Abstract

This article discusses ways in which the analytical tools of public health can be used in conjunction with emerging theories of human rights to craft effective advocacy strategies, focusing particularly on women's reproductive health and reproductive rights. Public health research, although often presented as an objective scientific inquiry, is actually a value-laden and therefore, highly political endeavor that should be used by advocates to elucidate the connections between women's health and the wider social, economic, and political conditions in which they live. Such research can then inform theory and practice in the dynamic field of women's human rights. This article suggests an approach to health and human rights collaboration that views women as committed, indispensable members of the collectivities in which they live, and that seeks to identify and implement social structures and cultural configurations that promote and support women's dignity and autonomy and thus, their health and well-being, in that social context.

Este artículo discute las maneras de como las herramientas analíticas de la salud pública pueden ser usadas en conjunto con las teorías emergentes de los derechos humanos para adaptar estrategias efectivas de apoyo, enfocándose particularmente en la salud y los derechos reproductivos de la mujer. La investigación en la salud pública, aunque con frecuencia es presentada como un objetivo del escrutinio científico, es de hecho influenciada por creencias personales y por lo tanto es una empresa altamente política que debiera ser usada por sus defensores para elucidar las conecciones entre la salud de las mujeres y las amplias condiciones sociales, económicas y políticas en las que estas viven. Este tipo de investigación puede entonces comunicar la teoría y la práctica en el campo dinámico de los derechos humanos de la mujer. Este artículo sugiere un enfoque de colaboración entre la salud y los derechos humanos que ve a las mujeres como miembros obligados indispensables de las colectividades en las que ellas viven y que busca el identificar y implementar estructuras sociales y configuraciones culturales que promuevan y apoyen la dignidad y autonomía de la mujer y por ende, su salud y bienestar en general y en el contexto social.

Cet article examine les circonstances dans lesquelles les méthodes analytiques de santé publique peuvent être utilisées conjointement avec les nouvelles théories sur les droits de l'homme pour la conception de plaidoyers se concentrant particulièrement dans le domaine de la santé et les droits à la reproduction des femmes. La recherche en matière de santé publique, souvent présentée comme une démarche scientifique objective, est en faite une tentative empreinte de jugements de valeurs et donc hautement politique; qui devrait être utilisée mettent à jour les liens existants entre la santé des femmes et les conditions sociales, économiques et politiques dans lesquelles elles vivent. De telles recherches peuvent alors nourrir la théorie et la pratique dans le domaine des droits de la femme. Cet article suggère une approche globale de la santé et des droits de l'homme qui considère les femmes comme des membres engagés et indispensables de la communauté dans lesquelles elles vivent. Cette approche tend aussi à définir et d'implanter des structures sociales et culturelles qui valorisent et contribuent à la dignité et à l'autonomie des femmes, améliorant ainsi leur santé et leur bien-être général dans ce contexte social.

REFLECTIONS ON EMERGING FRAMEWORKS OF HEALTH AND HUMAN RIGHTS

Lynn P. Freedman, JD, MPH

Public health and human rights are "powerful, modern approaches to defining and advancing human well-being"[1] and so are potentially powerful tools for generating change. Yet public health and human rights have also, at times, been powerful tools for maintaining the status quo, reinforcing hierarchies of power and domination based on race, gender, and class. Thus, just because a concern or policy or program adopts the label "health" or "human rights" does not give it unqualified value. To create a workable framework for health and human rights collaboration, we need first to define human well-being; only then will it be possible to clarify how the tools of public health and human rights can be used to advance that vision of it.

Of course, defining human well-being is a rather tall order, which I don't pretend to fill in these few pages. My aim is much more modest: in these reflections I try to expose some of the assumptions about human well-being that underlie traditional views of public health, human rights, and

Lynn P. Freedman is Assistant Professor of Clinical Public Health, and Director, Reproductive Rights Project, Columbia University, School of Public Health. Please address correspondence to Lynn P. Freedman, Columbia University, 60 Haven Avenue, B-3, New York, New York 10032, USA.

the connections between them, and to suggest some possible alternative directions for future discussion, elaboration, and action. In doing so, I write primarily from my perspective as a women's health advocate with a focus on reproductive health and reproductive rights. My approach is shaped not only by my academic training (in law and public health), but also by my engagement with the fields traditionally described as population, family planning, maternal/child health, women's rights, and human rights, and by my understanding of the forces that have historically driven programs, policies, and scholarship in those fields.

Perhaps because of this background and orientation, I view health and human rights advocacy as an essentially subversive activity, in the sense that my vision of "defining and advancing human well-being" ultimately requires overturning deeply-rooted social and political structures that produce ill health and that prevent all people—women and men—from fulfilling their highest potential as human beings. But the goal is not to destroy: it is to transform and create. The structures that now obstruct human well-being must be changed into modes of social organization and interaction that will promote and support it. The disciplines of public health and human rights offer ways of thinking, of working, and of organizing that can ultimately give expression and concrete direction to that endeavor.

The Tools of Public Health

Public health is a quintessentially social enterprise. Whereas medicine looks at the biological mechanisms of disease in individual people, public health looks at patterns of health and disease in populations. Most critical for present purposes, public health focuses on the links between an individual and the environment (physical, social, cultural, political, and/or economic) in which she lives, seeking in that linkage both an explanation for her health status and a potential entry point for policies and programs to address it.

The primary research and analytical tool of public health is epidemiology. Using statistics and probability theory, epidemiologists document a particular health phenomenon (e.g., maternal death) and measure the strength of its association

with particular "risk factors" (e.g., maternal age or parity). Through this measurement, epidemiologists quantify risk; they measure the probability that a particular health phenomenon will occur if a particular risk factor is present. When a sufficient likelihood of an association is repeatedly found, the epidemiologist can state with reasonable confidence that the association is "real," i.e., it is not due to chance, bias, or poor study design. From such an association between a phenomenon and a risk factor, as well as additional information, the epidemiologist can *infer*—not prove—causality. That understanding of possible causal relationships can then form the basis for making effective public health policies and programs.

To many activists this may sound like a dry and tedious exercise, but in fact it has truly revolutionary potential. Nancy Krieger, in an insightful article about the politics of public health data,[2] tells the story of how Louis René Villermé (1782-1863), one of the founders of epidemiology, used his classic study of mortality in early 19th century Paris to challenge theories of disease causation that had prevailed in European medical thought for nearly 2000 years. In this study, Villermé first documented and ranked variations in mortality rates across different neighborhoods in Paris. He then attempted to correlate the variation in mortality with variations in environmental factors such as altitude, seasonal temperature, humidity, and quality of air, water, and soil, all of which were thought to cause disease. In this first ever systematic test of long-accepted environmental theories of disease causation, it turned out that none of these factors could account for the differences in mortality rates.

Looking for an alternative explanation, Villermé turned to the field of sociology, just then emerging in Europe, to develop hypotheses about the effects of social factors such as poverty and wealth on health. This time he calculated the proportion of households in each neighborhood that were exempt from rent tax, which was levied only on the wealthy, in order to arrive at a proxy measurement for poverty. He then correlated those proportions with the mortality data. The result was an "almost perfect fit": the neighborhoods with the lowest mortality also had the lowest pro-

portion of tax-exempt households (i.e., were the wealthiest), while the neighborhoods with the highest mortality rates had the highest portion of tax-exempt households (i.e., were the poorest).[3] Villermé thus concluded that social factors such as wealth and poverty (factors amenable to manipulation through public policy) were the principal causes of wide variations in mortality—a conclusion that, as Krieger pointedly notes, was not unrelated to the politics of his own time and place:

> Villermé's ability to reach this conclusion in turn was shaped by the rapidly changing political realities and debates of his times: living in an era that saw the rise of industrial capitalism and the defeat of monarchies and mercantilism, Villermé, a firm supporter of the free market, could conceive of and receive public funds for investigating relationships between societally-produced—as opposed to divinely ordained—wealth, poverty, and disease.[4]

Villermé's study is a classic example of the basic methodology employed by epidemiologists; it also helps demonstrate several points that are key to this discussion about the potential for health and human rights collaboration. As Krieger points out, Villermé's important findings about the nature of disease, "did not depend on technological or biomedical breakthroughs, but upon broadening the 'natural' discourse of science with explicitly political concepts."[5] Moreover, I would add, what was (and is) uncritically accepted in science as "natural" and therefore immutable, has often served as effective camouflage for those in power to promote their own social and political goals—a phenomenon repeatedly uncovered in the histories of medical and "scientific" approaches to women's reproduction,[6] to racial differences,[7] and to colonial health policy.[8]

The influence of political ideology on health research and policymaking is fairly easy to see and accept in historical studies, especially with the benefit of nearly two centuries of hindsight, as in the example of Villermé. It is far more difficult to recognize and expose such assumptions when they are embedded in the daily discourse and routine work of public health today. To illustrate how politically or culturally conditioned assumptions about women's roles and lives influence current public health research and practice, I exam-

ine one article from the growing literature on the health effects of structural adjustment programs.

