# RIGHTS AND NEEDS: Rethinking the Connections in Debates over Reproductive and Sexual Rights

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At the March 1999 Preparatory Committee Meeting for the United Nations General Assembly Special Session's five-year review of the International Conference on Population and Development (ICPD+5), the "pro-family" newspaper *Vivant!* published a feature article, replete with statistical data and graphics, condemning the "flawed human rights–based approach to health."[1] Central to the article's attack was an argument embracing the discourse of "basic needs" as a framework ethically and socially superior to that of human rights. Associating such infrastructural conditions as safe water and nutrition with the "needs" approach and reproductive and sexual health with the "rights" approach, it alleged that "indiscriminate funding for the ICPD's idealistically high standards of reproductive and sexual health *rights*" had caused "underfunding and deterioration of more basic, practicable and affordable health *needs*" (emphasis added). The article further insinuated that such "flawed" priorities reflect a Western agenda (read, of Western feminists) with a blatant disregard for the genuine needs and priorities of women in the South.[2]

One does not have to defend the deplorable record of the U.S. government and U.S.-based corporations with regard to Southern women's health needs to see that this rhetoric has a primary strategic aim: to demonstrate the

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alignment of Vatican concerns in the context of UN politics with those of the global South against the North, and in the bargain to discredit the transnational women's movements. I have analyzed these strategic alignments and power blocs elsewhere.[3] Here I want to consider what is fundamentally wrong with the "pro-family" position or any ethical framework that asserts a *dichotomy* between rights and needs and, as part of that dichotomy, a hierarchy subordinating some health and bodily needs (especially those related to reproduction and sexuality) to others. On its face, such a dichotomy contains an implicit gender bias, which the Women's Coalition for ICPD+5 highlighted in its response to this attack (see box below). But at a deeper philosophical level, I will also argue that a position opposing needs and rights is based on mistaken and even illogical premises.

It is worth tracing the origins of this dichotomous thinking along with its gender and ethical implications. Historically, of course, the Catholic Church hierarchy represented in the Vatican has taken a strongly anti-Marxist and anticommunist stance in world politics, while Catholicism has generated one of the most venerable natural rights traditions in Western ethics. There is thus not a little irony in the fact that the concept of a "needs-based

**Excerpt from Women's Coalition for ICPD+5 Statement**[4]

Rights cannot be divorced from needs. Reproductive and sexual health and other basic human needs—education, sanitation, clean water, nutrition—are equally important and interdependent; *all* are human rights. Especially for women, good pre-natal and obstetric care, safe contraception, and other aspects of health are inseparable from such basic amenities as reliable transportation, hygienic conditions and clean water. At the same time, their rights to liberty, security of the person and development are unattainable without comprehensive, accessible and affordable reproductive and sexual health services and the freedom to make decisions about their fertility and sexuality. These rights form a seamless web, and all are grounded in basic human needs. To rank them denies the realities of women's lives, especially for poor women.

approach" as distinct from a "rights-based" one, invoked here by a Catholic NGO allied with the Vatican, actually derives from classical Marxism. Specifically, it harks back to the distinction Marx and Engels made between "the satisfaction of human needs" and "bourgeois rights." According to the orthodox interpretation of Marx's division of social relations into a material "base" and an ideological "superstructure," the former not only determines the latter but is the repository of the most basic necessities for the production of human life (i.e., material "needs"). "Rights," on the other hand, refer to the catalogue of civil and political freedoms that groups demand from those in power to assert their equal claims to citizenship. They are the means toward emancipation but not the ends, the conditions of "mental life" and "idealism" (note the *Vivant!* article's description of reproductive and sexual rights as "idealistically high standards") but not of real social and material life. In other words, there is a difference between voting or speaking freely about abortion ("rights") and eating ("needs").[5]

