and fraught with dangers for women and men in the context of rising



prevalence of HIV and STD infection (Berer 1993a; DAWN 1993). In addition to these immediate dangers—compounded by the now well-documented fact that many STDs increase women's susceptibility to HIV—there is the "vicious cycle" in which "women suffering the consequences of sexually transmitted disease find themselves in a social circumstance that further increases their risk of exposure to sexually transmitted infections and their complications" (Elias 1991). This cycle currently affects Sub-Saharan African women most drastically, but is rapidly becoming a worldwide phenomenon. It includes women's lack of sexual self-determination; the high risk they incur of infertility and ectopic pregnancy from STD infection; their dependence on men and in-laws for survival; the threat of ostracism or rejection by the family or male partner following infection or infertility; then the threat of unemployment, impoverishment, and prostitution, followed by still greater exposure to STD and HIV infection (Elias 1991; Wasserheit 1993).

The global crisis of HIV and AIDS complicates but does not diminish the right of all people to responsible sexual pleasure in a supportive social and cultural environment. For women and men of diverse sexual orientations to be able to express their sexuality without fear or risk of exclusion, illness, or death requires sex education and male and female resocialization on a hitherto unprecedented scale. This is why bodily integrity has a necessary social rights dimension that, now more than ever, is a matter of life and death.

*Personhood*

Listening to women is the key to honoring their moral and legal personhood—that is, their right to self-determination. This means treating them as principal actors and decisionmakers in matters of reproduction and sexuality—as subjects, not merely objects, and as ends, not only means, of population and family planning policies. As should be clear from our earlier discussion emphasizing a relational-interactive model of women's reproductive decisions, our concept of decisionmaking autonomy implies respect for how women make decisions, the values they bring to bear, and the networks of others they choose to consult; it does not imply a notion of solitude or isolation in "individual choices." Nor does it preclude full counseling about risks and options regarding contraception, prenatal care, childbearing, STDs and HIV, and other aspects of gynecologic health.

At the clinical level, for providers to respect women's personhood requires that they trust and take seriously women's desires and experiences, for example, concerning contraceptive side effects. When clinicians trivialize women's complaints about such symptoms as headaches, weight gain, or menstrual irregularity, they violate this principle. Qualitative studies of clinical practices regarding the use of Norplant® in the Dominican Republic, Egypt, Indonesia, and Thailand found that women's concerns about irregular bleeding were often dismissed, and their requests for removal of the implant not honored (Zimmerman et al. 1990).

Respect for personhood also requires that clients be offered a complete range of safe options, fully explained, without major discrepancies in cost or government subsidization. When some contraceptive methods are *de facto* singled out for pro-

motion (for instance, long-acting implants or sterilization), or clinical practices manifest strong pronatalist or antinatalist biases (as in programs governed by demographic targets), or safe legal abortion is denied, respect for women's personhood is systematically abused. "Quality of care" guidelines, which originated in women's health activism and were codified by Judith Bruce, reflect not only good medical practice but an ethic of respect for personhood (Bruce 1990; DAWN 1993; Jain, Bruce, and Mensch 1992; Mintzes 1992).

At the level of national and international policies and programs, treating women as persons in sexual and reproductive decisionmaking means assuring that women's organizations are represented and heard in the processes where population and health policies are made and that effective mechanisms of public accountability, in which women participate, are established to guard against abuses. It also means abandoning demographic targets in the service of economic growth, cost containment, or ethnic or nationalist rivalries and replacing them with reproductive health and women's empowerment goals (see Jain and Bruce 1994). Demographic targeting policies that encourage the use of material incentives or disincentives often work to manipulate or coerce women, particularly those who are poor, into accepting fertility-control methods they might otherwise reject, thus violating their decisionmaking autonomy.