In an essay entitled "A Public Health Approach to the 'Food-Malnutrition-Economic Recession Complex,'"[9] Leonardo Mata challenges the contention that shrinking food availability caused by economic crisis has led to declining child health. He questions whether economic conditions have significantly changed the "nutritional state and survival of children in less developed countries" because, in fact, the unavailability of food is not the usual cause of malnutrition and infant/child death. He demonstrates that infant and child mortality in developing countries is more often a complex interaction between malnutrition and infection conditioned by a multitude of factors other than the mere lack of food.

Mata then points to the fact that, given precisely the same financial resources and physical environment, certain children thrive while others are swept into the spiral of malnutrition and infection that ultimately ends in death or permanent disability. From this observation, Mata concludes that the true cause of poor child health is not lack of food: it is what Mata calls "deficient maternal technology." He defines "good" maternal technology as consisting of the following:

> (a) adequate knowledge and technique for preparation and administration of weaning foods; (b) appropriate handling of human and animal feces; (c) knowledge about signs and symptoms of dehydration and other life-threatening conditions; (d) acceptance of immunizations and other elements of modern medicine; (e) basic nutrition and health education; and (f) proclivity towards family planning.

Perhaps "technology" is the key word here, for Mata perceives a woman's inability to promote her children's health as primarily a failure to learn the technical lessons of primary health care. Nodding slightly to some vague social factors that may influence a woman's ability to protect her children, Mata tries to be careful not to lodge moral blame against mothers who fail. On the other hand, Mata stresses, faced with similar circumstances, some women seem to do just fine:

> Mothers are not entirely responsible for inadequacies in maternal technology, inasmuch as they are trapped in

ecosystems and societies that have not permitted them to acquire an understanding and knowledge of the ubiquitous fecal contamination of food and environment and other threats to child nutrition and survival. On the other hand, many women in villages and slums possess effective maternal technologies, and their children thrive well despite the odds and hardships.

For Mata, the implications of his insight are clear: food programs to buffer the effects of economic crisis and structural adjustment are not the solution, because lack of food is not the problem. Rather, poor mothers are the problem; thus improving maternal technology—creating better mothers—must be central to the solution.

Of course, Mata is not wrong when he states that a mother who makes sure the family's food is free from fecal contamination is more likely to have a healthy child than a mother who ignores the risks of contamination. Indeed, Mata and others who support his view probably would concede quite readily that in many cultures, the subordination of women does much to prevent them from learning or implementing the lessons of sanitation. The problem with the view exemplified by the Mata article is that it fails to invest that subordination of women with any importance, programmatically or theoretically.

By failing to pay attention to the elements of women's lives that lie outside the mother-child relationship—by failing to ask the right questions in his comparison of the children who thrive and those who die—he fails to see the multiple, fundamental ways in which economic crisis jolts women's lives and intensifies unequal gender and power dynamics within their households. These are dynamics that all too often lead to violence, marital breakdown, mental illness, and abject despair, and so, to an inability to cope with the effects of economic crisis.[10] At the same time, the intense focus on the mother-child relationship, and the tendency to view women as isolated actors whose sole role in life is the birth and rearing of children, obscures the incredible strength, assertiveness, and resourcefulness that many women have shown in the face of crisis, developing and carrying out strategies that require them to go well beyond conventional gender roles of wife and mother in order to insure their own and their families' survival.[11]

Thus, where Mata points to "maternal technology" as the solution to children dying from malnutrition-infection complex, other defensible solutions could be to change (or abandon) structural adjustment programs so that even children in families least able to cope with crisis can survive; and/or to facilitate women's ability to cope by taking measures to increase their autonomy, power, and rights within the families and communities devastated by adjustment programs. The public health practitioner trained only in the techniques of primary health care, and conditioned to think of them as "magic bullets" of unquestioned benefit, all too often will accept uncritically a conclusion such as Mata's. But the feminist or human rights activist attuned to the political implications of medical practice and health policy, will likely ask a different set of questions to understand the dynamics of the household and communities in which children die during economic crisis. Such questions yield a different range of policy conclusions, possibly with primary health care (albeit wrapped in a different implementation package) among them.

Finally, there is another, more general observation to make about the approach exemplified in the Mata article. Even when the potential influence of social factors such as macroeconomic crisis and structural adjustment programs is acknowledged, public health policymakers and practitioners often resort, almost reflexively, to the same kind of solution: individuals must modify their own behavior. In the case of women, this often means they must become "better" wives, mothers, or homemakers. This is a theme that has been repeated over and over again in current public health discourse and practice, particularly when it comes to health problems prevalent in marginalized populations.

For example, individual behavior change has long been the central theme in HIV/AIDS prevention policy, exhorting all people to "just say no" or to engage only in safer sex practices. Yet, for women who are powerless and vulnerable, caught in marital and sexual relationships over which they have little control, such advice may be worse than useless. Programs that address, or at least recognize, the power imbalances that shape women's lives, are now beginning to re-

ceive increased attention as the HIV/AIDS pandemic contin-
ues to ravage vast parts of the world.[12] But in the United
States, at least, this focus on individual behavior as the source
of and solution to all social ills is now reaching new rhetori-
cal heights with the Republicans' *Contract with America* and
its cynically-titled centerpiece, "The Personal Responsibil-
ity Act" which purports to address the public health issues
of "teenage pregnancy and illegitimacy" as well as the bud-
get deficit, by penalizing indigent women who have children.[13]

    I certainly do not mean by this discussion to imply that
individual behavior change is irrelevant to improving health
and preventing disease. Indeed, I would argue that, *as a mat-*
ter of human rights, individuals must be empowered to make
the kinds of decisions about their lives that will enable them
to protect their health. But it is also critical to recognize that
the decision to focus on individual behavior to the exclusion
of other social determinants of ill health is a *political choice;*
it is not an inescapable answer compelled by an indisput-
able, "scientifically correct" understanding of disease causa-
tion. Moreover, the model of behavior modification that typi-
cally underlies public health campaigns incorporates a kind
of individualism associated with biomedical approaches to
health, that actually does little to empower people to make
such changes. As Elizabeth Fee and Nancy Krieger explained
it in their article on the history of HIV/AIDS paradigms:

> The biomedical model is also premised on the ideol-
> ogy of individualism. Adopting the notion of the abstract
> individual from liberal political and economic theory, it
> considers individuals "free" to "choose" health behaviors.
> It treats people as consumers who make free choices in the
> marketplace of products and behaviors, and it generally ig-
> nores the role of industry, agribusiness and government in
> structuring the array of risk factors that individuals are
> supposed to avoid. There is little place for understanding
> how behaviors are related to social conditions and con-
> straints or how communities shape individuals' lives.[14]

    This kind of abstract individualism will surface again
in subsequent sections that consider the prevailing concep-
tions of rights which, like biomedicine, are influenced by lib-
eral theory. But to summarize here: public health tools, and
epidemiology in particular, expand our ability to see, to un-

derstand, indeed to measure, important aspects of the individual's relationship with the world. The fact that epidemiology is grounded in specific contexts, that it is based on statistical measurements that are testable and repeatable, is critically important to practice and effective advocacy. But we must beware of the "false conflation between scientific objectivity and value-free science."[15] Epidemiology—whether the question is which data to gather, how to interpret data we have, or how to craft policies and programs based on the data—will never be value-free, nor do I argue that it should be. But epidemiology and the tools of public health are just that—tools, and methodology. The values that drive their theory and practice cannot be found internally within epidemiology; they must come from outside of it.[16]

Can health, then, be a value, a "good," in and of itself? My answer is emphatically *yes*. Only a person blessed with perfect health and blind to the suffering of others could have the arrogance to seriously propose otherwise. Hence, my point here is not to deny that health has biological dimensions or to belittle the importance of physical health as a worthwhile policy goal; rather, my point is to show that even an individual's physical health—not to mention her mental and emotional health—is inextricably tied to the wider conditions of her life. Thus physical health cannot be detached from political and social concerns, posited as an objective state of biological being, and then treated as though the choices we make in pursuit of it are apolitical and compelled by some internal logic that derives solely from health itself.