Of course there is a certain kernel of truth here, which is what makes both the Marxist and the Vatican positions seem compelling at first. Northern and industrialized countries, particularly the U.S., surely do champion certain reproductive and sexual health rights to the virtual exclusion of health infrastructure needs such as safe water and sanitation. Consider the statement by a U.S. delegate participating in the Third Preparatory Committee Meeting (Prep Com) for Beijing in March 1995. She stated that the U.S. delegation must oppose a provision of the draft Platform's chapter on health urging governments to "ensure access to safe drinking water and sanitation and put in place effective public distribution systems by the year 2000." This, she argued, was an "infrastructural problem" and such time-based targets were "unrealistic."[6] On the other hand, as Mukhopadhyay and Sivaramayya have noted, Southern governments and local officials tend to associate "development" with large, publicly "visible" and structural projects, "such as building roads or digging wells," to the detriment of the less visible, less "material"

health needs of women and children.[7]

But the subordination by Northern countries of development to primarily political and civil rights, and the subordination by some Southern governments and the Vatican and its allies of human rights to economic development and poverty alleviation (associated with "basic human needs"), are *really two sides of the same coin*. Both imply that individual needs and social needs, or needs and rights, somehow belong to different realms. This dichotomization, as many critics have noted, was a major outgrowth of the Cold War political environment and has had a direct counterpart in debates over human rights themselves. Feminist and other critics of mainstream human rights organizations and discourses have argued that the very concept of different "generations" of rights implies the priority of "civil and political" over "economic and social" rights. Such prioritizing has a distinctly miserly side, as Florence Butegwa observes:

> Civil and political rights are characterized as negative and cost-free rights in that governments are only required to abstain from activities which would violate them. This is contrasted with economic, social and cultural rights which require governments to do something, thereby committing considerable resources, to ensure individuals the enjoyment of those rights.[8]

Although the World Conference on Human Rights in Vienna declared a consensus endorsing the *principle of indivisibility* among the different kinds of rights and their respective international conventions, as well as affirming the right to development as fundamental and inalienable, there is still very little effective international enforcement of economic, social and cultural rights.[9] The "right to the highest attainable standard of health" has been enshrined in the Constitution of the World Health Organization (WHO) since the 1940s and the International Covenant on Economic, Social and Cultural Rights (ICESCR) and other human rights treaties since their advent in the 1960s, but the human rights treaty bodies only began reviewing reproductive and sexual health violations around 1994–95—not coincidentally, following the Cairo and Beijing confer-

ences.[10] On the other hand, the main international bodies responsible for health and development, the World Bank and WHO, rarely if ever cast their policies in human rights terms as opposed to economistic "cost-benefit" terms. "Rights" and "needs" remain split even within the UN's institutional machinery.

Underlying the "rights"/"needs" dichotomy is a basic fallacy. What this dichotomy ignores is that rights are merely the codification of needs, reformulated as ethical and legal norms and thus implying a duty on the part of those in power to provide all the means necessary to make sure those needs are met. This duty is affirmative as well as negative; that is, "states have an obligation not only to respect (to not do harm) but also to take positive measures to ensure [the enjoyment of rights]."[11] The terminology of "human" and "universal" simply says that there should be no distinctions of class, gender, race, ethnicity, age, region, and so on; the rights belong to all persons and the duties to fulfill them to all authorities. Rights are meaningless, in other words, without needs. But needs cannot stand on their own as ethical principles, because they lack any intrinsic methods for (a) determining whose and which needs should take precedence, (b) assigning obligations to specific parties for fulfilling those needs, and (c) empowering those whose needs are at stake to speak for themselves. Without some principle of "personhood" or moral agency—available only through a human rights framework—there is nothing to prevent the state, medical experts, or religious authorities from deciding what is good for women or young people on the basis of political expediency, aggregate data, or fundamentalist interpretations of scripture.[12] Rights-bearers, on the other hand—who may be groups as well as individuals—are by definition those who are authorized to make official claims before established adjudicating bodies in defense of their own needs, now codified and formalized as rights. As a recent World Bank publication puts it, "[public] institutions matter."[13]

This may seem to beg the question of whether some needs, and their corresponding rights, are more "basic" or "fundamental" than others. But my whole point is that

there is a logical interconnection between rights and needs and the indivisibility of different forms of rights, so that prioritizing makes no sense. This is especially apparent when we look concretely at specific reproductive and sexual rights and the ways in which they cluster together with other rights in women's everyday lives. Even deciding whether to classify such rights as "social," "economic," "cultural," or also "civil and political" is very difficult. The right of all couples and individuals "*to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so*," the most generic yet still in many ways the most controversial of reproductive rights, involves at least the following range of issues involving additional human rights:[14]

