

Critical Issues in Reproductive Health

**Rights, Technology, and Services
in Reproductive Health**

P O P U L A T I O N C O U N C I L

**Rights, Technology, and Services
in Reproductive Health**

**Rights, Technology, and Services
in Reproductive Health**

A Report from a Meeting

**6-7 May, 1999
Population Council
New York, NY**

The Population Council is an international, nonprofit, nongovernmental institution that seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries.

The Council's Robert H. Ebert Program on Critical Issues in Reproductive Health, established in 1988, responds to an awareness that many important reproductive health problems—and the ways women experience them—have been neglected by policymakers, program planners, and practitioners. Currently the Program focuses on several areas that merit special attention: improving the quality of services in reproductive health programs, managing unwanted pregnancy and preventing the consequences of unsafe abortion, devising new approaches to postpartum care to meet the health needs of the mother and child, and designing programs that address sexually transmitted diseases, including AIDS, within the larger context of women's reproductive health.



The Robert H. Ebert Program
on Critical Issues in Reproductive Health
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017 USA
(212) 339-0500
Fax: (212) 755-6052
E-mail: pubinfo@popcouncil.org
www.popcouncil.org

© 2000 by The Population Council, Inc.



Cover and text printed on recycled paper in the USA

Acknowledgments

This report was compiled by Marion Carter and Elizabeth McGrory. We are grateful to the seminar presenters and participants for their willingness to join us in exploring this interesting and complex subject matter, and especially to Shelley Clark and Lynn Freedman who offered valuable comments on an earlier draft of this report. We also thank colleagues in the Robert H. Ebert Program on Critical Issues in Reproductive Health for their review and suggestions on earlier drafts. Special thanks to Sarah Braunstein and Virginia Kallianes for their assistance in organizing the meeting and in preparing this manuscript for publication.

We greatly appreciate the support of Swedish International Development Agency (Sida) and the John D. and Catherine T. MacArthur Foundation for the seminar and publication.

Introduction

The scope and quality of reproductive health programs rests on three key pillars: rights, technology, and services. Each of these elements intersects with the others in important and complex ways. First, several new reproductive technologies such as medical abortion and emergency contraception not only have the potential to increase women's autonomy and control over reproductive choice, but also to change the relationships between service providers and clients. Second, growing attention to the quality of care within reproductive health services has underscored the central importance of service delivery in introducing and providing reproductive technologies in a manner that is ethically sound and respects clients' rights. Finally, the debates and documents surrounding the United Nations International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995 helped to codify and popularize the notion of rights as a critical framework and motivating force for both population policy and reproductive health services.

This current situation has evolved from an interesting and complex history. In countries of the North, the right to control one's own fertility through access to contraception and abortion services has been central to feminist thinking and activism for decades; the "birth control" pill and legalization of abortion were key substantive and symbolic issues for the second wave of feminism starting in the 1960s. While there have been real problems with how reproductive technologies were used in some communities, advances in fertility control were generally viewed positively and credited with facilitating women's autonomy and greater participation and progress in the public sphere. In contrast, in many settings in the South fertility regulation technologies were introduced primarily for the purpose of controlling population growth rather than facilitating the exercise of individual choice. Much of the critique of population programs has centered on the violation of rights, including rights to autonomy and individual choice in contraception, and the need to protect women's health and rights in the process of testing

Selections from the Programme of Action of the 1994 International Conference on Population and Development

While the International Conference on Population and Development does not create any new international human rights, it affirms the application of universally recognized human rights standards to all aspects of population programmes. (Chapter I, 1.15)

All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind....Everyone has the right to life, liberty and security of person. (Chapter II, Principle 1)

Advancing gender equality and equity...and ensuring women's ability to control their own fertility, are cornerstones of population- and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. (Chapter II, Principle 4)

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education

and providing these technologies. In the past decades, many activists in these settings have viewed reproductive technologies as antithetical to, rather than facilitating, individual autonomy and reproductive rights.

In reality, reproductive technologies, including contraception, cannot meaningfully be assessed in isolation as inherently “good” (facilitating individual choice) or “bad” (hindering choice). Rather they must be examined and understood in context. From a rights perspective, evaluating these technologies must start with questions about who controls the technology and to what purpose it is used. Furthermore, these technologies are so inextricably linked with the services and people that provide them that considering technologies and services separately is not meaningful. Indeed, a number of new reproductive technologies, like medical abortion, emergency contraception, and microbicides, hold the promise of changing the relationship between technologies and services by being more directly within the control of women.

Finally, there are multiple and complex links among services, technologies, and rights. While there has been significant progress at the international level in articulating and codifying a rights-based framework for reproductive health, the implications for this “on the ground” are still being explored. What is the meaning of reproductive rights in the absence of services that enable women to exercise reproductive choice? How can a rights framework be used to advocate for quality services? What other considerations, such as autonomy, mobility, and financial resources, are key to making rights real for women?

The Population Council’s Robert H. Ebert Program on Critical Issues in Reproductive Health convened a two-day meeting to explore some of the compelling issues at the intersection of technology, services, and rights. Some 70 professionals from the research, policy, service delivery, human rights, and advocacy fields came together to grapple with some of the political aspects of reproductive technologies. Participants also discussed how these technologies can facilitate or constrain rights, depending on the interests involved and the particular social, political, and economic contexts in which they are used. Participants first reviewed the fundamental values and meanings behind reproductive rights and then explored several concrete examples that demonstrate how a rights perspective can influence formal policy, express individual notions of entitlement, and transform service delivery. Several compelling cases served to illustrate some of the physical, economic, and information barriers people can face in trying to exercise even those reproductive rights that formally exist. Participants considered the key role that information plays in facilitating individual choice and autonomy by examining the concepts of informed choice in family planning services and informed consent in research. In one session, speakers considered some of the reasons that different reproductive health technologies are viewed either positively or negatively in different settings, especially from the perspective of women’s health advocates and activists. Finally, participants considered the potential implications of a particular reproductive technology—medical abortion—along the dimensions of rights and services. This report summarizes a number of the key points raised by presenters and participants throughout the meeting.

Rights and Reproductive Rights: Conceptual Tools and Questions

Despite its wide and growing currency among groups and individuals working in the population and reproductive health fields, the concept of reproductive rights has many different meanings and is understood and used in many different ways. Therefore, a logical first step for the gathering was exploring the fundamental values and ideas behind reproductive rights and how the concept is understood and used in a variety of contexts.

The essential values and ideas behind reproductive rights derive from the basic notion that control over the body and over reproduction and sexuality is a fundamental aspect of human dignity and what it means to be human; as such, this control is considered a universal right. However, individuals are not isolated; rather, their lives are linked to family, community, and the state, all of which have multiple economic, political, and cultural dimensions. These contexts can function to support or constrain an individual's control over his or her body, reproduction, and sexuality. The actual meaning of reproductive rights for an individual woman is powerfully influenced by the values and meanings accorded to women's status and roles in society and to reproduction itself. Furthermore, women's reproductive capacity has, in different times and places, been used as a primary tool for many social, political, and commercial objectives, including population planning, religion, and enforcing distinctions of class, caste, and race.

The term "rights" is used in many different ways, and it is critical to draw out clearly both the distinctions and connections among them. "Rights" is often used to refer to formal law, enforceable through formal legal institutions. Often the norms most directly relevant to actual practice are found in local codes and customary law. These may be written or unwritten and may also include customary and religious systems. In practice, legal systems and activists can challenge and shape these local codes and laws by drawing on the broader principles of rights that are often found in national constitutions. For example, in the United States, the right to privacy implied in the Constitution has been a central principle on which laws related to contraception and abortion have been upheld or struck down. On a global level, human rights are defined in a body of formal international law found in conventions and treaties. Once ratified, formal human rights law obligates states to uphold rights in three distinct ways: through the respect, protection, and fulfillment of those rights. However, in the area of economic, social, and cultural rights (such as the right to health), human rights law obligates a state to take steps to the maximum of its available resources toward the progressive realization of the right. However, the local, national, and international systems of law are not related to each other according to a simple hierarchy. For the most part, human rights law does not function as a "super-constitution," and has no real controlling power unless a state chooses to accept it as such. Therefore the actual ramifications of implementing human rights as "law" are not straightforward.