Yet, the influence of this detached and narrowly bounded view of health is so deep and pervasive in Western biomedical models and the social policies that derive from them, that its impact and operation can be extremely difficult to recognize and even harder to contest.[17] Of course, the inability to perceive the influence of narrow health models or to grasp the fundamental truth that health is socially produced, is a malady that primarily afflicts those of us who are academics, theorists, policy analysts, or health professionals and have been born, bred, and/or trained in the ideology of science and Western biomedicine.[18] By contrast, for the people in every part of the world, north and south, who live the real-

ity of deprivation and discrimination in its harshest forms, the truth of the social production of health and disease is painfully obvious—even if its solutions are not.

Human rights is fundamentally about the struggle to make *their* voices heard and heeded. In a sense, then, the collaboration between health and human rights begins here, with the struggle to decide whose view of health will control the policies and programs that address it. Perhaps nowhere is this struggle more contentious, or the collaboration between health and human rights more urgent, than in the area of women's reproductive health and reproductive rights.

Alternative Visions of Health and Rights

The reproductive health and reproductive rights movements grow from the conviction that at the core of human dignity lies the ability to be an effective agent in guiding the course of one's own life. Much of the work by activists and theorists in this field is devoted to understanding what exactly this means across different cultures and political systems, and to finding the social structures and cultural configurations that will promote and support it. That work is underway, but far from complete. The evolving understanding of reproductive health advocated by women's movements and many others in the public health field incorporates a broad, holistic, multi-faceted approach to women's health and health care;[19] as theoretical understandings of reproductive health continue to develop, important initiatives on the ground can and do address specific health concerns in effective ways. There is certainly much to be said from a clinical or programmatic perspective about how such reproductive health initiatives are being designed and implemented (and, indeed, about how they contribute to the advancement of human rights, even if they are not ever perceived as human rights initiatives). But, for explanatory purposes here, it is perhaps easier to describe what reproductive health and reproductive rights are by showing what they are not, or rather, by showing what these movements have reacted against.

In the health field, they have reacted against population control efforts that treat women as "targets" of contraceptive programs, blatantly manipulating their reproductive

capacity in order to achieve demographic goals—goals set by dominant elites in pursuit of any number of different political agendas. They have reacted against maternal/child health policies that view the health of women as an instrument to ensure the health of children, and not as an important or valuable matter in its own right. They have reacted against medical institutions that focus on different pieces of women's bodies as discrete biological systems to be prodded, probed, and fixed, rather than seeing women's health as *women live it*, as part of complex interactive systems tied inextricably to the broader conditions of their lives. And they have reacted against domination by health professionals who present "risk" as if the only thing at stake in deciding whether or not to conceive or give birth is the possibility of physical injury; who obsess about reproduction but ignore sexuality; who preach about "personal responsibility" but fold on questions of power and resources, of vulnerability and discrimination.

This struggle around reproduction goes far beyond the health field, for women's reproduction is viewed as the primary tool for many other political projects as well. Thus, in many societies, a woman's sexuality and reproduction are symbols of her family's honor, to be guarded, watched, and controlled. They are the weapons with which the wars of identity politics are waged; most brutally, they are the scene of "ethnic cleansing." It is these political projects, and many others like them, against which the reproductive health and reproductive rights movements have been forced to define themselves.

Thus, stated in the negative, reproductive health and reproductive rights—indeed, human dignity—are about the right not to be alienated from one's own reproductive and sexual capacity; the right not to have that capacity used as an instrument to serve the interests of other individuals, collectivities, or states without one's consent and without the opportunity to participate in the political processes by which such interests are defined. Stated in the affirmative, the reproductive health and reproductive rights movements are about shifting perspectives, about changing whose point of view, whose values, whose experience, whose choices will control women's reproduction.

Such a shift in perspective will not happen automati-

cally by force of logic, nor will it grow out of a movement that focuses on health alone, or on health as a biological problem to be addressed solely through improved medical techniques. It can only happen when health is understood as a function of the same forces that structure a woman's relationship to the physical and social world around her, and is addressed in policies, programs, and activist movements as such.

Once health is understood in this way, then improving health necessarily means dismantling the systems that have wrested away from women the ability and entitlement to decide the meanings and uses of their bodies and their lives. But it also means building social systems that promote and support women as effective actors who are vested, committed, inseparable and indispensable parts of the families, communities, and states within which they live. This second task, the task of renovating or rebuilding, is not an optional afterthought. It is the essence of the search for human dignity and social justice that is the basic motivation for human rights advocacy. But for that search to be successful, human rights will need to be reclaimed and reshaped to fit a movement that seeks to reflect the experiences and serve the visions of women in diverse cultural and political settings.

Reclaiming Human Rights

If "health" as a political category has a problematic history for women's advocates, so too do "rights." Indeed, feminist theorists have been among the most articulate critics of rights-based legal regimes. While it is surely important for women's advocates and activists to consider these arguments, it is also essential to look beyond the academic debate surrounding rights; to acknowledge the different historically-grounded meanings that "rights" can have to the people who assert them;[20] to assess the ways that rights language has been used and manipulated in international discourse; and then to make a strategic decision about the potential utility of health and human rights collaboration in advancing the ultimate goals of their work. This is an ongoing, dynamic process that will not yield one "correct" strategic answer, but rather, different answers at different times and places, all of which can

effectively contribute to the same, shared political goals. Moreover, it is an exceptionally complex inquiry because it involves not only sensitivity to political dynamics at the international level (e.g., in UN conferences, in bilateral or multilateral governmental relationships, and in the increasingly influential world of international NGOs) but also a sensitivity to the multitude of ways in which international developments interact with very diverse and specific local realities in every part of the world.

Of course, a full treatment of all these issues is again well beyond the scope of these preliminary reflections about health and human rights. In the section that follows, therefore, I attempt only to give a very broad-brush, almost impressionistic, sense of conventional approaches to human rights, women's responses to them, and the political use that various forces have found for both. In doing so, I focus most heavily—even if still only superficially—on a few key aspects of a much bigger set of problems and on one key area of concern (reproductive health and rights) in the hope of stimulating more critical attention to the broader challenges we face as the field of health and human rights develop.

A. Conventional Approaches and Feminist Critiques

Human rights is conventionally approached as a formal body of law codified in treaties, conventions and covenants. This law was first articulated in its contemporary form in the Universal Declaration of Human Rights (1948) and then further elaborated in legally binding instruments in the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR) (1966), all of which together form what has sometimes been called the "International Bill of Rights." As an expression of basic values of human dignity and social justice, human rights draws inspiration from and resonates with historical and contemporary legal traditions of many different societies and cultures around the world.[21] However, as a body of formal law dealing primarily with the relationship between individual citizens and their governments, human rights took its initial doctrinal inspiration from concepts of civil liberties found in Western legal systems

which, in turn, derive largely from liberal political and economic theory.

