

SOCIAL ANALYSIS AND SELECTIVE INCLUSIONS IN RIGHTS-BASED APPROACHES TO REPRODUCTIVE HEALTH

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Introduction

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

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inclusions, draws attention to their partial nature, identifies other selective exclusions, and considers their implications for reproductive and sexual health.

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

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

Without resorting to the concept of 'social exclusion', around which there is a growing literature (e.g. De Haan and Maxwell 1998), our use of the terms 'inclusion' and 'exclusion' in relation to population policy will resonate with some of these debates. These processes not only mediate material access to services, they also play a role in constructing meanings and identities, as well as being a part of wider struggles about resources, power, culture, and social relations. Following Jackson (1999) and other feminist commentators on social policy (see Pascall 1997), inclusion *per se* is not necessarily a 'good thing', and attention needs to be paid to the terms of such inclusion, as well as the possibility of multiple and partial

inclusions and exclusions. Rights are a special form of 'needs talk', which, despite their moral appeal to absolute standards derived from 'human nature', are social constructions that evolve over time and that bear specific ideological characteristics. The bureaucratic interpretation of needs as a series of administrable wants often depoliticizes rights by 'enclaving' them within bounded arenas (Fraser 1989). Our focus here is on how, in social analytical terms, the challenge raised by reproductive rights is conceived, and in particular how reproductive health has re-envisioned the subjects and scope of its interventions, as well as on the political implications of these partial inclusions and selective exclusions.

Partial Inclusions?

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

The traditional targets of population policy have been (married) women of reproductive age, and the key distinctions drawn between them have revolved for the most part around age, age at first birth, and parity on the basis of biomedical assessments of risk and health. 'Good' outcomes remain defined as delaying, spacing, and limiting births using modern contraceptives. To these characteristics, which are deemed to be 'of interest', we can also add proxy indicators of women's status, typically their educational achievements or literacy and their employment status. Win-win theories hold that education and independent incomes improve the status of women and thus their autonomy and contraceptive use. Indeed, the use of contraceptive rates as a proxy measure of women's status illustrates the unquestioned strength of the association between greater female autonomy and reduced

fertility. Although women were always central to population policy, Greenhalgh (1995: 23) has commented that even today demography is 'almost prefeminist in the implicit assumption and biases that inform its work (for example, that only women aged 15–49 are reproductively "dynamic" and thus worth studying, that women and men occupy separate spheres, the former private, the latter public) and in the narrow range of women's characteristics considered demographically important'.

Although some of these inclusions and exclusions and related constructions of target groups have been progressively challenged by new thinking and advocacy, the Cairo ICPD has not so far marked a sharp break with past policies, and some troubling continuities remain within its broadened agenda. The Programme of Action (PoA) is significant in placing efforts to improve reproductive health at the centre of population policy and at embedding this vision within a rights-based understanding of reproductive health that puts women's empowerment firmly on the agenda. However, for many a rights-based approach to reproductive health simply means 'doing family planning better' (Greene 2000: 50). There is a fairly uncontroversial consensus over the need to work harder to eliminate 'unmet need', to improve the quality of services, and to broaden services. There is also a widely shared emphasis on the education of girls and on income generation, employment, and credit provision for women. Greater priority is given to the needs of adolescents, the involvement of men, and working on HIV/AIDS. These shifts represent changes of emphasis in population policy that were already growing in momentum before Cairo. The PoA added strength and legitimacy and took the agenda another step along the road, but it did not transform population policies in the way that many women's health advocates envisaged. The dimensions of this that concern us here include the incomplete and selective incorporation of reproductive interest groups and the enclaving of reproductive interests within a biomedical approach to reproductive health programming that fails to engage with social institutional constraints, as well as the limited engagement with the task of re-envisioning the client group as rights-bearers who might play a role in shaping policy, as well as in determining their own needs.