The term "rights" may also be used as an expression of people's entitlements—how individuals think about what is fair and just. Rights in this sense (for example, the right to sexual pleasure) can play a critical role in shaping context, but are not generally enforceable in law or in court. Finally, rights—especially human rights—can serve as a powerful social and political tool to transform priorities, analysis, and ways of thinking. Recent developments in the population field serve as a

compelling illustration of this notion. The International Conference on Population and Development (ICPD) held in Cairo in 1994 is widely referenced as a turning point in the recognition of the rights-based approach within the mainstream population and family planning field. The ICPD Programme of Action states:

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic 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, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. (Chapter VII, Section 7.3)

This language represents an important step: It is an elaboration of international law and rights of entitlement based on fundamental human rights. While rights concepts and language have been included in key international population documents since the 1960s, until the 1990s the notion of human and reproductive rights served primarily as a *limiting* factor—as a marker of when programs and services had gone “too far” and violated individuals’ rights. More recently, fulfillment of rights has become a key formative factor, or the *raison d’être*, for many people and institutions in the population field. These three dimensions of human rights—formal law, expression of entitlement, and the means to effect social and political change—are linked, and each influences the others.

Choice and consent are central to a discussion of rights, technology, and services. Rights can be used to analyze questions of choice and consent in a number of different ways depending on the way rights language is being used. For example, in U.S. law, rights, and especially reproductive rights, are interpreted as a very minimal concept limited to a relatively narrow idea about individual autonomy. In essence, rights in U.S. jurisprudence are used as a means for shielding personal choice from government intrusion; they are not used to describe an affirmative obligation of government to ensure access to services. For example, women have the right to an abortion, but no clear entitlement to the conditions that will enable them to exercise this right. In this connection, while a formal legal analysis might reveal that the government has very limited obligation, analysis of the same question from a human rights perspective, using rights principles and not simply formal law, would likely yield a different and far broader answer. Taking this further, this human rights framework can be used to press, for example, for the conditions needed to provide contraception optimally—such as technically qualified providers, screening for contraindications, comprehensive counseling, range of method choice, treatment for side effects, and so forth.

Another critical dimension of the analysis of the relationship between rights and choice begins with the recognition that all the conditions that either make choice possible—such as information, access to services, and education—or that burden it—such as incentives, targets, and poverty—are filtered through structures of inequality. The specific structures may differ across cultures, but race, class, and gender play a powerful role in virtually all settings. These structures shape the real meaning of individual liberty and individual autonomy in all societies and at the global level.

Therefore, an approach to rights that focuses only on individual liberty is one that inevitably privileges the powerful and affluent, as it draws only on their experience of liberty and choice. Considering individual autonomy without also addressing conditions of social justice or equality is a political choice. Conversely, an approach to liberty that focuses on the disempowered and most vulnerable in society—that understands choice from the perspective of those who are encumbered by poverty, discrimination, and violence—will insist on linking individual liberty with social justice. Connecting individual liberty and social justice in a way that makes choice meaningful for all women remains the key challenge when considering rights, choice, technology, and access to services.

Reproductive Rights in Action

The contextual and politicized nature of reproductive rights and the formal language used in international documents and laws has fostered a critique from some quarters that reproductive rights is not a meaningful concept in some cultural contexts and has limited utility to inform actual programs or services. The following section challenges this notion by illustrating how the concept of reproductive rights has been put in action in varied settings using the approaches of formal law and policy; how individuals perceive and express their entitlements; and applications to service delivery.

Formal Law and South Africa

South Africa's reproductive rights policy provides a striking example of an effort to draw on a reproductive rights framework to develop formal national policy, law, and practice. The country emerged from the apartheid era with stark inequalities in health status and health care. Choice of contraceptives and other reproductive services and technologies was very limited for all but a small, mainly white, portion of the population. However, when a democratic government came into power in 1994 and a new constitution was drafted, South Africa was in a position to make progressive change. The government was committed to social reform, and the country underwent transformation at a time when sexual and reproductive rights were high on the international agenda. Progressive activists seized this opportunity to organize locally to ensure that women's rights were accorded high priority when new policies and health services were developed. A network of national women's groups played a key role in developing and reviewing draft national policies on women's health, such as a national health bill and a liberal law legalizing abortion. Importantly, these policy changes, which were made with wide participation of social and community groups, also established new mechanisms to help safeguard these principles and rights.

The new South African constitution focuses on reducing the social injustice, institutionalized racism, and inequality that violated both group and individual human rights. It emphasizes protection from discrimination for all people on the basis of sex, race, ethnicity, age, marital status, pregnancy, and sexual orientation, among others. In particular, it promotes women's rights with explicit reference to reproductive health and violence against women. The government has also signed on to many of the major international human rights conventions and treaties that address the sexual and health rights of women.

While the articulated national policy is exemplary in its attention and dedication to human and reproductive rights, the nation is now grappling with the challenge of making these policies a reality. South Africa's history and circumstances have presented significant obstacles to realizing the vision

outlined in policy. Resources are limited, and the high and growing level of HIV in the population, as well as social violence and entrenched racism and sexism are impeding efforts to improve reproductive health care and make reproductive rights a reality for much of the population. For example, there have been a number of obstacles in implementing services to meet the goals of the abortion law. Abortion services have been well established in areas where good facilities and management already existed, and this has resulted in a rise in safe, legal abortions and a decrease in “back street” abortions. However, it is clear that many poor and rural women continue to be disadvantaged by lack of access to abortion services. Providing safe, good abortion services has been further hampered by the attitudes of health care providers who object to abortion or look down on their clients and refuse to provide the services. Advocates contend that retraining is needed not only on the technical aspects of the technologies and services, but also to promote gender equality and reproductive rights. Finally, culturally-sensitive public education is needed to ensure that people, especially young people, acquire knowledge about their health, sexuality, and rights. Thus, while the formal law and policies regarding reproductive rights in South Africa are comprehensive and in many ways exemplary, this example illustrates the difficulties that countries, communities, and advocates face as they work to make real a vision outlined in policy.

People’s Entitlements and the International Reproductive Rights Research Action Group

In addition to formal law, many people use rights language and concepts to capture their own sense of entitlement—how they understand and articulate what is fair and just. This notion of entitlement and the exact form of its expression may differ significantly by social context and from individual to individual. However, the degree to which

Learning from Women’s Voices About Reproductive and Sexual Rights: IRRRAG Findings

“I am the one to make decisions where family planning is concerned. After I decide, then I tell him that we should not have so many children, or that we should not space them so closely....Child-bearing is not by him....Getting up in the middle of the night to give them milk, taking them to the doctor when they are ill—all this is my responsibility. He does not suffer, the suffering is all done by me. So when I tell him that we need to use the contraceptive, he cooperates.” (Malaysia)

“I think that this decision should always be made by women. In my case I was the one who decided. When I had the second child I went to the Family Planning Department and asked for contraceptives. My husband got mad, but I told him I didn’t care and that I didn’t want to get pregnant.” (Mexico)

“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.” (Brazil)

“Religion and health are two different matters.” (Philippines)

“Sometimes when the baby was little he would bother me and I would say, ‘No, I’ll get pregnant again.’ One day he hit me very hard [with a shoe] because I said no....It was always forced, even now I have to run away to the street...” (Mexico)

“I had an abortion once. I was using a loop but I got pregnant....I never told anybody that I did it to myself, not even my husband. He is a religious man. I was afraid of God’s punishment, but at the same time I wonder, does God accept the suffering of the whole family if I have to stop work?...” (Egypt)

“[Birth control] is not in the church’s domain.” “It is not the church that will go hungry and experience poverty.” (Philippines)

personal entitlement is expressed across cultures and class using human and reproductive rights concepts and language challenges the notion that such rights are a “luxury” of international discourse and formal legal systems and are divorced from the reality of many people’s lives.