That theory, in its classical formulations, embraces an ideology of individualism that has been the lightning rod for much of the criticism of rights. Closely associated with the theory and operation of a capitalist free market economic system, liberal individualism views people abstractly, as self-made, self-contained, separate individuals, isolated from others, pitted against the collective, pursuing their economic self-interest without reliance on the state. In a world so conceived, the purpose of rights is to stake out and protect a sphere of personal freedom; but that freedom is imagined as one built on boundaries: its essence is the right to keep others out, the right to be left alone.

In a legal system premised on such a world view, freedom from others also depends on enforcing the separation between the public and the private: rights are theoretically meant to keep the state out of the private sphere all together, and to operate most meaningfully in the public sphere where they regulate the individual's participation in public life and civil society, and his or her interaction with the law enforcement mechanisms of the state (police and court systems). Thus civil and political rights include such areas as freedom of speech and association, freedom from torture and from cruel, inhuman, or degrading treatment and punishment, the rights to a fair trial, and to life, liberty, and security of person (traditionally interpreted to refer to matters such as genocide, arbitrary arrest and detention, and execution). These civil and political rights, codified in the ICCPR, are often called "negative" rights because they are aimed at limiting the state's ability to encroach on individual freedom, at stopping the state from arbitrary or coercive actions.

By contrast, economic, social, and cultural rights, often called "positive" rights, deal with the state's obligation to create the affirmative conditions that help ensure human well-being. They include such matters as rights to health, education, employment, and housing. By ratifying the ICESCR, a State party "undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized

in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."[22] Although these positive rights were certainly central to the initial expansive conception of human rights embodied in the 1948 Universal Declaration, for a variety of reasons—some practical and some political—work in the human rights field has centered almost exclusively on the protection of civil and political rights. Most human rights NGOs have chosen not to address economic, social, and cultural rights, in part because of the near total absence of any methodology to monitor enforcement or define violations of them. Not surprisingly, governments have been equally reluctant to tread on this uncharted territory where implementation implies not just refraining from wrongful action, but also affirmative steps to alter the distribution and spending of public and private resources.

Failure to maintain the interconnection between positive and negative rights is among the primary criticisms that have been levelled against liberal theory and the rights-based legal systems it spawned. At the heart of these criticisms is a fundamental challenge to the notion that people exist as atomistic, disconnected, self-enclosed individuals. A legal system premised on a strict dichotomy between individuals and the collective ignores the extent to which individuals define themselves through, and take meaning from, their relationships with others; it fails to recognize the extent to which "we come into being in a social context that is literally constitutive of us."[23]

Seeing the individual primarily in opposition to the collective, liberalism supports the prevailing "negative" view of rights that is designed essentially to keep the state in check and as far out of social and economic life as possible. Within the international human rights scheme, this means emphasizing civil and political rights rather than economic, social, and cultural rights and maintaining a strict distinction between them. As women's human rights advocates have repeatedly pointed out, this distinction results in a formalistic and ultimately hollow view of rights. For example, the right to decide on the number and spacing of children, however important to a women's health in theory, actually means little

in a woman's life in fact, if there are no health services in place and no contraceptives available.[24]

More specifically, feminist critics of liberal, rights-based legal systems have demonstrated how conventional interpretations of such laws—including international human rights law—reflect the experience and interests of male elites and fail to accomodate or acknowledge the realities of women's lives.[25] Their analyses elucidate the myriad ways in which the separation of the public and the private deflects the reach of rights from the site of women's most pervasive exploitation and deepest vulnerability—the domestic sphere—and obscures the crucial role that women play in the public sphere as well.[26] Though liberal legal systems purport to eschew all interference in the private sphere, particularly the family, feminist critics have shown that it is precisely the operation of such systems of law that structures the most intimate matters of private and family life, rendering the stated ideal of non-interference an incoherent principle and the purported neutrality of law an illusion.[27]

B. The Political Context of Debates Over Human Rights

At the international level, the debate over human rights has other, highly explosive, dimensions that take the discussion well beyond theory, into the harsh political reality within which women's movements operate internationally. Thus, any attempt to find a workable collaboration between health and human rights must also consider the ways that rights language has been manipulated for political ends that may have little to do with the defense or denial of the idea of rights *per se*.

In international discourse, the problem of rights is often posed as a series of oppositional dichotomies: universalism vs. cultural relativism; the individual vs. the collective; civil and political rights vs. economic, social, and cultural rights; North vs. South or East vs. West. The tensions that lie behind these dichotomies are real ones that need to be addressed carefully by the human rights community. I do not purport to do that here nor do I mean to dismiss such tensions lightly; rather, I wish to make a different point: while the tensions are real, the choice to *pose* the issues as either/or dichotomies presumes that the two poles exist only in opposition to

each other and that the resolution can be only to choose one pole or the other. That is a presumption that serves particular political interests, as becomes clearer when we examine who is using these dichotomies and how they benefit from doing so; and when we see how structuring the problem this way becomes a tactic to be used against women internationally, in an effort to divide and silence us.

Perhaps a start in the bigger task of unpacking and analyzing these dichotomies is to recognize that lying at the crux of the problem is this: foes of women's rights typically characterize any expression by women of their entitlement to guide the course of their own lives as a rejection and denial of any and all ties or responsibility to others or to the collective. In their scenario, there is no such thing as a woman who seeks and gains control over the conditions of her existence yet chooses to live a life built around commitments and connections to others; given the chance—allowed to escape from the domination of patriarchal families and communities—it is presumed that women will abandon those families and communities altogether, in an ghastly display of selfish and hedonistic individualism. This basic conception of the "uncontrolled" woman as a dangerous and destructive force explains, in part, why human rights, with its apparent defense of the individual *as against* the collective, has become so explosive, particularly when applied to women's reproduction and sexuality, the area in which control over women is guarded most jealously.[28]

Lest this seem like a melodramatic overstatement of the position of those who oppose women's rights, consider some of the recent pronouncements of leaders of that opposition. For example, in 1992, urging voters to reject the proposed Equal Rights Amendment that would have explicitly prohibited discrimination on the basis of gender, Pat Robertson, leader of the increasingly powerful Christian Coalition in the United States, made this now infamous statement:

> "The feminist agenda is not about equal rights for women. It is a socialist, anti-family political movement that encourages women to leave their husbands, kill their children, practice witchcraft and become lesbians."[29]

His statements were echoed in more apocalyptic, even if somewhat less picturesque, terms by representatives of the Holy See who, in 1994, led a determined effort to derail the International Conference on Population and Development (ICPD) and to undermine its Programme of Action, a document that explicitly endorsed concepts of reproductive health and reproductive rights and acknowledged their link to human rights. Portraying the Cairo Conference as "basically about a type of libertine, individualistic life style" being imposed by the United States under the sway of "a pervasive feminist influence" that amounted to "cultural imperialism,"[30] the Vatican made no bones about how serious it deemed the threat to be:

> "Civilization is at stake. We would be foolish to see in the Cairo conference anything else."[31]

The Vatican found willing allies for its position in parts of the Muslim world. In statements condemning the conference, officials at Cairo's Al Azhar University, perhaps the most prestigious institution for Islamic scholarship in the world, challenged the Programme of Action reportedly because it "aims to defend sexual relations between members of the same sex or between different sexes outside legal marriage," "undermines parental authority" and "might encourage prostitution."[32] Such statements helped touch off a wave of threats from Muslim extremists opposed both to the Conference and, perhaps more significantly, to the Egyptian government. Such opposition was broadcast over loudspeakers during sermons in neighborhood mosques:

> "We reject this conference . . . It is a Zionist and imperialist assault against Islam. This is a policy imposed on Egypt by the United States."[33]

Others, speaking to the international press, took their campaign to a more chilling level. As one leader of a militant group based in Cairo is reported to have commented:

> "Some brothers are preaching against this corrupt, immoral conference in the mosques. But others may decide to defend Islam by killing, and they would be willing

to die in the process. If the West is afraid of blood, it should stay away from us."[34]

It is thus a slippery slide between and among women's assertion of the right to control their reproductive lives; charges of destructive individualism; the spectre of cultural imperialism; and the evocation of North against South, East against West. Of course, as implied by the discussion of liberalism above, this is not a wholly frivolous position: human rights as classically formulated *are* Western in origin; and the kind of oppositional relationship between individual and collective that was projected by human rights theory, at least in its conventional formulations, *does* differ from that lived in most social and cultural arrangements, North and South. Moreover, governments clearly have been selective in the accusations of human rights violations made against one another, often having economic or other ideological interests as the primary consideration. And interactions involving human rights NGOs do sometimes suffer from the same arrogance and myopia that plagues all kinds of cross-cultural exchanges. These are issues in the human rights field that must be taken seriously and handled with honesty and circumspection.

