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SECTION K

FROM POPULATION CONTROL TO REPRODUCTIVE HEALTH: AN EMERGING POLICY AGENDA

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Abstract—This article reviews the background to the current debates between advocates of population control and reproductive health as frameworks for national and international health policies. Population control has been a dominant metaphor in international family planning programs since the 1960s. Population control has frequently meant pursuing a single-minded goal of fertility limitation, often without sufficient attention to the rights of family planning clients. This narrow focus has led to some coercive policies, numerous ethical violations, and ineffective family planning programs. In the last decade there has been the beginning of a policy shift, advocated by a growing number of activists and researchers in women's health, from population control to reproductive health. A reproductive health framework would provide a broader programmatic focus that could bring needed attention to such issues as sexually transmitted diseases, infertility, abortion, reproductive cancers and women's empowerment generally.

Key words—health policy, reproductive health, population, women's health

In the last decade there has been the beginning of a policy shift from population control to reproductive health. The concept of 'reproductive health' as a substantive area for research and policy is the result of advocacy on the part of activist groups, funding agencies, research organizations, and policy makers involved in women's health [1–9]. The efforts of these groups to define reproductive health as a cohesive field derive in part from frustration with the fragmentation of issues touching on women's health into disparate programs, including family planning, sexually transmitted diseases, maternal mortality and child survival [9]. Also important is the reaction against a population control approach that views women as potential 'contraceptors,' or 'producers of too many babies,' rather than as individuals whose health is inherently worth programmatic attention [5]. A reproductive health focus, therefore, is a comprehensive approach to women's health and wellbeing, that includes fertility and infertility, contraception, abortion, childbearing, maternal morbidity and mortality, sexuality, sexually transmitted diseases, menstruation and menopause. Some authors also specifically include, as part of a reproductive health approach, child survival [4, 9] and male reproductive health [4], whereas others limit their focus to the health of girls and women [5]. This new policy focus is rooted in both the second wave of feminism and in the feminist-led health consumer movement. Because many of the authors whose work has defined reproductive health as a policy focus are concerned with women's empowerment generally, many definitions specifically recognize the social and political context of reproductive health. The Population Council's Middle East Working Group on Reproductive Health, for example, defines reproductive health as, "The ability of women to live through the reproductive years and beyond with reproductive choice, dignity, and successful childbearing, and to be free of gynecological disease and risk" [1, p. 10].

This article is divided into four sections. First, I describe the various organizations involved in research and policy on population control and reproductive health. This first section is highly schematic, intended to indicate the broad range of groups involved in shaping policy, to direct the interested reader to the relevant literature, and to highlight some of the most important ongoing work in this area. The second section briefly reviews the history, successes and problems with population control. It describes how population control as a metaphor can lead to coercive, unethical and ineffective family planning programs. The third section outlines the emerging policy focus on reproductive health and describes the work of women's organizations and feminist population scholars in preparation for the upcoming International Conference on Population and Development to be held September 1994 in Cairo. The fourth section calls for increased attention on the part of social scientists to reproductive health policy and reproductive rights as areas for future research.

ACTORS, AUDIENCES, ARENAS AND AGENDAS

A review of policies in population control and reproductive health should begin with an understanding of who the different actors and their audiences are, what roles they play, and how they affect policy [10]. A large number of individuals and groups conduct research, participate in policy debates, set policy and provide funding for activities in population and reproductive health. Diverse groups reflect the concerns of academic or professional disciplines, of activist agendas or of governmental or international agencies. Each of these groups speaks to a different audience as well, often drawing on different types of information to determine policy. While not an exhaustive list, the following groups contribute substantially to research, discourse, and policy in population and reproductive health:

(1) university-based demographers and other social scientists;
(2) activist groups;
(3) research organizations;
(4) non-governmental organizations;
(5) private philanthropies;
(6) governmental agencies; and
(7) multinational agencies.

The important research on the development of contraceptives undertaken by biological and clinical scientists is not addressed in this paper.