The continued narrow focus on reproduction is accompanied by ambivalence over non-reproductive sex and sexual self-determination, de-links concerns of social reproduction and empowerment from reproductive health policy, and side-steps critical issues of power. These deficiencies are evident in the partial inclusion of adolescent reproductive health and the particular way in which adolescents and their health needs are constructed. Although the reproductive health needs of adolescents are receiving considerably more attention, these approaches are mainly not rights-based, work with homogenized understandings of adolescence (Gage 2000), and circumvent important aspects of power that are critical to improving well-being. The Cairo PoA notably fails to articulate reproductive rights for adolescents, emphasizing instead the need for 'appropriate' services 'suitable for that

age group' with 'proper regard for parental guidance and responsibilities' (UN 1994: PoA 7.44–7.47). These strategies do not engage with growing understandings about the realities of sexual and reproductive relations for younger men and women or draw up a vision of an appropriate enabling environment in which they can take control of their sexuality and reproduction (e.g. Gage 2000; Hawkins and Meshasha 1994). Although female genital mutilation (FGM) and gender violence, including sexual abuse, receive attention, they are constructed as a separate front of activity, thus obscuring the lines of power that impact on adolescent reproductive self-determination and health.

Without denying the many arguments that early marriages are often arranged, place untimely burdens of childbirth, social reproduction, and work on adolescents, and can close down opportunities and perpetuate powerlessness, it can be observed that adolescent reproductive health needs are overwhelmingly constructed around the perceived 'problem' of teenage pregnancy (see UN 1994: PoA 7.44). In many developing countries, these perspectives also incorporate overtones of religion and ethnocentrism in contexts where, until recently, low age at marriage and early childbearing were the approved social behaviour. Young married, and sometimes unmarried, mothers have usually been able to access reproductive health services, while unmarried young women without children have been excluded in many contexts. Today, changing social norms mean that, almost everywhere, the age at which young women and men marry has been rising, while in some contexts age at first intercourse has been declining, giving rise to a growing and differentiated set of sexual and reproductive interests and needs for teenagers. For example, Reysoo (1999) describes 'a new adolescent life stage' emerging in Morocco, where sexual relations outside marriage are illegal and age at marriage is rising: double standards permit sexual relations before marriage to men, but demand virginity in young women. Gage (2000) calls for an approach that disaggregates adolescents in terms of their life stage and relevant circumstances (out of school, unemployed, living on the street, not sexually active, and so on), rather than defining adolescents using broad age ranges.

While research has drawn attention to the importance of power relations in adolescent reproductive decision-making, policy approaches have been slow to engage with the implications for action. Poor adolescent girls may rely on sexual strategies for their economic survival and educational advancement, and these relationships often contain large power imbalances and the implicit or actual threat of male violence. Policy responses have tended to see the solution narrowly in terms of improving the flow of resources to these women and improving interpersonal skills to negotiate sex and condom use (*ibid.*). Efforts at empowerment need to address the reality that adolescents are under the authority of adults who have vested interests in their reproductive and sexual behaviours by focusing much more on the context of the family, community, peer groups, and the larger social system, particularly given the complicity of parents in determining the timing of

young women's entry into marriage and childbearing (Dubey and Dubey 1999; Gage 2000: 194). Although teenage pregnancy has recently been seen broadly in terms of social exclusion within the UK debate (Social Exclusion Unit 1999), the political will has not been there to defend their rights to a full range of reproductive health services for teenagers or to transform sex education effectively so as to address their concerns and interests (*Guardian* 2000).

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

Research into men's reproductive lives is a small but growing field (see Bledsoe *et al.* 2000 for a valuable contribution), and as far as we are aware, little progress has been made in differentiating male reproductive interests within health policy. Barroso and Jacobsen suggest that 'the growing interest in increasing male participation in reproductive health and family planning must be broadened to address the structural and cultural factors working against men's support of women's empowerment' (2000: 367). They see this as including the development of an 'enabling environment' in which men can develop their nurturing abilities and share responsibilities for child care, contraception, and reproduction in general. In order to do this, we need to understand much more about the 'co-operation and sharing between the sexes [which] already exists simultaneously with male practices and rhetoric that seek to generate power and authority' (Ali 2000: 120), as well as tackling broader social constraints, including, for instance, the paternity rights of workers.