Nevertheless, the structuring of the discussion as a set of oppositional dichotomies and, worse, the conflation of each dichotomous relationship with the others, is disastrous for women in both North and South. When any assertion of individual entitlement by women is automatically characterized as betrayal of the collective, when women are forced to choose between an assertion of themselves and assertion of their national, ethnic, or religious identity, then they have lost the first battle—the battle to set the terms of the debate. When this battle is lost then the result is silence: silence from those in the South who fear the accusation that they are "feminist" or "Western;" silence from those in the North who fear the accusation that they are "cultural imperialists."

The characterization of feminism or women's rebellion against patriarchal structures as simply an alien, Western import denies and attempts to suppress the leading role that women from Asia, Africa, and Latin America have played in defining the terms and setting the direction of women's hu-

man rights movements and reproductive health and rights movements in their own countries and on the international stage.[35] Moreover, it makes invisible the long and rich histories of women's resistance as individuals or as organized movements in those countries and in relation to the diverse cultures within them.[36] Finally, this conflation of dichotomies takes the genuine and appropriate circumspection of women in the North who are seriously concerned that their own voices and perspective have dominated some parts of the women's movement, and converts it from useful self-reflection and self-critcism into a paralyzing prescription for political correctness that prevents them from hearing and supporting those women in the South who are taking courageous stands to assert their own visions of human rights. At the same time, it prevents women in the South from building alliances with or supporting the struggles of women in the North by characterizing any attempt to make such alliances or connections, even on an *ad hoc* basis for specific purposes, as a breach of a different prescription of political correctness, one that views everyone located in the North as undifferentiated agents of imperialism and Western hegemony.

There is obviously much more work to be done to understand the historical and contemporary connections among all these phenomena; and to understand their political use in international discourse about human rights generally and women's human rights and reproductive rights in particular, and the strategic options for resisting them. That work is now urgent, as the politico-religious right will clearly remain a powerful force in international politics for a long time. But it is also important for women's health and rights advocates to remember that these are not the only forces threatened by the idea of women's control over their own reproductive and sexual lives. For many years, resistance to women-centered reproductive health and reproductive rights has also come from much quieter, even if more powerful, quarters. Perhaps the most influential of these are certain of the most conservative segments of the population "establishment" that has set the direction for many of the population policies that national governments have implemented over the last four decades often with the help of, or under pressure from, bilateral and multilateral aid agencies.[37]

This part of the population establishment certainly operates from a very different political agenda than the politico-religious right. It is therefore instructive to see the extent to which both camps have been driven by similar assumptions, particularly the belief that if women are allowed to escape the control of patriarchal families, communities, and states, they will abandon responsibility for and commmitment to the collective. Although this belief rarely surfaces in a strident or even explicit way in the writing or work of population and family planning specialists, its influence can be teased out nevertheless. For example, Susan Cotts Watkins, in an article entitled, "If All We Knew About Women Was What We Read in *Demography*, What Would We Know?" examines 25 years of this leading academic journal to try to understand the views of women that have driven demographers' work. She shows that demography as a field tends to share the basic view of liberal theory in which women are conceptualized as "separate selves," as "autonomous and impervious to social influence," and ultimately concludes that

> If all we knew about women was what we read in the articles on fertility, marriage, and the family, we would conclude that women are primarily producers of children and of child services; that they produce with little assistance from men; that they are socially isolated from relatives and friends; and that *their commitment to the production of children and child services is expected to be rather fragile* (emphasis added).[38]

This description of demographers' view of women is startlingly contrary to many women's own views of themselves, to their feelings of commitment, their experience of connectedness, and their valuing of relationships (including relationships with their own and others' children, relatives, and friends)—as expressed in narratives, demonstrated in everyday life, and even proven in social science research.[39] Yet, in many parts of the world, population and health policies have been routinely built *not* around women's own experience of the world (as advocated by the reproductive health and reproductive rights movements), but around the assumptions and world view exposed by Watkins. The result is precisely the kinds of programs that evidence a deep distrust of women

and the decisions it is presumed they would make if given
the chance. Thus, population policies and family planning
programs often tend to exclude women from planning and
decision-making processes, and instead impose on them,
through methods involving varying degrees of persuasion or
coercion, the so-called professional's view of what is good for
society, for families, for health and for women—and have the
power of the state to back them up.[40]

Given this orientation of the population establishment,
it is important to recognize—and question why—they have
historically been among the strongest advocates of recogniz-
ing "the right to decide freely and responsibly on the number
and spacing of children" as a human right. Elsewhere, I have
shown that when this was first articulated as a human right,
at the 1968 Teheran Conference on Human Rights, a primary
motivation was to find a wedge to get contraceptives into the
many countries (especially in the South) where they were
then illegal or otherwise blocked, in order to control popula-
tion growth.[41] Although those within the population move-
ment who advocated this human right no doubt genuinely
believed that individuals should have the right to use contra-
ceptives and to control their fertility, they perceived the lim-
its on an individual's right to decide whether to have chil-
dren very differently from the way women's movements un-
derstood the same right when they promoted it.[42] In short,
the primary goal of the population movement was to lower
population growth, not to ensure that women themselves had
both the right and the ability to control their bodies and lives;
thus the "freedom" of the individual to decide was, in the
view of the population movement, readily limited by the "re-
sponsibility" to make the fertility-limiting decision imposed
by government population policies purportedly in further-
ance of the greater good. As Susan Watkins put it, comment-
ing on the special issue of *Demography* on family planning
that was published in 1968, the year of the Teheran Confer-
ence, "Even when the language seems to empower women
by claiming they have the right and the power to choose to
control their fertility, they are expected to use this power to
control world population growth."[43]

Apparently, then, the population control movement be-

lieved that in the human rights framework as convention-
ally understood, it had found a useful tool for advancing to-
wards its own view of human well-being. Thus, one lesson is
clear: human rights, like public health, can be wielded as a
tool to promote quite particular political goals that might be
substantially different from—even contrary to—the goals of
women's advocates. This takes us back to the point made at
the very start: while public health and human rights can be
powerful tools for generating change, they can also be power-
ful tools for maintaining hierarchies of power and domina-
tion based on gender, race, and class.

Then Why Bother with Human Rights?

If rights, in their conventional interpretations, have failed
to recognize or redress women's experience of violation; and
if the human rights paradigm, when manipulated either by
those who purport to accept it or by those who vehemently
reject it, provides fodder to precisely the forces that seek to
oppress women, then one might legitimately ask, why bother
to use human rights at all? Aren't they more trouble than
they are worth, particularly given the notoriously weak en-
forcement mechanisms in the international system?

My answer begins with the refusal to accept the dichoto-
mies routinely imposed on the discussion. Human rights are
strategically valuable because they express, in the broadest
terms, basic values—human dignity and social justice—that
have historical and contemporary roots in cultures through-
out the world. But those values do *not* dictate a particular
lifestyle, or identity, or way of being in the world. Rather,
they affirm the fundamental value of human agency: the na-
ture of human beings as effective, social actors.

When read carefully and interpreted in its fullest dimen-
sions, the human rights paradigm enables us to reject as in-
accurate and destructive the abstract individualism of liberal
theory, the notion of individuals operating in isolation and
crude self-interest, seeking to keep others at bay, even while
imposing their will on everything, animate and inanimate,
around them. At the same time, the human rights paradigm
rejects treatment of any person as property, chained to
another's or a group's will, to be dominated, controlled, and

used. Rather, it seeks to create a world in which human dignity adheres in the still distant ideal of choice: the notion that human beings, constituted through relations with others, can still make choices about their lives, can still have something to say about how to structure and maintain relations with others, be they family, community, or state.