- safe, reliable maternal and child health services linked to a well-functioning primary health care system;
- adequate nutrition and general health conditions, to avoid a wide range of risks and complications, from anemia to HIV infection;
- access to safe contraceptive methods, good information and counseling, and follow-up care;
- literacy and education, e.g., to read package inserts or clinic wall posters;
- access to jobs, health insurance, or other financial resources to pay for the services, especially with the demise of social benefits and increase in user fees;
- convenient transportation to reach the services;
- freedom from oppressive religious and traditional codes that constrain choice;
- freedom from the threat of domestic violence or forced pregnancy through war rape and ethnic violence; and
- participation of individual women in community groups and women's NGOs, and of women's NGOs and their constituents, in all levels of government policy-making about reproductive and sexual health.[15]

We might visualize these different aspects of reproductive health rights as a series of concentric circles, beginning with the most intimate relations and radiating out to the

most societal and even global (see box below for an illustration). Women with their own jobs and incomes may still be dependent on a husband (if they have one) to get access to health insurance that will cover maternity care, since so many women work in marginal, informal, or uninsured sectors.[16] Likewise, the presence of adequate information and clinic services for contraception does not guarantee women freedom from domestic threats that put their well-being (or

**The Story of Futhi**

*The following is an imaginary profile based on real-world facts.*

Futhi is one of the 18.5 million women worldwide, and one of the nearly 10.5% of pregnant women using urban antenatal clinics in South Africa, who are infected with HIV. The roots of Futhi's infection start with marriage—a husband who works in the mines, is away a good deal, and has unprotected sex with prostitutes. But there was never a question of leaving him, since she is unable to earn enough on her own to support her two children. Thanks to South Africa's progressive reproductive health policy, Futhi has access to a caring reproductive health clinic nearby. Yet although she learned about condoms from the clinic nurse, she was afraid to suggest them to her husband for fear he would call her promiscuous and beat her. Besides, her culture tells women to accommodate their husbands' desires.

Then Futhi discovered she was pregnant *and* HIV-positive and faced the dilemma of what to do. In South Africa abortion is a woman's right for any reason during the first trimester. Nurses at the antenatal clinic have warned her she cannot breastfeed the new baby without great risk of infecting it with HIV, and there is not yet safe drinking water in her township to use for bottle feeding. She has heard there are drugs that can prevent HIV transmission to the fetus, but these drugs—made by U.S.-based pharmaceutical companies—are too expensive for the economically pressed South African government to buy on the world market. The government is therefore planning to create its own cheaper generic version despite U.S. threats to impose trade sanctions if it does. But even if South Africa manages to evade punitive actions by the U.S. government and its pharmaceutical companies, the cheaper drugs won't come in time for Futhi or help to assure her a longer life to care for her children. Apparently, abortion is her only "choice." Luckily, in South Africa at least it *is* a choice.[17]

their marriage) in jeopardy if they dare to utilize those services. As one rural worker in northeast Brazil reported to researchers in the seven-country field study conducted by the International Reproductive Rights Research Action Group (IRRRAG):

> He used to snoop in my things [until he found birth control pills hidden in a suitcase]. He knew what they were for. The label had all this. He asked me, "What do you have these for? Don't you want to live with me anymore? . . . Then he took the pills, put them in water, dissolved them and buried them, saying, "If I see these pills again you will pay me." Now, "pay me" means he will beat me.[18]

A substantial literature documents the numerous intersections between violence against women, both domestic and clinic-based, and threats or impairments to their reproductive health.[19] But the barriers to enjoyment of reproductive and sexual rights or the "right to the highest attainable standard of health" generally may be subtler and less obviously coercive. Studies show that grassroots women themselves, such as those active in the local government bodies in India known as *panchayats*, often comply with the hierarchy of priorities that puts road-building before preventing reproductive tract infections. Many women tend to see their own health problems as somehow less important "when cost is an issue" or even as natural and inevitable, thus "seeking medical care too late or not at all."[20]