(1) University-based researchers

University-based researchers, primarily demographers and other social scientists, have produced a wealth of information on population and reproduction topics generally. This research has contributed to the understanding of pregnancy, childbirth, and midwifery cross-culturally [11–23], to work on breast feeding and maternal/infant attachment [24–32], and to studies of gender, sex roles and reproduction [33–40]. A great deal of work by social scientists and demographers addresses issues of fertility [41–52] and family programs [53–56]. Less work focuses on the cultural acceptability of contraceptive methods [57–62] or menopause [63–66]. A growing body of literature addresses sexuality [36, 67–75] and AIDS [76–81], but many fewer studies examine other sexually transmitted diseases [82–84] or infertility [85, 86]. Considering the enormous controversy surrounding abortion in the United States and abroad, relatively little research by academic social scientists addresses abortion [87–92].

The politics of reproduction are the focus of a growing number of authors who analyze the negotiation of power relations in reproduction from the personal to the global levels [93–96]. Faye Ginsburg and Rayna Rapp [95] exhaustively review the anthropological literature on power and reproduction, specifically examining how power is structured in daily life, how economic interests and state power controls access to, or the imposition of, reproductive technologies, and how the power differentials between anthropologists and the people they study have shaped the type of work undertaken. Another recent collection, edited by W. Penn Handwerker [94], addresses the politics of reproduction, including birth, childbirth, abortion, family planning, below-replacement fertility and AIDS. Taking up the medicalization of childbirth and the proliferation of the new reproductive technologies, Oakley [97] and Raymond [98] critically address what they argue are attempts to control women's reproductive capacities.

Despite this enormous amount of research on issues of population and reproduction, of which only a fraction is cited here, it has not directly contributed to policy debates in proportion to the amount that has been produced. The work of demographers like John Bongaarts [41, 54], Kingsley Davis [42], Judith Blake [42] and Moni Nag [46] has had more influence in international policy debates than that of other social scientists, which may reflect a bias toward quantitative studies on the part of policy makers. However, the vehicle in which the work appears may in fact be a more important factor in determining its impact than the study's methodology. Academics who are the most widely read, and therefore have had a wider impact on the rhetoric of population control and reproductive health, have published in non-academic, popular journals [99]. With the exception of a few individuals, notably Margaret Mead's frequent columns in women's magazines in an earlier era, social scientists have not sought this type of exposure for their ideas. Moreover, although in many cases the work of social scientists is relevant to reproductive health policy, few have intentionally framed their work to have an impact in this area. A major reason for this lack of a policy framework is that many social scientists are motivated by theoretical developments internal to their disciplines. The audience for these studies, then, is primarily other academic social scientists rather than policy makers.

(2) Activist groups

Examples of activist groups in reproductive health and population include the Boston Women's Health Book Collective, the International Women's Health Coalition and the Population Crisis Committee. There are, in addition, a growing number of such organizations, but it is not possible to review each of them in this paper.

Our Bodies, Ourselves, first published by the Boston Women's Health Book Collective (BWHBC) in 1973 was a cornerstone of the consumer movement in health care and has sold three million copies to date [100]. The goal of the BWHBC has been to empower average women to participate actively in their own health care. The BWHBC has continued to provide information, through books, literature packets and outreach to the media, on such topics as aging, adolescence, hormone replacement therapy,

the abortion drug RU 486, sexually transmitted diseases, menstruation and the like [101]. Although it is impossible to measure its impact precisely, *Our Bodies, Ourselves* has been a major influence in informing a generation of women about how to take charge of their own health. Some of these women are now the activists, scholars, health professionals and policy makers conducting research and debating policy.

The BWHBC also consults internationally with women who want to write their own self-help manuals. One such group, the Cairo Women's Health Book Collective, published *Hiyaat Al-Maraa wa Sahithaa* (*Life of Women and their Health*) in 1991 [102]. Because of the large cultural differences between Cairo and Boston, this book is not a translation of *Our Bodies, Ourselves*. Rather, inspired by the BWHBC's experience, the Cairo Women's Health Book Collective wrote a manual that addresses how Egyptian women can take charge of their health. Thirteen such adaptations of *Our Bodies, Ourselves* have been published and the BWHBC is assisting with the production of additional volumes in Spanish, Armenian, Polish, Portuguese, Russian, Tagalog and Thai [103].