This idea of rights as an expression of an individual’s own sense of entitlement and fairness emerges strongly from the work of the International Reproductive Rights Research Action Group (IRRRAG). IRRRAG is an international consortium of researchers, activists, and health providers who collaborate on field research among diverse women to contribute to a better understanding of what is needed to empower women of all ages, classes, and ethnic groups to realize their aspirations regarding reproduction and sexuality. From 1993–96, IRRRAG’s international research teams conducted a seven-country study¹ that examined how ordinary women from all regions of the world talk and think about their reproductive lives and how societal factors influence their experience.² The research was organized around four topics: concepts of entitlement; reproductive decisionmaking and behavior; resistance and accommodation; and social, political, legal, and economic conditions. Based largely on in-depth qualitative research among hundreds of women, these studies show that notions of reproductive rights have profound resonance in the day-to-day lives of women among all social classes and in many diverse settings around the world.

The research demonstrates that women generally feel strongly that they should be able to make their own decisions about sexuality, childbearing, contraception, and, if necessary, abortion (whether or not it is supported in their social context). In particular, motherhood—with its status, burdens, and responsibilities—served as the primary basis for this sense of entitlement. At the same time, women are acutely aware of the multiple factors that constrain their ability to act independently, or force them to act in secrecy, including community and religious norms; the opposition of kin, husbands or partners, and public authorities; lack of material or financial resources; and poor quality of services. The researchers found consistently that the reality and threat of domestic and institutional violence plays a crucial role in shaping the degree to which women feel they can make and exercise their choices. IRRRAG’s research also elucidates some of the varied subtle strategies women employ to act on their sense of entitlement, whether through outright resistance, silence, or subterfuge, or by acceding to certain traditional gender roles in order to gain latitude in other areas. Thus, women’s notions of autonomy and entitlement are tempered by a pragmatism about the constraints and expectations society imposes on them.

IRRRAG’s studies highlight the universality of reproductive rights as an expression of personal choice and entitlement. While the women interviewed often had little knowledge of formal laws or “reproductive rights,” their sense of entitlement to choice and autonomy in some reproductive decisionmaking was both shared and strong. The documents and treaties that outline formal “rights” may be far from many women’s lives, however, rights concepts do play an important role in the lives of women from a variety of social classes and cultural settings.

¹ Brazil, Egypt, Malaysia, Mexico, Nigeria, Philippines, United States.

² *Negotiating Reproductive Rights: Women’s Perspectives Across Countries and Cultures* (Rosalind P. Petchesky and Karen Judd, eds., New York: St. Martin’s Press, 1998) is a compendium of the results from this project.

Developing and Implementing the International Planned Parenthood Federation's Charter on Sexual and Reproductive Rights

Within the international family planning and reproductive health field a number of programs that once drew their motivation and justification primarily from demographic and health perspectives are now drawing on reproductive rights as an important principle to guide service provision. For example, the International Planned Parenthood Federation (IPPF) has worked with its broad network of affiliates and service providers to incorporate a reproductive rights perspective into its work. One important tool has been the creation and promulgation of the 1996 IPPF Charter on Sexual and Reproductive Rights. The Charter explicitly links the human and reproductive rights language codified in international documents, such as the ICPD Programme of Action and the Universal Declaration of Human Rights, with service provision by outlining in clear language the implications of a rights-based approach for reproductive health services. The Charter is designed to demonstrate that reproductive rights are not abstract concepts, but, rather, are directly relevant to services and as such signify a new and better way to approach service provision. The initiative seeks to turn the principles underlying rights into practice in a way that is relevant to service delivery in a range of settings. For example, the connection is made explicit between the right to privacy and the right to confidentiality when using sexual and reproductive health care services. The Charter also states that individuals have the right to decide whether or when to have children, and their spacing, which requires access to information, education, means, and services if they are to exercise this right. IPPF has encouraged local adaptation of the Charter, and the twin nature of reproductive rights as both universal and particular is a prominent theme in IPPF's advocacy campaigns. The Charter has been used by local advocates to link rights language with programs and services. For example, in Africa, the medical associations of Kenya and Tanzania requested copies of the Charter to disseminate to their members as part of a campaign on medical ethics. PROFAMILIA in Colombia produced materials that explain the 12 rights outlined in the Charter and identify one issue per right relevant to the local setting.

Reproductive rights as manifested in formal law, individuals' sense of entitlement, and service delivery can conflict, even within the same social context. The formal law of a country may reflect one concept of reproductive rights, while its people hold another. The case of South Africa demonstrates how services may lag behind the formal rights designated in law and policy or as understood by people; in other situations, services may far exceed what is conferred in law. This tension can be used to work for constructive solutions and change. Advocacy campaigns and services drawing on a rights-based approach can raise awareness and offer new ways for individual women to think about and express their own entitlement, which can create pressure on

IPPF Charter on Sexual and Reproductive Rights

9: The Right to Health Care and Health Protection

IPPF recognizes and believes that all persons have a right to the enjoyment of the highest attainable standard of physical and mental health and, therefore, commits itself to the following:

- 9.1 All persons have the right to the highest possible quality in health care including all care related to their sexual and reproductive health.
- 9.2 All persons have the right to comprehensive health care services including access to all methods of fertility regulation including safe abortion and diagnosis and treatment for infertility and sexually transmitted diseases including Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS).
- 9.3 All persons, and in particular the girl child and women, have the right to protection from traditional practices which are harmful to health.
- 9.4 All women have the right to pregnancy and infertility counselling which empowers them to make their own decisions, based on information impartially presented.
- 9.5 All persons have the right to sexual and reproductive health care services as part of primary health care, which are comprehensive, accessible, both financially and geographically, private and confidential and which pay due regard to the dignity and comfort of that person.
- 9.6 All women have the right to appropriate services in connection with pregnancy, confinement and post-natal health care, as well as adequate nutrition during pregnancy and lactation.
- 9.7 All persons have the right to the protection of health, and safety in working conditions, including the safeguarding of the function of reproduction.
- 9.8 All working mothers have the right to be accorded paid maternity leave, or maternity leave with adequate social security benefits.

AND further commits itself to taking all steps to ensure the attainment of the following rights:

- 9.9 Every person has the right to sexual and reproductive health care including the following rights:

- Information* about the benefits and risks of all fertility regulation methods
- Access* to the widest possible range of services
- Choice* to decide whether to use services, and which contraceptive method
- Safety* concerning the methods and services made available
- Privacy* when being offered information and services
- Confidentiality* regarding personal information
- Dignity* when using sexual and reproductive health care services
- Comfort* concerning the quality of care of services offered
- Continuity* guaranteeing future availability of services
- Opinions* about the service offered

Source: International Planned Parenthood Federation. 1996. *IPPF Charter on Sexual and Reproductive Rights*. London: IPPF.

governments to modify laws and policies and contribute to bringing about change in the prevailing social norms regarding reproduction and rights. The South Africa situation, though somewhat particular, demonstrates how a rights-based advocacy campaign can lead to change in policies and contribute to raising expectations among women as to the services they believe they are entitled to. The IRRRAG research results are also being used by activists around the world to press for change. In Egypt, for example, research team members used the study findings and the IRRRAG framework, with its focus on rights and entitlement, to aid their successful campaign against government support of female genital cutting procedures in public hospitals.

Barriers to Making Reproductive Rights a Reality

Even with agreement on the individual's right to autonomy over reproductive health decisions and to choice of contraceptive method, a rights framework cannot ensure access to services or technologies. In order for individuals to exercise their right to choice through use of a particular service or technology, they need information about the service or technology, physical access to it, and the economic means to access it. In reality, people's choices are shaped and often restricted by economic, physical, and informational barriers that limit access to services or technologies. Participants at the meeting considered several examples that illustrate how these barriers can constrain the realization of reproductive rights. In each case, a variety of barriers existed simultaneously and, in some instances, over time, as efforts to eliminate one barrier precipitated the emergence of another. In all these cases, concerted efforts are being made by activists, providers, and communities to eliminate these obstacles or to mitigate their effects so that individuals may realize their rights.