But don't the very roots of such compliance and self-denial involve issues that directly affect women's right to development? In other words, can the right to development itself—usually classified in the "economic and social" category—be separated from the right to reproductive health and education, the right to participation in women's NGOs, and the cultural changes necessary to nourish women's empowerment and self-worth? What about the women in Iran who suffer infertility, birth complications, or stillbirths because of working since early childhood in the carpet-weaving industry and thereby suffering underdeveloped pelvises?[21] If they could bring their case before any of the UN human rights bodies, would they cite violations of their health

rights, their reproductive rights, their right to education, or their right not to be exploited by child labor practices or involuntary servitude? Of course all these rights are equally important here, all are interconnected, and all express needs essential to health. I would like to think as well that all should be understood as integral to what we mean when we speak not only of fundamental human rights but also of sustainable human development.

Feminists working in transnational movements have brought to the United Nations conferences and treaty bodies this synthetic perspective that refuses to separate rights from needs or to deny the personal, sexual, and health aspects of sustainable development. In doing so, they have transformed the discourses of both social needs and human rights and begun to evolve effective strategies for translating those rights/needs into enforceable policies. But there is still a very long way to go, and tremendous power structures block the way forward, even where political will exists at the level of the state. The Women's Health Project in South Africa—perhaps the most rights-conscious country in the world at present—reports that "according to the 1998 census, 20 percent of African households [in South Africa] live in a single room and 46 percent live in three or fewer rooms," while over half of such households are without potable water from an indoor tap or flushing or chemical toilets. They thus conclude: "Currently water and sanitation services, quality of life, and the absence of disease may be sounder indicators of health than access to formal medical care."[22]

Such basic conditions as clean water and decent, uncrowded habitations are surely integral to reproductive and sexual health and well-being—for example, using condoms or barrier methods safely, delivering and rearing healthy babies, or avoiding sexual abuse. Their lack puts women in untenable dilemmas, like those experienced by HIV-positive pregnant women who must choose between breastfeeding their infants and exposing them to the risk of HIV/AIDS or bottle-feeding them and exposing them to deadly bacterial infection from contaminated drinking water.[23] Moreover, that lack is integrally tied to global economic forces and the hegemonic power of U.S.-based phar-

maceutical corporations in global markets, assisted by the U.S. government's (often successful) attempt to prevent developing countries from manufacturing or importing cheaper generic drugs to treat pregnant women and other people living with HIV or AIDS (again, see box on page 23).[24]

Contrast these realities with the statement of the U.S. delegate in the Beijing Prep Com I quoted earlier. Belying the "pragmatic" tone of the U.S. position and underlying the public health context in which the Women's Health Project frames its South Africa report is a profoundly ethical truth: if certain "infrastructural" conditions and macroeconomic policies are indispensable for creating the enabling environment for reproductive and sexual rights to become practical realities, then those conditions and policies must be incorporated into our ethical framework and understood not only as "basic needs" but as fundamental human rights. Thus "social and economic" rights are no more or less important than those more obviously related to reproduction, sexuality, and health; rather, together they form a single fabric of rights that are interdependent and indivisible, all of them grounded in basic human needs.

## References

**1.** *Vivant!* was published daily during the Cairo+5 Preparatory Committee (Prep Com) meeting by a group calling itself the NGO Caucus for Stable Families. Its positions were consistently close to those of the Holy See (Vatican) delegation at the United Nations, and there is every reason to believe the paper's staff is closely allied to the Vatican. I am thus interpreting its statements as unofficial reflections of the church hierarchy's views.

**2.** The article prominently displays a photograph of a dark-skinned woman smiling happily as she gathers wheat in a field, with the caption: "Women in developing countries have a far greater need for nutrition, safe water, and other health services than for the 'reproductive' products and services treated as a priority by western nations." See R. Joseph, "Flawed Human Rights–Based Approach to Health," *Vivant! Pro-Family News from the United Nations*, 23 March 1999, 3.