Such an ideal has particular power and importance in our time. In a world increasingly consumed by the most brutal struggles of "identity politics," a politics in which access to power and resources is sought to be determined by group identification, and group identification is prescribed by allegedly immutable characteristics of birth (e.g., race, ethnicity, even religion), then women—whose appearance, behavior and, particularly, sexual conduct, are made to be the symbols of "purity," the quality that is believed to ensure group strength and continuity—are most vulnerable to control and domination.[44] At the same time, our world is increasingly, and irrevocably, international: in economics, politics, and communications, we are all now bound to each other through complicated webs of dependence, infiltration and, most painfully, inequality and domination. In such a world, human rights affirms the basic entitlement of *all* people to resources and to the respect and dignity that comes from the ability to consciously, willfully participate in setting the terms of their interactions with the world around them.

No one fools themselves into believing that we are close to such an ideal. No one fools themselves into thinking that its attainment will be easy or that it will come without massive social change, in which some will be required to relinquish power over others. But in the area of health, in which we can see in the most obvious physical terms the results of structures of inequality large and small, we have perhaps the best chance to make a difference, to determine and implement social configurations that can support and promote human well-being. In short, when human rights principles are applied to health, we begin to have the strategic, political basis upon which to mobilize across the divides of nation, culture, class, race, and religion, in support of each other and in pursuit of change.

Rethinking the Connections Between Health and Human Rights

To use health and human rights collaboration in this way means rebuilding our understandings of both health and human rights, as well as the vision of human well-being they define and advance, from the ground up. It means taking full account of the very real differences that shape our lives, while giving full respect to our common humanity. It means approaching health and human rights collaboration not as a theoretical puzzle that is worked through in a political vacuum, but rather as a very concrete, contextualized inquiry that begins from the experience of those whose health and human rights are most at stake.

Such work will require the combination of many different approaches at the same time. For example, the women's human rights movement has effectively used the analytically simple, but emotionally and rhetorically powerful, method of personal testimony to force recognition of women's violation, entitlement, and need. This has happened most notably in the area of violence against women, where substantial progress has been made in changing perceptions in both the human rights field[45] and the international health field.[46] To a significant extent, such progress has come as a result of women's demand, quite simply, to be heard. In "tribunals" held in all parts of the world and also in international fora, women's often courageous testimonies of violence inflicted with impunity in both the private and public spheres, demonstrated more powerfully than any amount of academic analysis ever could, that both fields, locked into formalistic, narrow ways of understanding both rights and health, had failed to listen to or acknowledge the impact or importance of such experiences and so had effectively excluded this aspect of women's lives from their purview.

In the area of reproduction and sexuality, enormously valuable work that will ultimately contribute to new understandings of health and human rights, is being done in multidisciplinary, action-oriented field research. This includes, for example, the project being conducted by the International Reproductive Rights Research Action Group (IRRRAG) in seven countries in Africa, Asia, Latin America, and North America, to uncover and document the ways that women

themselves understand and express their entitlement in matters of reproduction and sexuality;[47] and the project conducted jointly by Health Action Information Network in the Philippines and the Institute for Development Research in the Netherlands, which through participatory action-research in multiple countries, focuses more specifically on women's experiences of fertility-regulating methods and reproductive health care.[48]

Such reconceptualizing of health and rights beginning with the experiences of women, will also require working at a more theoretical level to transform the way the very words we use in health and human rights work, are interpreted and understood. For example, Rosalind Petchesky, in an essay entitled "Body As Property: A Feminist Re-Vision," attempts to "recuperate the notion of self-propriety"—the idea of "owning" or controlling one's body—by looking "at the variety of local meanings that women in noncapitalist societies, radical democrats, and slaves have given to the idea of owning their bodies, as well as the value that contemporary feminists of color are placing on re-owning their bodies as an aspect of self-definition."[49] As she puts it, "The 'objects of property' may have more to tell us from their vantage point than we can learn from positioning ourselves within the debates of the treatises, the lawbooks, and the political-theory canon."

As with women's approach to human rights more generally, Petchesky's point is not to make women's lives and claims fit within the four corners of the law as it currently is interpreted; rather, her point is to see how the powerful language so basic to that law—in this case, the concept of "property"—can be reshaped to serve the political goals defined by women. The aim is to understand "the language of self/body ownership as a rhetorical strategy for political mobilization and defining identities, not a description of the world." From this perspective, the very notion of "property" is given new meaning:

> Rhetorical claims on behalf of women's ownership of their bodies invoke meanings of ownership as a relationship of right, use, and caretaking — meanings that have different cultural moorings from the commercial idea of property that the regime of triumphal international capitalism conventionally takes for granted.[50]

The project she envisions has distinctly political impor-
tance:

> Perhaps there are good reasons to defend this language
> — particularly as it pertains to people's relationship to their
> bodies. Perhaps owning one's body is a necessary element
> of citizenship in an affirmative but noninterventionist
> state.[51]

All of these projects that focus intensely on the mean-
ings that women in a wide range of different political, social,
and cultural settings express for themselves, are vitally im-
portant for the ultimate collaboration between health and
human rights. But if we are really to escape the abstract indi-
vidualism of liberal theory and the biases it has imposed onto
biomedicine and conventional rights interpretations—that is,
if we are to demand that rights be understood not primarily
as a right to build boundaries or to be left alone, but rather as
a right to live with dignity in the context of social commit-
ments and relationships—and if we are to demand that health
and disease be understood not simply as a function of "free"
individual behavioral choices, but rather as a result of lives
constrained by social forces such as poverty and discrimina-
tion, then we will also need to develop a much more struc-
tural critique than can be gleaned from case studies or narra-
tives or anecdotal evidence alone.

This is where public health and its tools hold great po-
tential in strategic collaboration with human rights. As dis-
cussed much earlier, public health seeks to understand health
and disease not simply as a function of self-contained bio-
logical systems of the human body, but also as a function of
the wider conditions of a person's life. By looking not just at
the health of the individual, but at patterns of health in popu-
lations, public health allows us to go beyond isolated anec-
dotes or incidents and to see social patterns and configura-
tions associated with what is experienced as individual phe-
nomena of death, disability, or disease.

An excellent example of this is a recent article by Susan
Greenhalgh and Jiali Li that explicitly attempts to demon-
strate how feminists can use the discipline and methodology
of demography to reveal patterns and practices not observ-
able through qualitative research.[52] Working with data from

a rural area of China, they show how the one-child policy has in practice, been shaped over time through "politics of resistance," then "negotiation," then "submission." By projecting to the population level and documenting the shocking shifts in sex ratios in different age and birth-order cohorts, they enable us to see more than simply a rash of cases of selective abortion or infanticide; rather, they can demonstrate how a policy that began as gender-neutral, ultimately has come to involve massive violence and discrimination against the youngest girls in China and, in the most profound ways, has inflicted terrible damage on the wider society as well. Arguing for the importance of developing a feminist demography, they point out:

> [I]t may be that the more politicized the arena of reproduction, the more crucial demographic evidence becomes, for where reproduction is heavily contested, people work hard to hide their secrets, not only from other members of their society but from social scientists as well. In China the discrimination and violence directed against little girls were thickly cloaked until large-scale demographic evidence brought them to light.[53]

Not only do public health tools (including epidemiology and demography) help us identify and describe health issues as socially constructed human rights issues, they also begin to tell us what to do about them. This is critical in the area of positive rights, where the objective is not just to get the state to stop committing a violation, but rather to get the state to do the right thing to improve the social condition in question. Thus, epidemiologic evidence can show us not only the extent of a health problem and its general association with social conditions, it can also show us in far more refined ways, how particular social conditions interact with biological factors to yield patterns of ill health.[54] It thus can help us determine where to begin to address state responsibility for dealing with a particular health issue.