Barroso and Jacobsen (2000) highlight the construction of different 'core groups' for HIV/AIDS prevention strategies. Commercial sex workers (CSWs) have been seen as high-frequency transmitters of HIV and other sexually transmit-

ted diseases (STDs), and have been seen as objects of strategies that are largely designed to get CSWs to negotiate condom use with their clients, in order to prevent the spread of disease. They note (*ibid.*: 358) that 'CSWs have been treated as a 'separate' group of women, and development discourse and programmes have in practice paid little attention to the broader social and economic context of their lives and their subordination.' Heterosexual women who were not CSWs 'were largely invisible' in HIV/AIDS policies until recently, despite the fact that they represent the majority of HIV-positive women (Maine *et al.* 1994). It is now recognized that monogamous women are at risk from their partners, and that their economic dependence on male partners can increase their risk of infection if the partnership falls apart (De Zoysa 1996, and Elias and Heise 1994, cited in Barosso and Jacobsen 2000). Kemp's study of STDs in West Africa went further and concluded that understanding sexual behaviour needs 'to investigate the terms of the sexual contract within a cultural context' (1992: 76), thus echoing Bledsoe's warning that women were 'interpreting [official AIDS advice] through their own cultural categories or attempting to stretch their options to avoid the constraints posed by AIDS dangers and policy directives' (1989, cited in Kemp 1992: 76). While prevention programmes attempt to encourage condom practice within marriage, the development of microbicides for women that allow conception while protecting against HIV/AIDS is given marginal importance, despite a concerted campaign by feminist health activists (Maine *et al.* 1994; CHANGE 2001). International guidelines on HIV/AIDS and human rights have focused primarily on the rights of people living with HIV/AIDS, as well as on the rights of groups vulnerable to HIV/AIDS (UN 1998). While rights to life-prolonging drugs have at times been backgrounded (see FCO 2000; UN 1998), this position has been challenged by an active and, to some extent, successful international campaign addressing multinationals and international patents laws (see *Guardian* 2001). Progress has been made with respect to the prices of imported drugs in a few African countries, but the pandemic is also gaining momentum in other regions and countries where advocacy is less developed and the human suffering inflicted by HIV/AIDS has been given less media attention. Everywhere the issue of equal access to life-prolonging drugs at the national, local, and household levels remains a significant rights challenge.

Alternative statements of reproductive rights, such as Correa and Reichmann's (1994) feminist perspectives from the South, put questions of social justice more firmly on the agenda than the Cairo conference. Complex understandings of reproductive behaviour draw attention to the socially and culturally embedded nature of inequalities confirming the centrality of social and institutional factors in realizing greater reproductive health and freedom for all. While the PoA urges freedom from discrimination of all kinds, the lines of difference to which it gives prominence exhibit continuities from older population policies. Although disabled and indigenous groups are mentioned (UN 1994: Chapter VI), poverty is largely dealt

with in respect of questions of economic and population growth (*ibid.*: Chapter III), and the categories of social differentiation that are used most include female children/adolescents versus boys, women versus men, and women with early, low parity, well-spaced births, as opposed to women with high parity, closely spaced births. The differences in these ways of looking at inequalities implicitly reflect different understandings of the challenges to be met by reproductive health policy.