**3.** See R. P. Petchesky, *Reproductive and Sexual Rights, Social Development and Globalization: Charting the Course of Transnational Women's NGOs* (Geneva: United Nations Research Institute for Social Development, forthcoming), from which this commentary has been adapted; and R. P. Petchesky, "From Population Control to Reproductive Rights: Feminist Fault Lines," *Reproductive Health Matters* 1995, 6: 152–61.

**4.** Flyer dated March 1999. Full text available from Health, Empowerment, Rights and Accountability (HERA), c/o International Women's Health Coalition, 24 East 21st St., New York, NY 10010, USA; e-mail: hera@iwhc.org.

**5.** This is a very oversimplified summary of ideas contained variously in the 1859 Preface to *A Contribution to the Critique of Political Economy*; *The German Ideology*, Part I; and *The Communist Manifesto*. See Karl Marx, *Selected Writings*, ed. L. H. Simon (Indianapolis and Cambridge: Hackett, 1994). I do not mean to suggest that the author is deliberately or knowingly drawing from Marxism. The article's polemic against "rights" and in favor of "needs" no doubt has a more circuitous genealogy. In the 1960s and '70s, the concept of "basic human needs" was taken up by left-wing developmentalists and Third World countries as a shorthand for giving priority to poverty alleviation over corporate profits. See G. Sen, "Development, Population, and the Environment: A Search for Balance," in G. Sen, A. Germain, and L. C. Chen (eds), *Population Policies Reconsidered: Health, Empowerment, and Rights* (Cambridge: Harvard University Press, 1994), pp. 65–67. In their zeal to identify the Vatican with the South, Vatican advocates may not be thinking of the socialist and Marxist derivations of concepts of development that prevail in many Southern countries.

**6.** In the final Platform for Action, as a concession to the U.S. objection, the target date was omitted and replaced by the vague phrase "as soon as possible"; see United Nations, Fourth World Conference on Women, *Platform for Action and the Beijing Declaration*, Beijing, China, 4–15 September 1995 (New York, United Nations Department of Public Information, 1996), para. 106.x. The quotation from the U.S. delegate was obtained first-hand during my participation as an NGO observer at the Third Preparatory Committee Meeting for Beijing.

**7.** S. Mukhopadhyay and J. Sivaramayya, "Forging New Partnerships: Towards Empowerment," in Saroj Pachauri (ed), *Implementing a Reproductive Health Agenda in India: The Beginning* (New Delhi: Population Council, 1999), p. 349.

**8.** F. Butegwa, "International Human Rights Law and Practice: Implications for Women," in M. A. Schuler (ed), *From Basic Needs to Basic Rights* (Washington, DC: Women, Law & Development International, 1995), p. 34. See also, among others, C. Bunch, "Transforming Human Rights from a Feminist Perspective," in J. Peters and A. Wolper (eds), *Women's Rights/Human Rights: International Feminist Perspectives* (New York: Routledge, 1995), pp. 11–17; S. T. Fried, *The Indivisibility of Women's Human Rights: A Continuing Dialogue* (New Brunswick, NJ: Center for Women's Global Leadership, 1994); R. Copelon and R. Petchesky, "Toward an Interdependent Approach to Reproductive and Sexual Rights as Human Rights: Reflections on the ICPD and Beyond," in M. A. Schuler (see above), pp. 343–67; D. Otto, "Linking Health and Human Rights: A Critical Legal Perspective," *Health and Human Rights* 1995, 1(3): 272–81; L. P. Freedman, "Reflections on Emerging Frameworks of Health and Human Rights," *Health and Human Rights* 1995, 1(4): 314–48; and R. J. Cook, "Gender,

Health and Human Rights," *Health and Human Rights* 1995, 1(4): 350–66.

**9.** Vienna Declaration and Programme of Action, Vienna, June 1993, UN Doc. A.Conf.157/24 (1993).

**10.** Constitution of the World Health Organization, adopted by the International Health Conference, New York, 19 June–22 July 1946, and signed on 22 July 1946 by the representatives of 61 States; International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966). See also the thorough compendium of cases in J. Stanchieri, I. Merali, and R. J. Cook, *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of UN Treaty Bodies* (Toronto: University of Toronto Faculty of Law, 1999).