But, as the earlier discussion of "deficient maternal technology" in the context of structural adjustment programs demonstrated, this is not a value-free exercise. When health data are analyzed from a feminist perspective (such as demonstrated in the Greenhalgh and Li article), essentially bringing a politicized view of human well-being to the endeavor,

then the understandings developed from health research can begin to acquire the dimensions necessary to organize and advocate effectively within the framework of human rights law. Rather than simply shouting that *something* must be done to meet, for example, obligations to ensure a right to health under the ICESCR, we can begin to show that "progressive achievement of rights," requires very specific steps, and then demand that such steps be taken.[55]

Finally, it is important to see that health research can also be used the other way around. Not only can we study particular health phenomena to understand how they are socially produced and can be socially ameliorated; we can also study particular human rights phenomena to understand their implications for health. Mann et al point out that a "coherent vocabulary and framework to characterize dignity and different forms of dignity violations are lacking," and suggest that "a taxonomy and epidemiology of violations of dignity may uncover an enormous field of previously suspected, yet thus far unnamed and therefore undocumented, damage to physical, mental, and social well-being."[56] While this is certainly true, from the perspective of the affirmative building of health and human rights collaboration, we also need to study advancements in human rights. For example, while some feminist theorists are working from within legal and social science frameworks to "reconceive" the concept of autonomy (in somewhat the same way that Petchesky is doing with "property"),[57] demographers and public health researchers are attempting to understand how changes in women's status/power/autonomy (variously defined) in many different social and cultural settings affect the health and well-being of women, their children and families, and their wider communities.[58]

It is perhaps this research, as much as anything else, that actually built the momentum for the major shifts in perspective within the population and family planning community that were ultimately incorporated in the Cairo Programme of Action. Many years of careful public health research and writing provided the fuel for advocates of reproductive health and reproductive rights to elaborate and assert a women-centered approach. In the end, the proof that the well-being of all people—men, women, and children—depends on dramatic

changes in the ability of women to set the course of their lives, became undeniable. To a significant extent, that understanding is now incorporated in the theoretical literature and rhetorical statements that shape the population/family planning/maternal-child health fields—and thus the evolving reproductive health field is beginning, slowly, to convert them, in substantial part, in the reproductive health field. But it will take a human rights movement, one that insists on our common humanity yet respects our diversity, to give those statements real meaning in transforming the relationships of power that shape the health and lives of us all.

References

1. J. Mann et al., "Health and Human Rights," *Health and Human Rights* 1(1994):8.
2. N. Krieger, "The Making of Public Health Data: Paradigms, Politics, and Policy," *Journal of Public Health Policy* (Winter 1992):412-427.
3. Ibid. p.416.
4. Ibid. p.416.
5. Ibid.
6. E. Martin, *The Woman in the Body: A Cultural Analysis of Reproduction* (Boston: Beacon Press, 1987).
7. See Krieger's description of the early work of Dr. James McCune Smith, and her own work on racial differences in infant mortality in the U.S., Krieger, see note 2.
8. E.g., D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Delhi: Oxford University Press, 1993). Arnold shows that colonial medicine was not simply a process of importing European ideas and practices wholesale and then imposing them on colonial populations. Rather, the entrenchment of Western medicine in colonies such as India, was very much a process shaped by interaction between the colonizers and the colonized, a process that continues to have important ramifications for work by epidemiologists in South Asia, at least. K. S. Khan, "Epidemiology and Ethics: The Perspective of the Third World," *Journal of Public Health Policy* (Spring 1994):218-225.
9. L. Mata, "A Public Health Approach to the "Food-Malnutrition-Economic Recession Complex," in D. Bell and M. Reich, eds., *Health, Nutrition and Economic Crisis: Approaches to Policy in the Third World*. (Dover, Mass.: The Auburn Publishing House, 1988).
10. See, e.g., C. Moser, "The Impact of Recession and Adjustment Policies at the Micro-level: Low Income Women and their Households in Guayaquil, Ecuador," in UNICEF, *The Invisible Adjustment: Poor Women and the Economic Crisis* (Santiago, Chile: UNICEF,1989); L. Beneria and M. Roldan, *The Crossroads of Class & Gender: Industrial Homework, Subcontracting and Household Dynamics in Mexico City* (Chicago: University of Chicago Press, 1987).
11. UNICEF, *The Invisible Adjustment: Poor Women and the Economic Crisis* (Santiago, Chile: UNICEF, 1989); Commonwealth Secretariat, *Engendering Adjustment for the 1990s*. Report of a Commonwealth Expert Group on Women and Structural Adjustment. (London: Commonwealth

Secretariat, 1989).

12. L. Heise and C. Elias, "Transforming AIDS Prevention to Meet Women's Needs: A Focus on Developing Countries," *Social Science & Medicine* 40(7) (1995): 931-943; E. Fee and N. Krieger, "Understanding AIDS: Historical Interpretations and the Limits of Biomedical Individualism," *American Journal of Public Health* 83(10) (1993):1477-1486.

13. The Personal Responsibility Act of 1995, H.R. 4 (104th Congress, 1st session).

14. Fee and Krieger, see note 12, p.1481.

15. Krieger, see note 2, p. 421.

16. K. S. Khan, see note 8.

17. See e.g., J. Walsh and K. Warren, "Selective Primary Health Care," *New England Journal of Medicine* 30 (1979):967-974, an extremely influential article in the development of primary health care strategies, for an example of how this kind of thinking has driven health policies in a way that is, on its face, objective and scientific, but in fact incorporates unarticulated values about whose health is more socially valuable. For a discussion of how this notion affects our understanding of risk in reproductive decision-making, see D. Maine, L.P. Freedman, F. Shaheed, and S. Frautschi, "Risk, Reproduction, and Rights: The Uses of Reproductive Health Data" in *Population and Development: Old Debates, New Conclusions*, ed. R. Cassen (Washington, D.C.: Overseas Development Council, 1994).

18. Although this view of health originates most strongly in Western medicine, it is not only people in the North who are trained and conditioned into understanding health and health policy this way. See Kausar Khan's discussion of the ethical dilemmas faced by epidemiologists and other health professionals in Pakistan and, presumably, other southern countries who, feeling an intellectual and professional affinity with their colleagues in the North, find themselves to be what she calls "First World 'Islanders'" who "inadvertently violate local beliefs and practices, and thereby also their [local populations among whom they conduct research] value systems." See note 8, p. 219.

19. The most commonly used definition of reproductive health is Mahmoud Fathalla's: a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of disease or disorders of the reproductive process. Reproductive health, therefore, implies that people have the ability to reproduce, to regulate their fertility and to practise and enjoy sexual relationships. It further implies that reproduction is carried to a successful outcome through infant and child survival, growth and healthy development. It finally implies that women can go through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex. M. F. Fathalla, "Reproductive Health: A Global Overview," *Annals of the New York Academy of Sciences* 626(1991):1-10.

20. See P. J. Williams, *The Alchemy of Race and Rights* (Cambridge, Mass.: Harvard University Press, 1991), particularly the essay entitled "The Pain of Word Bondage," for a powerful statement of the need to assess the value of rights not only from the privileged position of those who have always had them, but also from the position of those to whom they have been denied: "For the historically disempowered, the conferring of rights is symbolic of all the denied aspects of their humanity: rights imply a respect that places one in the referential range of self and others, that elevates one's status from human body to social being. For blacks, then, the attainment of rights signifies the respectful behavior, the collective