Access to Abortion in Brazil

While most abortions in Brazil are criminalized, since 1940 women who have been raped or whose lives are threatened by continuing a pregnancy have been legally entitled to an abortion. In reality, however, women face multiple barriers to exercising this right. Women who are entitled under formal law to an abortion either remain unaware of this right or find it nearly impossible to find services or technologies that will allow them to realize it. Until recently there were almost no abortion services available, and even now this vast country has only a few abortion providers. In addition, bureaucratic obstacles prevent women from gaining access to these few providers. A qualitative study conducted in Brasília in 1998 by the Population Council indicates that the vast majority of women who are entitled to a legal abortion and initially desired one are unable to obtain one. Women are not well informed about their rights and available services and thus are fearful and uncertain about the process. Typically, even if rape victims find their way to a health care center they are treated with hostility and are not referred to the proper facilities. Some women must repeat their stories sometimes several times, and in a setting that lacks privacy, often to be told that there is nothing that can be done. They are not told about emergency contraception and generally receive no information about abortion services should they become pregnant. It is not surprising, therefore, that by the time women eventually reach a reliable abortion provider, many of them are past the 12-week gestational age limit.

The findings from the Council study sparked considerable interest: In addition to generating two newspaper articles on this topic, there are plans to present the findings to a local legislative body and to hold a workshop for judicial professionals. As a result, efforts are underway in several parts of Brazil to train more providers, encourage institutions to make services available, and streamline the process for certifying and obtaining a legal abortion. In the future, it is possible that new abortion technologies, such as manual vacuum aspiration and medical abortifacients, could also play a role in making these services more widely available by expanding the number of providers qualified and willing to offer them.

Emergency Contraception in the United States

The history of the availability of emergency contraception (EC) in the United States illustrates the interrelationship between technology, services, and rights, and how the kinds of barriers around a particular technology can shift over time. Initially, the primary barrier to EC was lack of information: For years the Yuzpe regimen of EC was an inexpensive, off-label application of widely available oral contraceptive pills to help prevent pregnancy following unprotected sex. However, this regimen was not registered with U.S. regulatory agencies; thus, information about EC was limited. In 1997, use of contraceptive pills for EC was effectively preapproved when the U.S. Food and Drug Administration made an official statement that declared the method safe and effective, despite the fact that no commercial entity had filed for product registration. Thereafter, information about the method became more widely available to providers and clients. The method—in reality just a small number of inexpensive contraceptive pills—soon encountered economic barriers, however. Concerned about liability and low profitability, large companies showed little interest in marketing a dedicated EC product. When, in 1998, a small pharmaceutical company decided to market EC as Preven[®], the product included a pregnancy test kit with the EC pills, which has made it relatively expensive. In addition, some pharmacists have refused to sell Preven[®], charging that it is an abortifacient. Thus, as information about this relatively simple and inexpensive method has become more widely available, it has also become more expensive and encountered other kinds of resistance.

Hospital Mergers in the United States

Changes at health care institutions can create new barriers that prevent women from exercising reproductive rights to which they are formally entitled and have previously enjoyed. The relatively new and growing phenomenon of mergers between secular and religious hospitals in the United States has created profound barriers to physical access to reproductive services and technologies in some communities. Increasingly driven by market forces, U.S. hospitals are under pressure to cut costs; and merging with neighboring hospitals has become a primary cost-cutting strategy for many institutions. Particularly in smaller communities, these mergers often occur between secular and Catholic institutions, a corollary effect of which can be that the Catholic Church's ideology then determines what services the new hospital offers.³ In a number of communities, this has meant the elimination of most reproductive health services from the area hospital—including not only abortion, but also fertility treatment, sterilization, and contraception. This happens either formally as part of the merger agreement or de facto through increased use of “conscience clauses,” by which individual providers refuse to offer certain reproductive services and technologies. Inevitably, this chain of events also presents economic barriers that affect poor women disproportionately, because they have fewer resources that would enable them to seek other service providers or travel to distant services.

³ All Catholic hospitals are governed by a set of religious principles known as the *Ethical and Religious Directives for Catholic Health Care Services*, issued by the National Conference of Catholic Bishops. This document contains 70 rules that spell out which services can or cannot be provided, depending on whether they are deemed “morally and spiritually harmful.”

In a number of settings, community activism has played a large role in mediating the effect of these mergers and preserving all or some of the services and technologies that allow women to exercise their reproductive rights. For example, in New York State's mid-Hudson Valley, two nonsectarian hospitals announced plans to merge with a Catholic hospital. The two hospitals would have been required to follow the Catholic directives on allowable health services, and a wide range of reproductive health services would have been lost, including tubal ligations and vasectomies, contraceptive counseling, abortions, and infertility treatment. The hospitals proposed to refer women seeking the banned services to a separate, unrelated women's clinic. However, community members objected on the grounds that this option would fragment health care, was financially infeasible, and would subject women seeking these services to harassment from anti-abortion protesters. Women's groups and community activists engaged in a two-year struggle against the proposed merger. Individuals and interest groups formed a broad-based coalition; reached out to community members, including local religious leaders, business people, health care providers, advocates, and political leaders; and put pressure on the hospitals to reject any collaborations that would result in restrictive religious-based rules and the loss of health care services. The coalition prevailed and the merger was called off. Yet, in six other locations in New York State alone, similar mergers have been completed, and critical reproductive health services in those areas have been lost. Nationally, nearly 130 similar mergers have compromised women's access to reproductive health services and technologies.

Informational Barriers and the Power of Information: A More In-depth Look

Information plays a critical role in individuals' ability to exercise their rights. Information about what those rights are, what services are available, how to access them, and about the qualities of different technologies is critical in order for women to make truly informed choices among different providers, services, and technologies. Lack of information is a clear barrier to realizing rights to choice, as is information that is biased, misleading, inaccurate, or misunderstood. Providers and researchers possessing information have a moral, and in some cases legal, obligation to ensure that it is conveyed and used in a way that enhances individual rights and autonomy. For example, in the previously discussed case of Brazil, women who had been raped were unaware of their right to abortion services and did not know how

to locate them. In other instances, women who need a family planning method or other reproductive health care may not be informed about all of their options. Instead of giving women a real choice, providers may consciously or unconsciously make the choice for them. An observational study in Brazil looked at provider-patient interactions in decisionmaking about cesarean section procedures and found that physicians can subtly, or blatantly, direct women into making certain "choices." The "choices" may in fact better serve the medical personnel than the patient but be justified as the woman's own "choice."

Meeting participants examined the theoretical frameworks and practical issues surrounding information provision and informed consent in services and in research. The emerging concept of informed choice in service delivery derives primarily from consensus documents and treaties that affirm the right of individuals and couples to decide freely and responsibly the number and spacing of their children. A number of service-delivery organizations, particularly AVSC, have developed the notion of informed choice as an important and feasible way of implementing a rights-based approach in service delivery. In research, the principle of informed consent derives from the ethical principles surrounding the autonomy of research subjects to decide whether to participate in research; informed consent is a critical component of ethical research with human subjects. Both informed choice and informed consent are about creating conditions that will allow people to exercise their rights and make informed choices based on full information and on their own assessment of their interests, risks, and benefits.

Brazil: Provider-Patient Discourse

Dr. S.: (attending B., a woman in labor with her first child) We get a lot of pressure from the women to do cesareans during prenatal visits and during labor, because they don't want to go through the pain. (turning to B.) You came to my office already wanting to do a cesarean, didn't you?

B.: Well, I talked about it, didn't I? I don't want to have to go through the pain.

B.: (later, in the midst of a contraction) Oh, I can't take it anymore!

Dr. S.: You see? That kind of thing is subliminal. We suffer pressure. Psychological pressure.

B.: (later) Now I'm putting on the pressure.

Dr. S.: We have an alternative called analgesia [an epidural]. Do you want it?

B.: Oh, I don't know.

Dr. S.: You want to do a cesarean right now, don't you? (after breaking amniotic sac) Meconium.... Even though the baby is okay, it's an indication for a cesarean. (turning to B.) You won! You won!