The question of "incentives" is clearly a complicated one, since in some circumstances they may expand women's options and freedom (Dixon-Mueller 1993). Feminists and human rights activists have justly criticized programs that promote particular fertility control methods or antinatalist campaigns through monetary inducements or clothing to "acceptors," fines or denials of child care or health benefits to "offenders," or quotas reinforced with "bonuses" for village officials or clinic personnel (Freedman and Isaacs 1993; Ravindran 1993). What would be our reaction, however, to a system of women-managed comprehensive care clinics that provided child care or free transportation to facilitate clinic visits? A distinct difference exists between these two cases, since the former deploys the targeting and promotional strategies that undermine women's personhood, whereas the latter incorporates the kinds of enabling conditions we earlier found necessary for equalizing women's ability to exercise their reproductive rights. To distinguish *supportive* or *empowering* conditions from *coercive* incentives or disincentives, we need to assure that they respect all four ethical principles of reproductive rights (bodily integrity, personhood, equality, and diversity). When poor or incarcerated women are expected to purchase other rights "for the price of their womb" (for example, a job for sterilization or release from prison for Norplant®), "incentives" become corrupted into bribes (Williams 1991). Women's social location determines whether they are able to make sexual and reproductive decisions with dignity.

*Equality*

The principle of equality applies to sexual and reproductive rights in two main areas: relations between men and women (gender divisions), and relations among



women (conditions such as class, age, nationality, or ethnicity that divide women as a group). With respect to the former, the impetus behind the idea of reproductive rights as it emerged historically was to remedy the social bias against women inherent in their lack of control over their fertility and their assignment to primarily reproductive roles in the gender division of labor. "Reproductive rights" (or "birth control") was one strategy within a much larger agenda for making women's position in society equal to men's. At the same time, this notion contains the seeds of a contradiction, since women alone are the ones who get pregnant, and in that sense, their situation—and degree of risk—can never be reducible to men's.

This tension, which feminists have conceptualized in the debate over equality versus "difference," becomes problematic in the gender-neutral language of most United Nations documents pertaining to reproductive rights and health. For example, article 16(e) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) gives men and women "*the same rights* to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights [emphasis added]." Might this article be used to mandate husbands' consent to abortion or contraception? Why should men and women have "the same" rights with regard to reproduction when, as not only child-bearers but those who in most societies have responsibility for children's care, women have so much greater stake in the matter—when, indeed, growing numbers of women raise children without benefit of male partners? (The language of "couples" in family planning literature raises the same kinds of questions.)

If we take the issue of contraception as an illustration, the principle of equality would seem to require that, where contraceptive methods carry risks or provide benefits, those risks and benefits must be distributed on a fair basis between women and men, as well as among women. This would suggest a population policy that puts greater emphasis on encouraging male responsibility for fertility control and scientific research into effective "male" contraceptives. In fact, many women express a sense of unfairness that they are expected to bear nearly all the medical risks and social responsibility for avoiding unwanted pregnancies (Pies n.d.). But such a policy might also conflict with the basic right of women to control their own fertility and the need many women feel to preserve that control, sometimes in conditions of secrecy and without "equal sharing" of risks.

On the surface, this dilemma seems to be a contradiction within feminist goals, between the opposing principles of equality and personhood. The feminist agenda that privileges women's control in reproductive rights would seem to reinforce a gender division of labor that confines women to the domain of reproduction. Yet exploring the problem more deeply reveals that women's distrust of men's taking responsibility for fertility control and reluctance to relinquish methods women control are rooted in other kinds of gendered power imbalances that work against a "gender equality" approach to reproductive health policies. These include social systems that provide no educational or economic incentives toward men's involve-

ment in child care and cultural norms that stigmatize women's sexuality outside the bounds of heterosexual monogamy. Thus, while a reproductive health policy that encourages the development and use of "male methods" of contraception may increase the total range of "choices," in the long run it will not help to realize women's social rights nor gender equality until these larger issues are also addressed.

Applying the equality principle in the implementation of sexual and reproductive rights also requires attention to potential inequalities *among* women. This means, at the least, that risks and benefits must be distributed on a fair basis and that providers and policy makers must respect women's decision-making authority without regard to differences of class, race, ethnic origin, age, marital status, sexual orientation, nationality, or region (North-South). Returning to our example of contraception, there is certainly ample evidence that access to safe methods of fertility control can play a major role in improving women's health, but some contraceptive methods can have negative consequences for some women's health (National Research Council 1989). Issues of equal treatment may arise when certain methods—particularly those that carry medical risks or whose long-term effects are not well known—are tested, targeted, or promoted primarily among poor women in Southern or Northern countries. Indeed, when clinical trials are conducted among poor urban women, who tend to move frequently or lack transportation, the necessary conditions for adequate medical follow-up may not exist, and thus the trials themselves may be in violation of the equality principle. Meanwhile, issues of discrimination arise when safe, beneficial methods such as condoms or diaphragms, low-dose hormonal pills, or hygienic abortion facilities are available only to women with the financial resources to pay for them.