This difference of emphasis is perhaps best illustrated by the interpretation of empowerment within the official reproductive rights agenda. Despite considerable rhetorical emphasis on supporting empowerment, financial allocations are weak and remain focused on girls' education and on women's employment and income-generation (Barroso and Jacobsen 2000: 353). The contribution of these programmes to transforming underlying gender inequalities is highly questionable, and more radical interpretations of empowerment and reproduction suggest different foci for research and policy that include issues such as unwanted sex and unsafe sex (Presser and Sen 2000). The contradiction between the routine inclusion of empowerment in official reproductive rights agendas and the continuing controversy over women's reproductive and sexual self-determination (Keyzers 1999) is emblematic of the accommodations that have been made to secure consensus around the final PoA at the Cairo ICPD.

Selective Exclusions?

The official framing of reproductive rights has been pursued in a manner that effectively 'enclaves' (Fraser 1989) concerns focusing on reproduction and addresses them to an audience of reproductive health policy-makers and service-providers. This process not only influences the nature of inclusions in population policies, it also selectively excludes some interests and concerns from this agenda. Prominent among those raised by both social analysis and activists are how enabling conditions, including macroeconomic policy, international power relations, and fundamentalism, have been left off the agenda; how certain kinds of rights talk have occluded social differences, thus de-centring objectives concerned with social justice; and the reductionism of an approach that sees social institutional and cultural dynamics as undesirable traditions obstructing more modern and/or individuated forms of reproductive behaviour.

Despite the endorsement of reproductive rights, official social policy relating to reproduction continues to neglect 'enabling conditions and the absence of institutional and political environments that promote and protect rights' (Jacobsen 2000: 26), including poverty, globalization, privatization, fundamentalism, political movements, and the lack of transparency and accountability of governments, donors, and reproductive health services. These go to the heart of international power relations concerning reproduction and have concrete implications for the

capacity of 'better' reproductive health to contribute to improved well-being and freedom. Although the World Summit on Social Development (WSSD) established two international development targets reflecting reproductive health concerns (UN 1995), the ICPD at Cairo was notably out of tune with its 'social integrationist' perspective (Anon. 1995: 10–19) and was firmly embedded within a neoliberal economic agenda for health sector reform (Petchesky 2000). Ollila *et al.* (2000: 87) argue that, despite the rhetorical prominence given to reproductive rights at Cairo, 'the increased emphasis on the general market agenda was more important...as was evident in the greater stress on cost-recovery mechanisms and non-governmental agencies'. This neo-liberal agenda is widely seen as inimical to expanding the realization of reproductive rights, both directly—in terms of its residualization of social services and the consequences of shifting of caring burdens back to the household and exacerbating inequalities in health-seeking behaviours—and indirectly, by undermining livelihoods and social security, and creating conditions of vulnerability which lead to ill-being, powerlessness, and the greater commodification of women and sex (Barroso and Jacobsen 2000: 358).

Keyzers puts the view of many feminist observers succinctly when she says that 'the broad concerns of women's health were narrowed down to reproductive health only and to a de-politicised plea for more choice in contraceptive means' (1999: 21). Southern women's groups have been instrumental in broadening the understandings of international women's health advocates about reproductive health, and in particular have stressed the importance of embedding reproductive behaviour within material interests. However, livelihoods, and even concerns relating to social reproduction and parenting, were marginalized in the Cairo PoA. Although reproductive health targets are now more prominent in international social policy, concern for reproductive rights has not penetrated important arenas. For example, the development of voluntary codes of conduct is now a significant component of emerging mechanisms for the global regulation of capital, but as Pearson and Seyfang (2001) point out, none makes specific reference to the known violations of sexual and reproductive rights that occur within export processing factories. These include, among other things, loss of employment following pregnancy, enforced contraception and pregnancy testing, and restrictions on taking toilet breaks.