Realizing Informed Choice in Service Delivery

In the service-delivery context, the exchange of information takes place in the personal interactions between clients and providers, and the primary mechanism for ensuring informed choice in service delivery is counseling. At its best, counseling is an open exchange of information between providers and clients that is free from fear or pressure and respectful of clients' rights and the social context. Years of work at the service level have identified many challenges to offering high-quality counseling, including lack of time, incentives, class and gender differences between providers and clients, bias, and incomplete information. Several recent efforts on the part of service-delivery organizations have sought to identify and build support for tangible steps providers can take to safeguard and promote informed choice among clients. Eliciting client feedback, institutionalizing heightened supervision and quality controls, and orienting entire staff teams to counseling have been adapted and used with great effect in some settings. Informed choice has become one of the ways that service-delivery organizations and providers are seeking to make operational the rights framework that has emerged in the population and reproductive health fields. Providing good information on a range of technologies to allow individuals to make truly informed choices about their reproductive health care is a central link among rights, technology, and services.

Realizing Informed Consent in Research

Informed consent is a legally mandated component of research involving human subjects, as a safeguard against abuse on the part of the participant and against liability on the part of the researcher. Researchers are legally obligated to provide forms, obtain signatures, and carefully document "informed consent." However, the genuine difficulty of explaining often complex research concepts and the often litigious environment around conducting research mean that completing forms and filing documentation often take precedence over truly educating potential study participants so that they can make informed decisions about their participation. This places the researcher's interest in the informed consent process over the participant's. The language of such informed consent forms may be legalistic, technical, and simply not readable or comprehensible to many research participants. Studies examining both recall and comprehension of research participants about the consent process show that too often they are not aware of their risks, benefits, or rights. However, little is done to supplement the legal requirements and ensure that consent is truly informed.

Recognition that informed consent counseling and documentation often fall short of their ideals has brought about some research investigating the quality of the informed consent process itself. For example, the Population Council is studying ways to improve informed consent in its clinical trial in South Africa of a vaginal microbicide to prevent infection with HIV and other STIs. Given that this trial involves a new type of product, a complex study design, and a stigmatized and still fatal disease, and touches on charged issues of gender, power, and sexuality, obtaining truly informed consent is especially challenging. Pilot-testing a carefully developed informed consent process prior to the study showed that women felt that too much information was provided, that they were unclear about the primary and secondary purposes of the study, and that they significantly overestimated the health risks associated with participation. Based on this information, the forms and process have been extensively revised and retested.

The premise of informed consent is to protect the rights of potential research participants. Even with careful planning and strong commitment to making consent truly informed, it is a challenge. In keeping with this initial motivation, researchers and funding agencies need to devise innovative methods to ensure that comprehension among research participants is accorded higher priority in study design and reporting.

“Good” and “Bad” Technologies

A critical dimension of the intersection of rights, technology, and services is the effect of technologies on individuals' reproductive rights. Having considered a range of barriers that affect reproductive choices, meeting participants next examined more specifically the complex role of reproductive technologies in reproductive rights. Whether reproductive technology per se furthers or undermines women's reproductive rights has been the subject of considerable debate for decades within and among the population, reproductive rights, and feminist communities. The general premise of this meeting was that reproductive technology in and of itself is not “good” or “bad,” but rather may be used in ways that facilitate or constrain individual choice. Therefore, the evaluation of any reproductive technology from a rights perspective must begin by examining who controls it and to what purpose it is used. These dimensions of reproductive technologies and the degree to which individuals can exercise real choice are powerfully influenced by the service provider and the service-delivery environment. Important factors include the nature and quality of the services where a technology is provided, the degree to which an individual has freely chosen to use the technology, and, critically, the quality and amount of information that s/he has brought to bear on this decision.

As notions of choice and reproductive rights have developed over time, reproductive technologies have been assessed in different ways. Advocates of population control have tended to favor long-acting, highly effective contraceptives. Some feminist discourse has stressed evaluating contraceptive technologies based on whether methods were provided in a program driven primarily by a concern with population control or one motivated more by promoting choice and autonomy over reproduction, were provider- or user-controlled, and whether the mode of action was physical (barrier) or systemic (hormonal). Other dimensions have included effectiveness, safety, risks, benefits, reversibility, and removability. In the face of the HIV/AIDS epidemic and growing evidence of high prevalence of STIs and RTIs throughout the world, the effect of specific technologies on facilitating or preventing disease has assumed heightened importance. Other equally important concerns relate to accessibility, availability, affordability, and effect on partner and sexual relations.

Participants reviewed the complex history of reproductive technologies in India to explore these issues further. Over the long history of India's family planning program, a variety of technologies have come into favor at different times. For decades the program was driven largely by demographic goals aimed at reducing the country's population growth, with individuals' reproductive rights and choice accorded little consideration, resulting in some technologies and services being provided in clear violation of human and reproductive rights. In the recent past,

however, the program has made some policy changes that reflect a more rights-based approach, including a commitment to method mix and reproductive health rather than an exclusive concern with family planning. However, the longstanding and, to some extent, still entrenched focus on curbing population growth, combined with the very real problems of providing quality services with limited resources in such a large and complex country, have meant that reproductive technologies have had a mixed history in India.

This history has precipitated ongoing debate among feminists in India and elsewhere about reproductive technologies and the introduction of new methods. Some groups and individual users strongly favor including methods such as injectables and Norplant[®] because of their convenience and because their inclusion promises women more choice. Others take a more guarded approach to certain contraceptives, wary to different degrees of the way they have been used without due respect for women's rights and health and the exigencies of their daily lives. Still others have worked hard through the courts and other channels to keep particular technologies out of the country on the grounds that health facilities are simply not able to provide them in a way that offers women real choice, adequate safety, and backup for any complications. Balancing these and other factors related to the provision and use of reproductive technologies in a way that best serves the rights of clients and their partners is ethically and practically challenging. India's history with reproductive technologies powerfully illustrates their potential to facilitate or violate rights and their inextricable links with the services through which they are provided, which, in turn, are a product of political choice and resource allocation.

Bringing It All Together: The Case of Medical Abortion

To illustrate the range of questions and issues raised throughout the meeting, the final section was dedicated to looking in more depth at these issues as they relate to medical abortion. Medical abortion is a reproductive technology with great potential to enhance reproductive rights. Effective and safe, medical abortion methods promise to provide women and couples with an important new choice in the face of an unintended pregnancy. They may also change the way abortion services are provided in some settings. In many respects, medical abortion exemplifies the complexity of forces and links underlying the intersection among technology, services, and rights in reproductive health. Since its development in France in the early 1980s, medical abortion (here referring to the mifepristone-misoprostol regimen) has stirred controversy, concern, and hope. As with most reproductive technologies, the gatekeepers and barriers are numerous. Making the product legally available—from research to governmental approval to distribution and marketing—has faced many hurdles especially in the United States. Anti-choice groups have charged that the product is categorically harmful to women and have wielded their political strength to burden the process of approval and to erect barriers at every turn. While most feminists laud the method for the control and privacy it offers women who want an abortion, others question its safety and feel the technology may work against women's interests. This case exemplifies how a single technology can evoke very disparate reactions and create tension that affects individual women's ability to use it.

Although it has been available for more than a decade and has numerous studies documenting that it is safe, effective, and acceptable to many women, medical abortion is far from being a real choice

for most women, even in settings where abortion is legal and widely available. One barrier strongly limiting its accessibility and use is its over-medicalization within service provision, based in part on the fact that it has been grafted into existing surgical abortion services. The restrictions on who can use and provide medical abortion and on when, where, and how they do so are extensive. Even in Europe, where it is legal, increasingly well-known, and less politically charged than in the United States, medical abortion continues to be burdened by restrictions. Current protocols for providing the method often include a time limit of 49 days since last menstrual period, with an ultrasound recommended (and in some places required) to confirm gestational age. Clients are usually asked to endure hours of medical observation and make repeat clinic visits. New research shows, however, that these protocols are more stringent than what is medically necessary to provide the method safely and effectively. Women's own assessments of their eligibility and the method's effectiveness are proving to be very reliable, and providers working in low-resource settings are showing that they can effectively and safely provide the method. For example, ongoing studies in Vietnam and Tunisia show that ultrasound is not routinely necessary, and that women can safely manage part of the process at home.