For governments and international organizations to promote sexual and reproductive rights in ways that respect equality among women requires addressing at least the most blatant differences in power and resources that divide women within countries and internationally. In the case of safe, effective methods of contraception, laws that guarantee the "freedom" of all women to use whatever methods they "choose" are gratuitous without geographic access, high-quality services and supplies, and financing for all women who need them. We are saying that the economic and political changes necessary to create such conditions are a matter not just of development, but of (social) *rights*; indeed, they are a good example of why development *is* a human right and why women's reproductive rights are inseparable from this equation (Sen 1992).

*Diversity*

While the equality principle requires the mitigation of inequities among women in their access to services or their treatment by health providers and policy makers, the diversity principle requires respect for differences among women—in values, culture, religion, sexual orientation, family or medical condition, and so on. The universalizing language of international human rights instruments, reflecting a Western liberal tradition, needs to be reshaped to encompass such differences (see



Freedman and Isaacs 1993; Cook 1993a, 1993b). While defending the universal applicability of sexual and reproductive rights, we must also acknowledge that such rights often have different meanings, or different points of priority, in different social and cultural contexts.

Differences in cultural or religious values, for example, affect attitudes toward children and childbearing, influencing how diverse groups of women think about their entitlements in reproduction. In her study of market women in Ile-Ife, Nigeria, anthropologist Tola Olu Pearce (1994) found that the high value placed on women's fertility and the subordination of individual desires to group welfare in Yoruba tradition made the notion of a woman's individual right to choose alien. Yet Yoruba women in Ile-Ife have also used methods of fertility control to space their children and "avoid embarrassment" for untold generations and no doubt consider it part of their collective "right" as women to do so. A similar communal ethic governing women's reproductive decisions emerges in a study of Latina single mothers in East Harlem (New York City), who consider their "reproductive rights" to include the right to receive public assistance in order to stay home and care for their children (Benmayor, Torruellas, and Juarbe 1992).

Local religious and cultural values may also shape women's attitudes toward medical technologies or their effects, such as irregular menstrual bleeding. Clinic personnel involved in disseminating Norplant® have not always understood the meanings menstrual blood may have in local cultures and the extent to which frequent bleeding—a common side effect of Norplant®—may result in the exclusion of women from sex, rituals, or community life (Zimmerman et al. 1990). Imposing standards of what is "normal" or "routine" bleeding (for example, to justify refusal to remove the implant upon request) could constitute a violation of the diversity principle, as well as the bodily integrity and personhood principles.[5]

It is important to distinguish between the feminist principle of respect for difference and the tendency of male-dominated governments and fundamentalist religious groups of all kinds to use "diversity" and "autonomy of local cultures" as reasons to deny the universal validity of women's human rights.[6] In all the cases cited above, women's assertion of their particular needs and values, rather than denying the universal application of rights, clarifies what those rights mean in specific settings. Women's multiple identities—whether as members of cultural, ethnic, and kinship groups, or as people with particular religious and sexual orientations, and so forth—challenge human rights discourse to develop a language and methodology that are pluralistic yet faithful to the core principles of equality, personhood, and bodily integrity. This means that the diversity principle is never absolute, but always conditioned upon a conception of human rights that promotes women's development and respects their self-determination. Traditional patriarchal practices that subordinate women—however local or time-worn, or enacted by women themselves (for example, genital mutilation)—can never supersede the social responsibility of governments and intergovernmental organizations to enforce women's equality, personhood, and bodily integrity, through means that respect the needs and desires of the women most directly involved.

