GENDER PLANNING: DIFFERENT POLICY APPROACHES TO REPRODUCTIVE HEALTH

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MS. MOSER: I am neither a lawyer nor a health expert, so really I am somewhat of an imposter in this symposium. I have worked, however, on gender issues in developing countries over the last two decades, particularly on the development of a rationale to integrate gender into planning. I would like to focus, therefore, less on the legal framework for women's reproductive rights per se, and more on the entry points for the *implementation* of a rights-based framework for reproductive health. In an operational agency, this is a primary concern.

Which health-based issues are the most appropriate entry points for action? To answer this question I will introduce the methodological framework for gender planning that I have developed. Anne Tinker, my colleague, will then examine the extent to which she has found it a useful framework in terms of World Bank work in the health sector. In this way, together, we will identify whether such methodological tools are useful in deconstructing complex issues relating to reproductive health. This symposium has provided us with an interesting opportunity to try and work collaboratively, from different perspectives, on the same issue.

I want to start by raising three sets of issues. First, whose rights are we talking about, and whose needs? How are these identified? Are they global, national, or local in nature? How far are women themselves involved in the definition of these rights?

Second, how do we achieve change? Is it best achieved top down, through what has been termed "equity," through changes in the legal

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framework? Or is it best achieved bottom up, through what has been termed "empowerment?"

Finally, are we talking about women, or are we talking about gender? There is a very big difference between these two concepts. The last decade has witnessed an important debate concerning the shift from what is called "women in development" (WID), which focuses on women as a special group—often in isolation—to a "gender and development" (GAD) approach. This focuses on gender, by which we mean not men or women, but the relations between them—and the way these are socially constructed. When we look at women as victims, for example, are we looking at women on their own? Or are we not looking at the relationship between men and women? I am uncertain whether this symposium is concerned with the issue of rights for women, or about gender rights—rights that relate to men and women and the relationships between them.

I want to introduce three tools that I have developed over the last decade working on gender planning, elaborated in greater detail in two recent publications.[1] I have worked not only as an academic but also as a trainer, not only with multilaterals and bilaterals but also with nongovernmental organizations (NGOs). I have tried to translate complex feminist debates into practical planning language—to make it more accessible to development practitioners.

The first tool I find useful is to differentiate between the different roles and relations men and women have in the household and in society. Men generally have the primary productive role; women, in contrast, tend to have three roles. They have a reproductive role, which obviously links to caring for family health needs. Most poor women also have a productive role as well. Finally, women have what I have called a community managing role. This relates to the unpaid work women undertake within their communities, managing the delivery and maintenance of social services, particularly in the area of health and nutrition. At the community level, men also have an important role, generally in local politics. Gender divisions of labor, therefore, exist not only within the household, but also within communities.

The implications of this are twofold. First, women balance three roles and responsibilities, with important implications for time management. Second, much of the work undertaken by women is not

1. *See generally* CAROLINE MOSER, GENDER PLANNING AND DEVELOPMENT: THEORY, PRACTICE AND TRAINING (1993); Caroline Moser, *Gender Planning in the Third World: Meeting Practical and Strategic Gender Needs*, 17 WORLD DEV. 1799, 1799-1825 (1989).

valued—only productive work with its exchange value tends to have a value. My particular interest in community managing relates to the unpaid nature of such work. Many of you will have seen primary health care programs with paid, mainly male, doctors and unpaid, mainly women, community workers with responsibility to implement whole programs.

If men and women have different roles in the household and society, then logically they also have different needs. The second tool in gender planning relates to gender needs, and the distinction between practical and strategic gender needs. Practical gender needs are the needs that women themselves identify in their socially accepted roles in society.

If you ask a woman what she needs, she may reply, for example, that she needs water. In fact, her whole household needs water. Because in her reproductive role, however, securing water is her responsibility, consequently she identifies this as her need.

Strategic gender needs are very different. These are the needs that women identify because of their position in society. These are the needs, then, that assist women to achieve greater equity in their relationship with men in society. It is very important to recognize that such needs vary widely not only within different contexts, but also between different classes and ethnic groups.

The third tool relates to the underlying policy approaches to women in development. Over the past twenty years these have changed, not in isolation but reflecting changes in macro-level economic and social policy approaches to Third World development. Five different approaches can be identified. In describing each, the important question concerns the extent to which they provide an entry point for health concerns. Are there different entry points in different contexts, utilizing different policy approaches?

Of the five approaches, the earliest and most popular is the welfare approach. This is based on three assumptions: first, that women are passive recipients of development, rather than participants in the development process; second, that motherhood is the most important role for women in society; and third, that child rearing is the most effective role for women in all aspects of economic development. This approach focuses entirely on women in their reproductive role, and identifies the mother-child dyad as the unit of concern.

The second approach is equity, originally introduced during the 1970s. This approach recognizes that women are active participants in the development process, who through both their productive and reproductive roles provide a critical, if often unacknowledged

contribution to development. This is a "top down" approach. It focuses particularly on reducing inequality between men and women and meeting strategic gender needs through legislative measures. In challenging women's subordinate position, the equity approach has been considered threatening. It was widely criticized by many as Western feminism, and was not popular with many governments.

It was quickly replaced by the antipoverty approach, a "toned-down version of the equity approach"[2] in which the economic inequality between men and women is linked not to subordination, but to poverty. The focus here shifts to women's productive role, to reducing income inequality, with the prioritization of income-generating projects and increased access to productive resources.

The fourth approach is the efficiency approach, now the predominant WID approach, particularly since the debt crisis of the 1980s. Here the emphasis shifts away from women and towards development, on the assumption that increased economic participation for women is automatically linked with increased equity. Efficiency recognizes that development needs women, even if women's condition is not necessarily improved by development.[3] The efficiency approach addresses a diversity of practical gender needs relating to women's triple role, but often assumes elasticity of women's time and their capacity to extend their working day to undertake both paid and unpaid work.