Social attitudes toward abortion underlie the often strong and polarized reactions toward this technology as well as the kinds of barriers erected against it and the service restrictions encoded in its provision. The influence of these social and cultural factors again points to the contextual nuances of reproductive rights and technologies. In the United States, for example, social attitudes toward abortion affect services: Women are required to receive counseling and often bear a burden of guilt and fear of stigma when they decide to seek an abortion. The entrenched medicalization of abortion services and technologies also reflects cultural notions about the role of medicine and about women's autonomy. Debates over the right to and morality of abortion are replete with assumptions about women's sexuality; the value of the fetus relative to the woman; and the meaning of sex, pregnancy, and motherhood.

Many questions about the future of medical abortion remain uncertain. Will it become a technology that can be provided in a way that enhances reproductive rights? What new barriers will emerge as current ones are addressed? How will it change abortion services? As the meeting made clear, the potential of medical abortion to enhance reproductive rights depends upon the alignment of an array of factors, including addressing the barriers created by protocols for service delivery, the perceived entitlement to medical abortion on the part of women facing unwanted pregnancies, and the meaning of reproductive rights in a given social context.

Concluding Thoughts

Reproductive rights has become a key framework for providing reproductive services and technologies and as such, presents great opportunities to benefit clients and those who serve them. Internationally, a number of agencies and providers are grappling with the numerous challenges and exciting opportunities presented by putting this framework into practice.

The concept of reproductive rights is complex. They are drawn upon by a wide range of individuals and interests and in a variety of ways: expressed as formal law, as individuals' sense of entitlement

to make decisions about their bodies and sexuality, and as signals of a paradigm shift prioritizing rights over other social objectives. The disparate ways in which reproductive rights are understood and how reproductive technologies are perceived across societies and communities further complicates the implementation of the approach. Despite the many examples that illustrate reproductive rights in action, real choice in services and technologies is still remote for many people worldwide. In addition to resource constraints, physical, economic, and informational barriers to services and technologies constrain the fulfillment of these rights.

In order for program managers and health care providers to provide quality reproductive health care, employing technologies in accordance with clients' reproductive rights is key. For those developing or seeking to implement reproductive technologies, it is important to understand the concept of reproductive rights and the parameters of service-delivery systems. Similarly, reproductive rights advocates must be knowledgeable about reproductive technologies and the service delivery contexts in which they are used. Those working in each of these areas can benefit from understanding how those working in the others affect their work.

A key element of this perspective on reproductive health work is that it closely links this work with issues of social justice and women's status in civil society. Reproductive rights affirm personal autonomy and control over reproduction and sexuality. By raising questions about where such power and control lie within families and societies, the reproductive rights approach points squarely to social and gender inequalities. It provides a way to recognize and, with implementation, redress social inequalities and makes reproductive health and family planning services function explicitly in the interest of broader social justice as well as individual welfare, adding a new and profound dimension to the way reproductive health services and technologies are positioned and perceived.

***Rights, Technology, and Services in Reproductive Health:
Current Issues and New Alliances***
6–7 May, 1999
Population Council, New York

AGENDA

Thursday, May 6

9:00–9:30

Coffee

9:30–10:00

Introduction and Overview

Beverly Winikoff, Population Council, New York

10:00–11:00

Rights and Reproductive Rights

Lynn Freedman, Law and Policy Project, Columbia University School of Public Health, New York

This presentation will review general concepts related to rights and explicate some of the limitations of a rights-based approach to social organization. It will also describe the many forces that govern reproductive rights: traditional law, formal constitutional law, religious tradition, international agreements, and so forth. The speaker will provide a critical assessment of the strengths and limitations of a reproductive rights approach for ensuring access to services and technologies.

Questions and Discussion

11:00–11:15

Break

11:15–1:00

Reproductive Rights in Action

Speakers in this session will present several examples of ways reproductive rights have been adapted and used to inform policy and service delivery, and how women interpret and understand these concepts.

Rights and Services in the New South Africa

Margaret Hoffman, Department of Community Health, University of Cape Town, South Africa

Developing and Implementing IPPF's Charter on Sexual and Reproductive Rights

Karen Newman, International Planned Parenthood Federation, United Kingdom

The International Reproductive Rights Research Action Group

(IRRRAG)

Rosalind Petchesky, Hunter College and IRRRAG, New York

Simone Grilo Diniz, Coletivo Feminista Sexualidade Saúde and IRRRAG,
Brazil

Discussion

1:00–2:00 Lunch

2:00–2:15 Video presentation of IPPF’s *Lifelines* series of human rights TV spots in support of reproductive rights worldwide

2:15–3:10 Choice Without Choices: Rights and Access to Services and Technology

Even with agreement on the right to autonomy over reproductive health and to choice of contraceptive method, a rights-based approach cannot ensure access. In reality, choices are shaped and often restricted by barriers to access. In order for individuals to exercise their rights, they need information about the technology, physical access to the technology, and the economic means to purchase the technology. Speakers in this session will focus primarily on geographic and economic barriers. The issues surrounding obtaining full information about a technology will be explored in a later session.

Introduction

Elizabeth McGrory, Population Council, New York

Access to Legal Abortion in Brazil

Loren Galvão, Population Council, Brazil

Emergency Contraception

Kelly Blanchard, Population Council, New York

3:10–3:25 Break

3:25–5:00 Choice Without Choices, *continued*

Hospital Mergers in the United States

Lois Uttley, MergerWatch Project, Family Planning Advocates of New York

The Role of the “Gatekeeper” and Commentary

Juan Díaz, Population Council, Brazil

This presentation will examine the role of the “gatekeeper” in limiting access to certain technologies, including the scenario when limiting the number of technologies might enhance rights. The presenter will also comment on the previous presentations.

Discussion

5:00–6:30 Reception

Friday, May 7

9:00–9:30

Coffee

9:30–11:00

Services and Research: Realizing Informed Choice and Informed Consent

This panel will examine in depth the role that “information” plays in facilitating the exercise of rights in services and research. Speakers will outline concepts and complexities and present examples of realizing truly informed choice in service delivery and informed consent in research.

Introduction

Rachael Pine, AVSC International, New York

Informed Choice: AVSC’s Experience

Jan Neamatalla Kumar, AVSC International, New York

False Choice: Patient–Provider Discourse

Kristine Hopkins, Population Council, New York

Informed Consent

Benjamin Popkin, Family Health International, North Carolina

Informing the Informed Consent Process in a Microbicide Trial

Elizabeth McGrory, Population Council, New York

Discussion

11:00–11:15

Break

11:15–12:30

“Good” and “Bad” Technologies in Reproductive Health

In the North, controlling fertility and exercising reproductive rights have been central tenets of feminist thinking and activism for decades. In contrast, in many settings in the South, fertility regulation technologies were introduced primarily for the purposes of controlling population growth rather than facilitating individual rights. Many activists in these settings have viewed reproductive technologies as antithetical to, rather than facilitating, the exercise of individual autonomy and reproductive rights. Speakers in this panel will examine the ways that various reproductive health technologies are viewed as “good” or “bad” in different settings, especially by activists.

Introduction and Overview

Saroj Pachauri, Population Council, India

Technology and Activism in India

N.B. Sarojini, Shodhini Network, India

Beyond “Good” and “Bad”

Marge Berer, *Reproductive Health Matters*, United Kingdom

12:30–1:30

**Discussion
Lunch**

1:30–3:30
Abortion

Rights, Technology, and Services: The Case of Medical

The case will begin with the complex and charged history of this technology related to abortion rights and services in the United States. Specifically, does the right to abortion imply the right to abortion technologies? If such rights exist, can the U.S. government withhold FDA approval? Can the government compel manufacturers to produce them?