**11.** R. Copelon and R. Petchesky (see note 8), p. 358.

**12.** On the concept of "personhood," see S. Corrêa and R. Petchesky, "Reproductive and Sexual Rights: A Feminist Perspective," in G. Sen, A. Germain, and L. C. Chen (note 4), pp. 107–26; R. Petchesky 1999 (note 3); and L. P. Freedman (note 8).

**13.** S. J. Burki and G. E. Perry, *Beyond the Washington Consensus: Institutions Matter* (Washington, DC: World Bank, 1998); see also, in the same vein, *World Development Report 1997: The State in a Changing World* (Washington, DC: World Bank, 1998).

**14.** *Programme of Action Adopted at the International Conference on Population and Development*, Cairo, 5–13 September 1994 (New York: United Nations Population Fund, 1996), para. 7.3.

**15.** See R. Petchesky and K. Judd (eds), *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (London and New York: Zed Books and St. Martin's Press, 1998), especially Chapter 9, which discusses the IRRRAG research findings on group participation and women's empowerment to make reproductive and sexual decisions.

**16.** Women's Environment and Development Organization (WEDO), *Risks, Rights and Reforms: A 50-Country Survey Assessing Government Actions Five Years after the International Conference on Population and Development* (New York: WEDO, 1999), p. 125.

**17.** Sources: M. Berer (see note 23); UNAIDS, *AIDS Five Years since ICPD: Emerging Issues and Challenges for Women, Young People and Infants* (Geneva: UNAIDS, 1999); Weiss and Rao Gupta (see note 18), p. 10; "South Africa," in WEDO (see note 16), pp. 53–58; and K. Silverstein (see note 24), p. 16.

**18.** Quoted in S. G. Diniz, C. de Mello e Souza, and A. P. Portella, "Not Like Our Mothers: Reproductive Choice and the Emergence of Citizenship among Brazilian Rural Workers, Domestic Workers and Housewives," in R. Petchesky and K. Judd (see note 15), pp. 59–60.

**19.** See S. T. Fried (note 8); L. L. Heise, "Violence, Sexuality and Women's Lives," in R. G. Parker and J. H. Gagnon (eds), *Conceiving Sexuality* (New York: Routledge, 1995), pp. 109–34; L. L. Heise, K. Moore, and N. Toubia, *Sexual Coercion and Reproductive Health: A Focus on Research* (New York: Population Council, 1995); E. Weiss and G. Rao Gupta, *Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention* (Washington,

DC: International Center for Research on Women, 1998); R. Petchesky and K. Judd (note 15); and Latin American and Caribbean Committee for the Defense of Women's Rights (CLADEM) and Center for Reproductive Law and Policy (CRLP), *Silence and Complicity: Violence Against Women in Peruvian Public Health Facilities* (New York: CRLP, 1999).

**20.** The quotations are from WEDO (see note 16), p. 11; see also S. Mukhopadhyay and J. Sivaramayya (note 7), p. 347.

**21.** WEDO (see note 16), p. 101.

**22.** WEDO (see note 16), p. 56, and B. Klugman et al., *From Words to Action: Sexual and Reproductive Rights, Health Policies and Programming in South Africa, 1994–1998* (Johannesburg: Women's Health Project, 1998).

**23.** M. Berer, "Reducing Perinatal HIV Transmission in Developing Countries: Ethical and Practical Dilemmas and the Need for a Comprehensive Approach," unpublished manuscript, and "HIV/AIDS, Pregnancy and Maternal Mortality and Morbidity: Implications for Care," in M. Berer and T. K. S. Ravindran (eds), *Safe Motherhood Initiatives: Critical Issues* (London: Blackwell Science, 1999), pp. 200–201 and *passim*; see also H. Kanaaneh, F. McKay, and E. Sims, "A Human Rights Approach for Access to Clean Drinking Water: A Case Study," *Health and Human Rights* 1995, 1(2): 190–204.

**24**. K. Silverstein, "Millions for Viagra, Pennies for Diseases of the Poor," *The Nation*, 19 July 1999, 13–19.