responsibility, properly owed by a society to one of its own." p. 153.
21. See, e.g., A. An-Na'im, *Toward an Islamic Reformation: Civil Liber-ties, Human Rights, and International Law* (New York: Syracuse University Press, 1990); R.T. Nhalapo, "International Protection of Human Rights and the Family; African Variations on a Common Theme" *International Journal of Law and the Family* 3(1989):1-20.
22. International Covenant on Economic, Social, and Cultural Rights, G.A. Res.2200(XXI), U.N. GAOR, 21st. Sess., supp. No. 16, at 49, U.N. Doc. A/6316(1966).
23. J. Nedelsky, "Reconceiving Autonomy: Sources, Thoughts and Possibilities," *Yale Journal of Law and Feminism* 1 (1989):7-36.
24. See, e.g., S. Correa and R. Petchesky, "Reproductive and Sexual Rights: A Feminist Perspective" in Sen, Germain, and Chen eds., *Population Policies Reconsidered* (Cambridge, Mass: Harvard University Press, 1994).
25. H. Charlesworth, C. Chinkin, and S. Wright, "Feminist Approaches to International Law, "*American Journal of International Law* 85 (1991): 613; C. Bunch, "Women's Rights as Human Rights: Toward a Re-Vision of Human Rights," *Human Rights Quarterly* 12(1990):486.
26. H. Charlesworth, "The Public/Private Distinction and the Right to Development in International Law," *Australian Year Book of International Law* 12 (1992):190-204.
27. F. E. Olsen, "The Myth of State Intervention in the Family," *Journal of Law Reform* 18 (1985):835.
28. See, for example, an article by Fatima Mernissi that examines the Qur'anic concept of *nushūz* (women's rebellion), its relation to *bid'a* (innovation), and the fear of individualism, which she believes explains much about the rise of religious extremism and its focus on the behavior of women in some parts of the Muslim world today. F. Mernissi, "Femininity as Subversion: Reflections on the Muslim Concept of *Nushūz*," in *Speaking of Faith,* D. Eck and D. Jain, eds. (Philadelphia: New Society Publishers, 1993).
29. *The Washington Post*, August 23, 1992.
30. "Vatican Fights U.N. Draft on Women's Rights," *The New York Times*, June 14, 1994.
31. J. Navarro-Valls, "The Courage to Speak Bluntly" *The Wall Street Journal*, September 1, 1994.
32. "Muslims Protest U.N. Draft on Population," *The New York Times*, August 12, 1994.
33. "Muslim Preachers in Egypt Condemn Population Conference," *The New York Times*, August 23, 1994.
34. Ibid.
35. See, e.g., S. Correa in collaboration with R. Reichman, *Population and Reproductive Rights: Feminist Perspectives from the South* (London and New Jersey: Zed Books Ltd. and New Dehli: Kali for Women, 1994).
36. See K. Jayawardena, *Feminism and Nationalism in the Third World* (New Jersey: Zed Books, Ltd, 1986); L. Ahmed, *Women and Gender in Islam: Historical Roots of a Modern Debate* (New Haven: Yale University Press, 1992).
37. Although the population field includes a fairly diverse range of organizations and individuals in the North and South, who actually lie along a fairly broad spectrum of political positions, it is possible to generalize about the theories and forces that have motivated decision-makers in this field." See L.P. Freedman, "Censorship and Manipulation of Reproductive Health Information: An Issue of Human Rights and Women's Health" in *The Right to Know: Human Rights and Access to Reproductive Health Information* (London: Article 19, 1995).
38. S.C. Watkins, "If all We Knew About Women Was What We Read in

Demography, What Would We Know?" 30(4) *Demography* 551(1993): 553.
39. See C. Gilligan, *In A Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982); and also numerous studies demonstrating that, even in times of severe economic crisis, women tend to use their time and such income as they control to promote the well-being of the family over their own personal needs, whereas men often spend such resources on themselves; Commonwealth Secretariat, "Engendering Adjustment for the 1990s" in *Report of a Commonwealth Expert Group on Women and Structural Adjustment* (London: Commonwealth Secretariat, 1989); J. Leslie, M. Lycette and M. Buvinic, "Weathering Economic Crisis: The Crucial Role of Women in Health," in D. E. Bell and M. R. Reich, eds., *Health, Nutrition and Economic Crisis: Approaches to Policy in the Third World* (Dover, Mass.: The Auburn Publishing House, 1988).
40. D. Maine, L.P. Freedman, F. Shaheed, and S. Frautschi, "Risk, Reproduction, and Rights: The Uses of Reproductive Health Data" in *Population and Development: Old Debates, New Conclusions*, ed. R. Cassen (Washington, D.C.: Overseas Development Council, 1994); and L.P. Freedman, see note 37.
41. L.P. Freedman and S.L. Isaacs, "Human Rights and Reproductive Choice," *Studies in Family Planning* 24 (1993):18-30.
42. Ibid.
43. Watkins, see note 38, p. 557.
44. See H. Papanek, "The Ideal Woman and the Ideal Society: Control and Autonomy in the Construction of Identity," in *Identity Politics & Women: Cultural Reassertions and Feminisms in International Perspective*, ed. V.M. Moghadam (Boulder, Colorado: Westview Press, 1994).
45. For example, General Recommendation 19 issued by the Committee that oversees the Convention on the Elimination of All Forms of Discrimination Against Women. See also Vienna Declaration and Programme of Action, World Conference on Human Rights, UN Doc. A/CONF.157/24 (1993).
46. For example, L. Heise, J. Pitanguy, A. Germain, "Violence Against Women: The Hidden Health Burden," World Bank Discussion Papers no. 255 (Washington, D.C.: The World Bank, 1994).
47. "Reproductive and Sexual Health as Women's Human Rights", a workshop held by IRRRAG during the 1994 ICPD as part of the series, "Human Rights Dimensions of Reproductive Health." Transcripts available from the author.
48. *Gender, Reproductive Health and Population Policies*, Reports from the Manila Workshop, 7-10 April 1994 (Quezon City, Philippines: HAIN and InDRA,1995).
49. R. Petchesky, "The Body as Property: A Feminist Re-vision," in F. Ginsburg and R. Rapp, *Conceiving the New World Order: The Global Politics of Reproduction* (Berkeley: University of California Press, 1995).
50. Ibid.
51. Ibid.
52. S. Greenhalgh and J. Li, "Engendering Reproductive Policy and Practice in Peasant China: For a Feminist Demography of Reproduction," *Signs* 20 (1995):601-641.
53. Ibid., p. 636.
54. Compare, for example, the framework of biological and social determinants that has been used effectively to address infant mortality with that which should be used to address maternal mortality. W.H. Mosley and L. Chen, "An Analytical Framework for the Study of Child Survival in Developing Countries," *Population & Development Review*, supp. to vol. 10(1984):25-45; J. McCarthy and D. Maine, "A Framework for Ana-

lyzing the Determinants of Maternal Morality," *Studies in Family Planning* 23(1992): 22-33.

55. L. Freedman and D. Maine, "Facing Facts: The Role of Epidemiology in Reproductive Rights Advocacy," *The American University Law Review* 44(1995):1085-1092.

56. Mann et al., see note 1.

57. Dutch anthropologist Joke Schrijvers traces the first use of "autonomy" as a feminist concept to a 1979 seminar in Bangkok, involving mostly women from Asia and other countries of the South, where the term was put forward to describe an element of the long-term goals of feminism. Schrijvers herself later used very specific case studies in Sri Lanka to try to understand and describe the personal qualities and social configurations that allowed certain women to resist violence in domestic relationships, working from those observations to define the elements of autonomy. J. Schrijvers, "Feminist Science and Research Philosophy: History and General Principles," in *Gender, Reproductive Health and Population Policies*, see note 48. Theoretical work in this area is also being done from a legal perspective. See, e.g., Nedelsky, see note 23.

58. See, generally, S. Mahmud and A.M. Johnston, "Women's Status, Empowerment, and Reproductive Outcomes," in *Population Policies Reconsidered: Health Empowerment and Rights*, eds., G. Sen, A. Germain, L. Chen (Cambridge, Mass.: Harvard University Press, 1994); R. Dixon-Mueller, *Population Policy and Reproductive Rights: Transforming Reproductive Choice* (Westport, CT: Praeger Publishers, 1993); N. Sadik, *Investing in Women: The Focus of the 90's*, (New York: United Nations Population Fund, 1991); K.O. Mason, "The Status of Women: Conceptual and Methodological Issues in Demographic Studies," *Sociological Forum* 1(1986):284-300; J. Caldwell and P. Caldwell, "Women's Position and Child Mortality and Morbidity in LDC's," paper presented at the Conference on Women's Position and Demographic Change in the Course of Development, Oslo, Norway, June 15-18, 1988; J. Caldwell, "Routes to Low Mortality in Poor Countries," *Population and Development Review* 12 (1986):171-200.