The final approach is the empowerment approach. Differences between empowerment and equity are important to identify. If the equity approach aims to meet strategic gender needs through "top down" state legislation, the empowerment approach, in contrast, addresses strategic gender needs through the "bottom up" interventions of women's organizations. The origins of the empowerment approach are derived less from Northern research and more from the feminist movement and grassroots organization experience of women in the South. It identifies power less in terms of domination over others (with the implicit assumption that a gain for women implies a loss for men) and more in terms of the capacity of women to increase their own self-reliance.

I want to end by emphasizing that although these five different approaches were developed during different historical periods, all are still in use. One policy approach is not necessarily *a priori* "better"

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2. Mayra Buvinic, *Women's Issues in Third World Poverty: A Policy Analysis, in* MAYRA BUVINIC ET AL., WOMEN AND POVERTY IN THE THIRD WORLD 14 (1983).

3. *See* P. MAGUIRE, WOMEN IN DEVELOPMENT: AN ALTERNATIVE ANALYSIS (1984) (mimeo document).

than another. They have different underlying rationales for development; they relate to different women's roles; they address different practical and strategic gender needs; consequently, they provide alternative entry points for addressing women's reproductive health issues.

MS. TINKER: What are some of the entry points for policy and planning in reproductive health, using a gender analysis framework? First is the *welfare* approach, which focuses on women's roles as mothers. The objective is to reduce fertility, promote breastfeeding, and improve family health. With the emphasis, however, on women's reproductive role, women's other roles are not addressed, including alternatives to childbearing or combining work with breastfeeding and childcare, for example.

The second approach is based on *equity*, where women's inferior socio-economic status—relative to men—is the focus. The objective is to reduce discriminatory practices affecting women's access to health services. The emphasis is on laws and policy dialogue. The World Bank has been discussing with India, for example, the age of marriage, and with some African countries, the laws and policies related to female genital mutilation. As we all know, however, while the law sets the standard and can provide an enabling environment, behavior is much more difficult to change.

The use of amniocentesis or ultrasound for the purpose of sex-selective abortion, which is being practiced in India, China, and Korea, for example, is equity confounded. When it is outlawed as discriminatory, it deprives women of the right to choose.

Third, women are disproportionately poor and their potential underutilized. The objective of the *antipoverty* approach is to increase their contribution to development and reduce economic constraints on access to health services. Examples of this approach include iron supplementation in the cotton mills of China or the tea plantations of Sri Lanka, so that women are no longer anemic, and as a result are more healthy and more productive.

Another example of the antipoverty approach is the safety-net protection for poor women. The Bank-assisted project in China, for example, will ensure that women with life-threatening pregnancy-related complications will be treated regardless of income level. They are now being turned away at maternal hospitals because they cannot pay. The antipoverty approach does not deal adequately with the fundamental issue that women are generally paid less for equal work,

and that much of their work, which is reproductive and domestic, is not renumerated.

Fourth, women's health is cost effective. With the *efficiency* approach, the objective is to achieve high impact at low cost. The Bank and the World Health Organization have undertaken disease-burden studies and cost-effectiveness analyses of different interventions to improve the health of adults and children. They found that among all interventions for adults, the most cost-effective were the reproductive health interventions for women aged fifteen to forty-four. This approach is supply-driven, emphasizes technology, and is very effective with ministers of finance and planning.

The cost-effective argument needs to be tempered with adequate regard to social and cultural issues that affect women's access to, and use of, services, such as the sex of the provider and the opportunity costs for the woman to seek care. The value of her time, for example, has to be considered, given her many responsibilities.

The final approach is *empowerment*, which views women as potential positive agents of change. Health, particularly in combination with education, can increase self-reliance and potential. The objective is a multifaceted life-cycle approach, emphasizing women's involvement in improving their health. Focus-group discussions and the involvement of women and nongovernmental organizations are part of the planning process. A more integrated approach is taken, whereby, for example, adolescent fertility is viewed in the context of education, employment, and self-esteem. Nontraditional issues, such as violence against women, are receiving increasing attention.

This approach requires a longer-term strategic view, more coordination between sectors, and the sharing of power, which can be very threatening. Governments and assistance agencies, generally centralized, hierarchical, and drawn on sector lines, are not generally set up to support this approach.

The U.N. Population Conference in Cairo endorsed this approach, by asserting that the achievement of population stabilization and overall development goals really depends on empowering women.

Currently, the fastest growing sectors in the Bank are health and education, with a particular emphasis on women. The Bank's assistance program now represents an expanded approach, which views reproductive health more broadly than population and also sees the linkages between health and education. In fact, there are now 100 projects with women's health components in the Bank, as compared to six similar programs only five years ago.

Women's NGOs are becoming more involved in our project-development work. For example, in the Philippines, the result of the safe motherhood working group to help develop a women's health project, which has recently been negotiated with the Government, is a study on violence against women. This is what the women wanted. It was not in the initial plan.

Our current discussions in India are very much focused on a broader approach to population, shifting away from targets for contraceptive prevalence to quality of care and enabling women to take greater control over their lives. A number of our recent publications reflect this change, such as *A New Agenda for Women's Health and Nutrition* and a paper we commissioned on *Violence Against Women: The Hidden Health Burden.*

All of the entry points to improving women's health can contribute to the planning process. Some traditional planners, however, have tended to adopt too much of a "top down" approach to solving what they see as the development problem, of which women are considered a part. The empowerment approach, on the other hand, involves women in the solution, recognizing them as agents of change for their own health, as well as the health of their families and communities.