Control over the population agenda and responsibility for delineating and monitoring reproductive rights are disproportionately influenced by Western powers. The continuing inequality between North and South in international policy arenas has given rise to calls from international women's health advocates for reforms of international financial institutions and international organizations. The role of the Roman Catholic Holy See within the UN has come under repeated criticism and was again highlighted at Cairo after Islamic fundamentalist groups and the Holy See attempted a strategic alliance against abortion and perceived threats to religious and family values. Although supposedly set within an international

human rights framework and therefore universal in outlook, the reproductive rights agenda remains one in which the North addresses the South in many important respects. Keyzers notes that 'the reformulated population agenda...still tends to keep attention and funding narrowly focused on fertility management in the economic South' (1999: 20). In the United States, a major player financially and politically, support for rights approaches to population concerns has been weak, and traditional support for family-planning efforts continues to be motivated by perceived threats to the environment, the global economy, and international security (Jacobsen 2000). Keyzers argues that, in these ways, population policy categorizes populations into the 'wanted' and the 'unwanted', 'the "us" and "them"' (1999: 20), and that scrutiny of developed and donor country population policies, including immigration policies, is overdue.

Official talk on reproductive rights has curiously occluded key processes of social exclusion, despite the traditional association of rights discourse with concerns regarding social justice. Reproductive rights have been constructed in international social policy in ways that divert attention from concerns regarding social structural inequalities, power, entitlements, and freedom. Considerable research has shown that reproductive experiences are differentiated not only in terms of sex, age, and parity, but also potentially in terms of gender, life stage, social identity, wealth, ethnic group, caste, location, political affiliation and other lines of inequality (see Greenhalgh 1995). For example, Lane *et al.* (1998: 1089), looking at the 'economics of abortion safety' in Egypt, confirm that reproductive rights are differentiated by poverty. Ram (1994) shows how class and caste shape women's experiences of medical institutions around childbirth in Tamil Nadu, while Reyssoo (1999) describes how a complex series of life stages structures women's sexuality in Morocco. Reproductive health policy has been slow to engage with these differences in interpreting the needs of different reproductive and sexual health interest groups, and this reluctance is manifest in the continuing disengagement with questions concerning well-being, and narrow approaches to entitlements and sexual and reproductive freedoms. International monitoring of reproductive rights is poorly developed and focused on assessing reproductive health. Traditional population indicators such as total fertility rates and contraceptive prevalence rates remain pre-eminent in WHO guidelines for global monitoring, despite a review carried out in the light of the Cairo conference (WHO 1997a). As Graham says, 'concerted research effort is needed if those activities related to well-being, rather than to ill-health, which were endorsed in the Cairo ICPD, are to be tracked for progress' (1998: 1926).

It has been widely acknowledged that although human rights discourses have been used world wide by social movements in making claims for greater well-being and freedom (Petchesky 2000; Ferguson 1999), they are rooted in Western liberalism and its vision of the individual. For example, the PoA bestows reproductive rights on 'couples and individuals' (UN 1994: Para. 7.3), thus side-

stepping thorny questions about power struggles between 'couples' and alienating such struggles from the relational context of child-bearing and processes of family-formation in developing countries (see Ali 2000; Harcourt 1997). Although it is rarely acknowledged in rights debates, sexual and reproductive strategies within developed countries are also relational to varying degrees and in varying ways: everyday occurrences include subtle and not-so-subtle pressures from partners, parents, in-laws, and peers, including to begin child-bearing once married, to avoid child-bearing outside marriage, to select particular types of marriage partner, or to have a certain number of children and to nurture them in specific ways. These interests within developed countries may sometimes have less economic content than strong emotional, cultural, or religious significance, and undoubtedly have a real impact on sexual and reproductive experiences.