### Bringing a Feminist Social Rights Approach to Population and Development Policies

The above analysis has attempted to show that the individual (liberty) and the social (justice) dimensions of rights can never be separated, as long as resources and power remain unequally distributed in most societies. Thus the affirmative obligations of states and international organizations become paramount, since the ability of individuals to exercise reproductive and sexual rights depends on a range of conditions not yet available to many people and impossible to access without public support. In this respect, the language of "entitlement" seems to us overly narrow, insofar as it implies claims made by individuals on the state without expressing the idea of a mutual *public* interest in developing empowered, educated, and politically responsible citizens, including all women. Likewise, the language of "choosing freely and responsibly" still contained in most international instruments that address family planning and reproductive rights is at best ambiguous and at worst evasive (see Boland, Rao, and Zeidenstein 1994). What does it mean to choose "responsibly"? Who, in fact, is responsible, and what are the necessary conditions—social, economic, cultural—for individuals to act in socially responsible ways? The correlative duties associated with sexual and reproductive rights belong not only to the bearers of those rights, but to the governmental and intergovernmental agencies charged with their enforcement....

Documents developed in preparation for the 1994 International Conference on Population and Development (ICPD), in Cairo, have begun to reflect the vision of reproductive and sexual rights as social rights that we have presented here. This is true not only of documents produced by women's NGOs, but also of official conference preparatory meetings and summaries, where for the first time in international population discourse, issues of gender equality and women's empowerment overshadow demographic targets and economic growth and are recognized as part of "sustainable development."...

...Years of organizing and advocacy by women's health groups throughout the world have clearly had an important effect *at the level of official rhetoric* on intergovernmental forums concerned with "population" issues. To what extent are we likely to see governments, UN agencies, and international population organizations move from awareness to action to translate this rhetoric into concrete policies and programs that truly benefit women?

Many women's health groups, in both the South and the North, are concerned that feminist-sounding rhetoric is being used by international population agencies to legitimate and gloss over what remain instrumentalist and narrowly quantitative ends. Perceiving the history of population control policies and programs as all too frequently oblivious to women's needs and the ethical principles outlined above, they fear the language of reproductive rights and health may simply be co-opted by the Cairo process to support business as usual.

Our position is slightly more optimistic but nonetheless cautious. Feminists are putting pressure on population- and family-planning agencies to acknowledge



women's self-defined needs and our conceptions of reproductive and sexual rights. This should move us closer to social and policy changes that empower women, but whether it does will depend on even more concerted action by women's NGOs, including alliances with many other groups concerned with health, development, and human rights. One such action should be to insist on full participation by women's rights and health groups in all relevant decisionmaking bodies and accountability mechanisms. In the long run, however, it is not enough that we call population agencies to account. To bridge the gap between rhetoric about reproductive and sexual rights and the harsh realities most women face demands a much larger vision. We must integrate, but not subordinate, those rights with health and development agendas that will radically transform the distribution of resources, power, and wellness within and among all the countries of the world (DAWN 1993; Sen 1992). These are the enabling conditions to transform rights into lived capacities. For women, Cairo is just a stop along the way.

### Notes

1. The term seems to have originated with the founding of the Reproductive Rights National Network (R2N2) in the United States in 1979. R2N2 activists brought it to the European-based International Campaign for Abortion Rights in the early 1980s; at the International Women and Health Meeting in Amsterdam in 1984, the Campaign officially changed its name to the Women's Global Network for Reproductive Rights (Beret 1993b). Thereafter, the concept rapidly spread throughout women's movements in the South (for example, in 1985, under the influence of feminist members who had attended the Amsterdam meeting, the Brazilian Health Ministry established the Commission on the Rights of Human Reproduction). See also Garcia-Moreno and Claro 1994.
2. In fact, the principle of "ownership of one's body and person" has much deeper roots in the history of radical libertarian and democratic thought in Western Europe. Historian Natalie Zemon Davis traced this idea to sixteenth-century Geneva, when a young Lyonnaise girl, brought before the Protestant elders for sleeping with her fiancé before marriage, invoked what may have been a popular slogan: "*Paris est au roi, et mon corps est à moi.*" (Paris is the king's, and my body is mine). The radical Levellers in seventeenth-century England developed the notion of a "property in one's person," which they used to defend their members against arbitrary arrest and imprisonment (Petchesky 1994). But the principle is not only of European derivation. Gandhi's concept of *Brahmacharya*, or "control over the body," was rooted in Hindu ascetic traditions and the Vedas' admonition to preserve the body's vital fluids. Like that of nineteenth-century feminists and the Catholic church, Gandhi's concept was theoretically gender-neutral, requiring both men and women to engage in sexual restraint except for purposes of procreation (Fischer 1962; O'Flaherty 1980). Islamic law goes further toward a sexually-affirmative concept of self-ownership. Quranic provisions not only entitle women to sexual satisfaction in marriage, as well as condoning abortion and contraception; they also allow that, upon divorce—which wives as well as husbands may initiate—a woman regains her body (Ahmed 1992; Musallam 1983; Ruthven 1984).
3. In Latin America, a new resolution of the Colombian Ministry of Public Health "orders all health institutions to ensure women the right to decide on all issues that affect their health, their life, and their sexuality, and guarantees rights 'to information and orientation to allow the exercise of free, gratifying, responsible sexuality which cannot be tied to maternity' " (quoted in Cook 1993a). In North Africa, Dr. Hind Khattab's field research among rural Egyptian women