The second speaker will draw on the themes discussed in the previous session and provide insights into why many activists worldwide consider medical abortion to be a “good” technology, promising advances in areas of autonomy for women, freedom from medical control, and better access to reproductive choice, and why many others see it as a “bad” technology, possibly repeating the experience with other imported, high-technology, medically driven, hormonal inventions.

We will then focus on how restrictive and cumbersome service provision limits this technology’s potential. Speakers will examine how these service-delivery patterns have inhibited use of the drug and describe other aspects of the regimen that need modification for the drug to fulfill its promise, such as not allowing women to take the second set of pills at home. Finally, we will explore how the introduction of medical abortion could potentially lower many of the economic and physical barriers to access and thereby enable women to more fully exercise their right to abortion.

Introduction

Batya Elul, Population Council, New York

The History of Mifepristone in the United States

Sandra Waldman, Population Council, New York

Is Medical Abortion a “Good” or “Bad” Reproductive Technology?

Jennifer Jackman, Feminist Majority Foundation, Virginia

N.B. Sarojini, Shodhini Network, India

Cumbersome Services and Revolutionary Technologies

Beverly Winikoff, Population Council, New York

Anne Furedi, British Pregnancy Advisory Service, United Kingdom

Setting Medical Abortion Free: Enhancing Rights with

Progressive Services

Charlotte Ellertson, Population Council, Mexico

Discussion

3:30–3:45

Break

3:45–5:00

Closing and Discussion

Beverly Winikoff, Chair

Comments

Christopher Elias, Population Council, Thailand

Esther Muia, Population Council, Kenya

Marge Berer, *Reproductive Health Matters*, United Kingdom

Rights, Technology, and Services in Reproductive Health

6-7 May, 1999

Population Council, New York

PARTICIPANTS

Amal Abdel Hadi
Cairo Institute for Human Rights
c/o Rutgers University
Hubert Humphrey Fellowship Program
33 Livingston Avenue, Suite 366
New Brunswick, NJ 08901
Phone: (732) 932-3429 x589
Fax: (732) 932-4090
E-mail: manal@eden.rutgers.edu

Ayo Ajayi
Population Council
Multichoice Towers, Upper Hill
P.O. Box 17643
Nairobi, Kenya
Phone: (011) (254) (2) 713-480/1/2/3
Fax: (011) (254) (2) 713-479
E-mail: aajayi@popcouncil.or.ke

Sandra Arnold
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0663
Fax: (212) 755-6052
E-mail: sarnold@popcouncil.org

Marie Bass
Bass and Howes, Inc.
1818 N Street, NW, Suite 450
Washington, DC 20036
Phone: (202) 530-2900
Fax: (202) 530-2901

Marge Berer
Reproductive Health Matters
29-35 Farringdon Road
London EC1M 3JB
United Kingdom
Phone: (011) 44-171-242-8686
Fax: (011) 44-171-242-9696
E-mail: RHMjournal@compuserve.com

Kelly Blanchard
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0656
Fax: (212) 755-6052
E-mail: kblanchard@popcouncil.org

Martha Brady
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0618
Fax: (212) 755-6052
E-mail: mbrady@popcouncil.org

Sarah Braunstein
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0638
Fax: (212) 755-6052
E-mail: sbraunstein@popcouncil.org

George Brown
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0600
Fax: (212) 755-6052
E-mail: gbrown@popcouncil.org

Stuart Burden
The John D. and Catherine T.
MacArthur Foundation
140 S. Dearborn Street, Suite 1100
Chicago, IL 60603
Phone: (312) 726-8000
Fax: (312) 917-0334
E-mail: sburden@macfdn.org

Marion Carter
Princeton University
Office of Population Research
21 Prospect Avenue
Princeton, NJ 08544
Phone: (609) 258-4945
Fax: (609) 258-1039
E-mail: mwcarter@princeton.edu

Wendy Chavkin
Columbia University–CPFH
60 Haven Street, B-3
New York, NY 10032
Phone: (212) 304-5553
Fax: (212) 305-7024

Ellen Chesler
Open Society Institute
400 West 59th Street
New York, NY 10019
Phone: (212) 548-0600
Fax: (212) 548-4677
E-mail: Echesler@sorosny.org

Nahid Chowdhury
Population Council
P.O. Box 6016
Gulshan, Dhaka, Bangladesh
Phone: (011) (880) (2) 882-1227/6657
Fax: (011) (880) (2) 882-3127/3132
E-mail: 62020447@eln.attmail.com

Shelley Clark
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0617
Fax: (212) 755-6052
E-mail: sclark@popcouncil.org

Silvie Cohen
UNFPA
220 East 42nd Street
New York, NY 10017
Phone: (212) 297-5232
Fax: (212) 297-5145

Jacqueline Darroch
Alan Guttmacher Institute
120 Wall Street, 21st floor
New York, NY 10005
Phone: (212) 248-1111
Fax: (212) 248-1951
E-mail: jedarroch@agi-usa.org

Juan Díaz
Population Council
Caixa Postal 6059, Cidade Universitária
13084-970 Campinas
São Paulo, Brazil
Phone: (011) (55) (19) 249-0121/0122
Fax: (011) (55) (19) 249-0123
E-mail: jdiaz@popcouncil.org.br

Martha de la Fuente
Hampshire College
School of Social Science, Population &
Development Program
Franklin Hall
Amherst, MA 01002-5001
Phone: (413) 559-5708
Fax: (413) 559-5620
E-mail: mbdSS@hampshire.edu

Simone Grilo Diniz
Coletivo Feminista Sexualidade Saúde
Rua Bartolomeu Zunega, 44–Pinheiros
CEP 05426-020 São Paulo, SP Brazil
Phone: (011) 55-11-2128681/8144970
Fax: (011) 55-11-8138578
E-mail: sdiniz@ax.apc.org;
cfssaude@alternex.com.br

France Donnay
UNFPA
220 East 42nd Street
New York, NY 10017
Phone: (212) 297-5232
Fax: (212) 297-5145

Chris Elias
Population Council
P.O. Box 138
Pratunam Post Office
Bangkok 10409
Thailand
Phone: (011) (66) (2) 251-4766/7066
Fax: (011) (66) (2) 255-5513
E-mail: pcbkk@popcouncil.th.com

Charlotte Ellertson
Population Council
Apartado Postal 21-152, C.P. 04021
11560 Mexico, D.F.
Mexico
Phone: (011) (52) (5) 659-8541/8537
Fax: (011) (52) (5) 554-1226
E-mail: cellertson@popcouncil.org.mx

Batya Elul
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0627
Fax: (212) 755-6052
E-mail: belul@popcouncil.org

Goli Fassihian
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0614
Fax: (212) 755-6052
E-mail: gfassihian@popcouncil.org

Lynn Freedman
Columbia University
School of Public Health
600 West 168th Street (7th floor)
New York, NY 10032
Phone: (212) 304-5281
E-mail: lpf1@columbia.edu

Barbara Friedland
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0629
Fax: (212) 755-6052

E-mail: bfriedland@popcouncil.org
Ann Furedi
British Pregnancy Advisory Service
Church House
Throwley Road
Throwley, Nr Faversham
Kent ME13 0PF
United Kingdom
Phone: (011) 44 (0) 1795 890557
Fax: (011) 44 (0) 1795 890535
E-mail: anne-furedi@easynet.co.uk

Loren Galvão
Population Council
Caixa Postal 6059, Cidade Universitária
13084-970 Campinas
São Paulo, Brazil
Phone: (011) (55) (19) 249-0121/0122
Fax: (011) (55) (19) 249-0123
E-mail: lgalvão@popcouncil.org.br

Timothée Gandaho
Population Council
BP 21027
Dakar, Senegal
Phone: (011) (221) 824-1993/94
Fax: (011) (221) 824-1998
E-mail: pcdakar@sonatel.senet.net

Veronique Goblet
UNICEF
3 United Nations Plaza
New York, NY 10017
Phone: (212) 824-6340
Fax: (914) 381-2408
E-mail: 110104.2316@compuserve.com