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

Although theoretically the international human-rights framework makes room for local interpretations of what fundamental rights mean in specific contexts, in reality almost no official attention has been given to considering what reproductive rights might look like in different places. The International Reproductive Rights Action Group (IRRAG) have conducted sensitive research into the cross-cultural meanings of reproductive rights that confirm an ethical core of agreement over fundamental rights, while demonstrating local variation in expression (Petchesky and Judd 1998). Freedman and Isaacs (1993: 18) stress that we 'need to examine much more closely what we really mean by an individual human right to reproductive choice, freedom, or autonomy in a world as demographically complex and culturally diverse as ours'. However, the international reproductive rights agenda is ambivalent and inconsistent in relation to local social practice and culture. For example, international statements that condemn female genital mutilation—which is normative for particular ethnic groups—as a 'harmful "traditional" practice' (WHO 1997b: 1) suggests that the 'good' and 'bad' parts of culture can simply be

retained and weeded out respectively. Despite the rhetoric that justifies the rejection of 'harmful "traditional" practices', official discourse on reproductive rights pays almost no attention to 'beneficial "traditional" practices' (ibid.). Nevertheless, research has shown that 'traditional' social relations can perform important reproductive and sexual health functions that may be marginalized by the pace of contemporary changes, thus leaving an important vacuum in respect of knowledge, social care, and support. For example, Kinuthia-Njenga (1999) argues that the breakdown in social and family traditions is leading to poor sexual and reproductive health for poor women at different life stages in Nairobi's slums. Similarly, Harcourt notes that in Ghana, 'modernity has disrupted traditional knowledge-transfer of reproductive health and sexual behaviour, so that grandparents, once so important in educating young people at puberty, are no longer consulted, and birthing rituals involving the whole family are now abandoned' (1997: 3).

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

Despite broad rhetorical support for rights-based approaches to reproductive and sexual health, this has rarely been conceived in terms of expanding sexual and reproductive freedoms. While it may be desirable to support the expansion of comprehensive reproductive health services, it is important to recognize that both research and activists point to other lines of action that some argue are more critical in expanding freedoms (Pillai and Wang 2000). Although there is scope for legal reforms, legal literacy, greater accountability and consultation over social policy, and supporting the development of reproductive rights organisations and related strategies aimed at changing social and gender norms and practices, the rights element of this agenda has been largely conceived of in terms of improving client rights. Reproductive health policy needs to go beyond respecting the 'rights

of the client' in order to focus on strengthening entitlements to sexual and reproductive freedoms and care through informal and formal social institutions. As Cornwall and Gaventa (2000) point out, a rights-based approach also means re-figuring clients as rights-bearers who have a role in making and shaping policy and services. Reproductive and sexual empowerment has a collective dimension, and support for greater accountability nationally and internationally needs to take stock of the fact that everyday entitlements to sexual and reproductive rights can only be improved by transforming social values. The advocacy of self-articulated priorities by different sexual and reproductive interest groups has an important role to play in legal, policy, and social change.

Future Challenges?

We have argued that reproductive health policy has responded to the increasingly sophisticated social analysis of reproductive behaviour and to the consensus concerning reproductive rights by constructing needs in ways that extend rather than transform policy-making. This response does not adequately engage with the differentiated interests and needs of rights-bearers, nor does it address the complex and ambiguous nature of power and autonomy in reproductive and sexual relations at the individual, community, or global levels. Selective inclusions and partial exclusions are not simply oversights but bear the marks of older political and professional interests that continue to shape the population agenda. The identification of social categories 'in need' of reproductive rights remains largely informed by biomedical perspectives and the motivation of overcoming constraints to the success of programmes. The underlying motivation of inducing lower fertility remains influential and has encouraged instrumentalist interpretations of the empowerment agenda. The perspective on culture is ethnocentric, focusing on 'obstacles' and 'harmful' practices in the South, and denying the social context of reproduction in developed countries. The 'project' is defined as extending and improving comprehensive reproductive health services, thus backgrounding social change and political action concerning sexual and reproductive norms and entitlements. The challenge for the future therefore cannot just be seen technically as one of improving the social analytical content of policy, but must also be seen politically as one of transforming the way reproductive rights, needs and policy are defined, interpreted, and addressed. Social analysis can inform and support this process, but the business of creating forces that can use the consensus over rights to articulate the claims of disadvantaged groups for sexual and reproductive freedoms and well-being is a much broader undertaking.

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