has revealed strong sentiments of their sexual entitlement to pleasure and gratification from husbands (Khattab 1993).

4. Feminist theory and practice have witnessed a long history of division over this question. Whether with regard to protective labor legislation, prostitution, pornography, or providing contraceptive implants to teenagers or poor women, conflicts between "liberals" (advocates of "freedom to choose") and "radicals" (advocates of social protection or legal prohibition) have been bitter and protracted.
5. Not only clinicians but feminist activists maybe guilty of imposing their own values and failing to respect diversity. Feminist groups that condemn all reproductive technologies (for examples, technologies that artificially assist fertility) as instruments of medical control over women against "nature" ignore the ways that such technologies may expand the rights of particular women (for example, lesbians seeking pregnancy through artificial insemination or in vitro fertilization).
6. It seems crucial to us to recognize that religious fundamentalist movements are on the upswing in all the world's regions and major religions—Catholicism, Protestantism, Judaism, and Hinduism as well as Islam. Despite vast cultural and theological differences, these fundamentalisms share a view of women as reproductive vessels that is antipathetic to any notion of women's reproductive rights. In an otherwise excellent discussion of the clash between religious and customary law and human rights, Lynn Freedman and Stephen Isaacs (1993) place undue emphasis on Muslim countries and Islamic law.

# 11.
# AFRICAN FEMINISM: TOWARD A NEW POLITICS OF REPRESENTATION

*Gwendolyn Mikell*

I am convinced that I am observing the birth of feminism on the African continent—a feminism that is political, pragmatic, reflexive, and group oriented.[1] These observations have grown out of my work in various parts of West Africa, in the 1970s and 1980s, and in South Africa, in 1992; out of my dialogues with women from Kenya and other parts of the continent; and most recently out of workshops on women and legal change that I conducted in Liberia, Sierra Leone, and Nigeria during May 1994. My research and involvement with Africa goes back to the early 1970s, when the charismatic energy of nationalist leaders like Kwame Nkrumah and Julius Nyerere had faded, the disillusionment with modernization and the capitalist economy was strong, and a rash of military coups marked the emergence of a new crisis orientation. In the nationalist phase, women had played crucial roles, but their importance in politics had waned by 1971 when I began research on cocoa farmers in Ghana and visited many West African countries. I have watched the episodic rise of women's movements during the United Nations Decade of Women (1975–1985) and during the difficult economic crises and structural adjustment program experiments of the 1980s, but I see the peaking of a new feminism now as African states reinvent themselves in the 1990s.

This recognition of an emerging African feminism has been met with unanticipated enthusiasm by some of my Japanese, female, African studies colleagues who pursue autonomy within their own unique cultural environment, with ambivalence by some colleagues who work in Africa, and with amused tolerance on the part of many Western feminists who saw it as a moot point which I had (fortunately) resolved in the affirmative. There were relatively few African women who used the term "feminism" prior to the 1990s, and those who do so now are explicit in acknowledging the breadth that appears within it. For me, the recognition of a new African feminism represents a gargantuan change, because previously I was unwilling, for several reasons, to apply the feminist label to the African women's movement.

First, there was the recurring issue of hegemony. To a large extent I responded to the anger many African women have felt toward what they perceived as attempts by Western academics and activists to co-opt them into a movement defined by extreme individualism, by militant opposition to patriarchy, and, ultimately, by hostility to males. This has been reflected most cogently in the reaction of African