Baochang Gu
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0602
Fax: (212) 755-6052
E-mail: bgu@popcouncil.org

Nicole Haberland
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0676
Fax: (212) 755-6052
E-mail: nhaberland@popcouncil.org

Judith Helzner
IPPF/WHR
120 Wall Street (9th floor)
New York, NY 10005-3902
Phone: (212) 248-6400 x245
Fax: (212) 248-4221
E-mail: info@ippfwhr.org

Margaret Hoffman
Department of Community Health
Faculty of Health Sciences
University of Cape Town
Anzio Road, Observatory 7925
Cape Town, South Africa
Phone: (011) 27-21-406-6484
Fax: (011) 27-21-406-6163
E-mail: mh@anat.uct.ac.za

Kristine Hopkins
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0686
Fax: (212) 755-6052
E-mail: khopkins@popcouncil.org

Jane Hughes
Population Sciences
The Rockefeller Foundation
Population Sciences Division
420 Fifth Avenue
New York, NY 10018-2702
Phone: (212) 852-8370
Fax: (212) 852-8278
E-mail: jhughes@rockfound.org

Jennifer Jackman
Feminist Majority Foundation
1600 Wilson Blvd., Suite 801
Arlington, VA 22209
Phone: (703) 522-2214
Fax: (703) 522-2219
E-mail: jjackman@feminist.org

Anrudh Jain
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0639
Fax: (212) 755-6052
E-mail: ajain@popcouncil.org

Annika Johansson
Division of International Health
(IHCAR)
Department of Public Health Sciences
Karolinska Institutet
171 76 Stockholm, Sweden
Fax: (011) 46-8-311590
E-mail: Annika.Johansson@phs.ki.se

Karen Judd
208 W. 30th Street, Room 901
New York, NY 10001
Phone: (212) 216-0676
Fax: (212) 216-0677
E-mail: karenjudd@aol.com

Virginia Kallianes
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0625
Fax: (212) 755-6052
E-mail: vkallianes@popcouncil.org

Barbara Katz Rothman
Baruch College–CUNY
Department of Sociology &
Anthropology
17 Lexington Avenue
New York, NY 10010
Phone: (212) 387-1709

Fax: (212) 387-1708

Karima Khalil
Population Council
P.O. Box 115
Dokki 12211
Cairo, Egypt
Phone: (011) (20) (2) 571-9252
Fax: (011) (20) (2) 570-1804
E-mail: pcouncil@pccairo.org

Georgann Neamatalla Kumar
AVSC International
79 Madison Avenue
New York, NY 10016
Phone: (212) 561-8000
Fax: (212) 779-9439
E-mail: gneamatalla@avsc.org

Ann Leonard
Ipas
300 Market Street, Suite 200
Chapel Hill, NC 27516
Phone: (919) 967-7052
Fax: (919) 929-0258
E-mail: aleonard@ipas.org
Web: <http://www.ipas.org>

Ann Leonard
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0606
Fax: (212) 755-6052
E-mail: aleonard@popcouncil.org

Elizabeth Maguire
United States Agency for International
Development (USAID)
Center for Population, Health, and Nutrition
Washington, DC 20523
Phone: (202) 712-0540
Fax: (703) 237-2450

Le Thi Phuong Mai
Population Council
37A Van Mieu Street
Hanoi, Vietnam
Phone: (011) (84) (4) 747-2670/733-0577
Fax: (011) (84) (4) 733-0588
E-mail: pchanoi@netnam.org.vn

Elizabeth McGrory
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0604
Fax: (212) 755-6052
E-mail: emcgrory@popcouncil.org

Esther Muia
Population Council
Multichoice Towers, Upper Hill
P.O. Box 17643
Nairobi, Kenya
Phone: (011) (254) (2) 713-480/481
Fax: (011) (254) (2) 713-479
E-mail: emuia@popcouncil.or.ke

Martha Murdoch
Family Care International
588 Broadway, Suite 510
New York, NY 10012
Phone: (212) 941-5300
Fax: (212) 941-5563
E-mail: mmurdoch@familycareintl.org

Karen Newman
International Planned Parenthood
Federation (IPPF)
Regent's College, Inner Circle
Regent's Park
London NW1 4NS
United Kingdom
Phone: (011) 44-71-487-7854
Fax: (011) 44-171-487-7831
E-mail: knewman@ippf.org

Tiana Norgren
Open Society Institute
400 West 59th Street
New York, NY 10019
Phone: (212) 548-0600
Fax: (212) 548-4677
E-mail: TNorgren@sorosny.org

Saroj Pachauri
Population Council
Zone 5A, Ground Floor
India Habitat Centre
Lodi Road
New Delhi 110003, India
Phone: (011) (91) (11) 464-2901/2902/4008
Fax: (011) (91) (11) 464-2903
E-mail: monica@pcindia.org

Cindy Pearson
National Women's Health Network
514 Tenth Street, NW, Suite 400
Washington, DC 20004
Phone: (202) 347-1140
Fax: (202) 347-1168
E-mail: cpearson@
womenshealthnetwork.org

Rosalind Petchesky
International Reproductive Rights Research
Action Group (IRRRAG)
c/o Hunter College–West Building
695 Park Avenue
New York, NY 10021
E-mail: rpatches@igc.org

Rachael Pine
AVSC International
79 Madison Avenue
New York, NY 10016
Phone: (212) 561-8000
Fax: (212) 779-9439
E-mail: rpine@avsc.org

Benjamin Popkin
Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709
Phone: (919) 544-7040 x229
Fax: (919) 544-7261
E-mail: BPopkin@rtp-exchange.fhi.org

Saumya RamaRao
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0603
Fax: (212) 755-6052

E-mail: sramarao@popcouncil.org
N.B. Sarojini
Shodhini Network
Magic Lantern Foundation
J-1881, Chittaranjan Park
New Delhi 110 019
India
Phone: (011) 91 11-622-1405
Fax: (011) 91-11-622-3894/623-1801
E-mail: magiclf@vsnl.com

Hania Sholkamy
Population Council
P.O. Box 115
Dokki 12211
Cairo, Egypt
Phone: (011) (20) (2) 571-9252
Fax: (011) (20) (2) 570-1804
E-mail: hsholkamy@pccairo.org

Nancy Sloan
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0601
Fax: (212) 755-6052
E-mail: nsloan@popcouncil.org

Ann Starrs
Family Care International
588 Broadway, Suite 510
New York, NY 10012
Phone: (212) 941-5300
Fax: (212) 941-5563
E-mail: astarrs@familycareintl.org

Gaye Tharawan
Population Council
P.O. Box 138
Pratunam Post Office
Bangkok 10409
Thailand
Phone: (011) (66) (2) 653-8586
Fax: (011) (66) (2) 255-5513
E-mail: pcouncil@ksc15.th.com

Nahid Toubia
RAINB? (Research Action Information
Network for Bodily Integrity of Women)
915 Broadway, Suite 1109
New York, NY 10010
Phone: (212) 477-3318
Fax: (212) 477-4154

Lois Uttley
The Merger Watch Project
Family Planning Advocates, New York State
17 Elk Street, 3rd Floor
Albany, NY 12207
Phone: (518) 436-8408
Fax: (518) 436-0004
E-mail: lois@mergerwatch.org

Janneke van de Wiggert
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0611
Fax: (212) 755-6052
E-mail: jvandewiggert@popcouncil.org

Patricia Vaughan
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0575
Fax: (212) 755-6052
E-mail: pvaughan@popcouncil.org

Sandra Waldman
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0525
Fax: (212) 755-6052
E-mail: swaldman@popcouncil.org

Beverly Winikoff
Population Council
One Dag Hammarskjold Plaza
New York, NY 10017
Phone: (212) 339-0623
Fax: (212) 755-6052
E-mail: bwinikoff@popcouncil.org

Judith Winkler
Ipas
300 Market Street, Suite 200
Chapel Hill, NC 27516
Phone: (919) 967-7052
Fax: (919) 929-0258
E-mail: jwinkler@ipas.org
Web: <http://www.ipas.org>