In contrast to the BWHBC's focus on informing the consumer, the International Women's Health Coalition (IWHC) directs its efforts toward informing policy makers. IWHC's recent publications have called attention to the enormous, nearly unrecognized, problems of reproductive tract infections among women in the developing world [104], cervical cancer and contraceptive safety [105], and to population policy and women's health [5]. The IWHC also helped to produce a special issue of the *International Journal of Obstetrics and Gynecology* on "Women's Health in the Third World: The Impact of Unwanted Pregnancy" [106].

The Population Crisis Committee also produces pamphlets and booklets summarizing demographic and reproductive health information in a clear, readable format for busy policy makers. Unlike the reproductive health agenda of women's activist groups, however, the Population Crisis Committee's seeks to call attention to the dangers of population growth. Critical to this discussion of population control and reproductive health is a summary of United States population policy during the 1980s published by the Population Crisis Committee [107].

(3) Research organizations

A number of independent research organizations contribute to the debates on population control and reproductive health. Two of the most influential of these organizations are the Population Council and Family Health International. The Population Council both funds and conducts policy-relevant and basic demographic research in the United States and abroad. Judith Bruce, a Senior Associate of the Population Council, developed a major initiative in quality of care for family planning services [108, 109]. This strategy, which draws on the earlier work of Scrimshaw [110], calls for attention to how well family planning programs serve the needs of clients, both technically and interpersonally. Bruce's quality of care framework has had a critical impact on family planning programs world-wide. Rather than focusing solely on client factors—largely how to persuade women to use contraceptives—program planning has now begun to involve questions of how to make the services good enough to attract and satisfy clients.

Family Health International similarly conducts policy-oriented research in population and reproductive health issues. Judith Fortney, Corporate Director for Scientific Affairs of Family Health International, is currently coordinating a five country (Egypt, Bangladesh, Indonesia, Ghana and India) study on maternal morbidity [111]. The work in each country is being undertaken by national research teams. This study is in the final phase of analysis, so only a portion of the data are publicly available. Those data that have been released indicate that the study may profoundly alter how pregnancy and childbirth in the developing world are viewed by policy makers. Before this study, experts assumed that the incidence of morbidity to maternal mortality was 16:1 [112]. Data from the five countries indicate that the figure is closer to 300 morbidities to each mortality, although not all of these morbidities are life-threatening. This study demonstrates that pregnancy and childbirth are not the safe, naturally easy processes that they have naively, and perhaps romantically, been assumed to be.

Other research institutes, such as the Alan Guttmacher Institute, are influential in providing demographic data for policy makers. The Alan Guttmacher Institute's mandate is research, policy analysis and public education. Largely focused on domestic, U.S. issues, the Alan Guttmacher Institute compiles demographic data on fertility, family planning and contraception [113–115]. The Population Council [116], the Alan Guttmacher Institute [117], and the Population Information Program of The Johns Hopkins University [118] also publish journals and other periodicals that inform the political debates on population control and reproductive health. Studies conducted by the staff of these independent research agencies tend to directly address current policy questions.

(4) Non-governmental Agencies (NGOs)

NGOs are usually privately funded agencies that implement programs. Internationally, many more NGOs are involved in child survival activities than in reproductive health and population. The exception to this limited focus on child survival, and the leading NGO in the population field, is the International Planned Parenthood Federation (IPPF), headquartered in London. Established in 1952, IPPF is a federation of autonomous national family planning

programs in over 120 nations [119]. In addition to its primary mission of training and support for family planning programs, IPPF provides smaller amounts of support for abortion activities [3, p. 75] and other such efforts as advocacy against traditional female genital surgeries.

(5) Private philanthropies

Private philanthropic organizations often play a fairly large role in the development of international population policy by funding key research projects, providing support for activist groups or NGOs, and by bringing together researchers, activists and policy makers in workshops and conferences. During the 1960s and 1970s, for example, the Ford Foundation played a leading role in funding reproductive and contraceptive research and in supporting demographic institutes in many developing countries [4]. In 1989, the Ford Foundation reoriented much of its population and child survival programming to focus on reproductive health. This new direction is critical to the analysis presented in this article and will be discussed in greater detail in the following sections.

(6) National governmental agencies

Most governments have one or more agencies involved in setting policy, conducting research and funding population and reproductive health research. This section will highlight three such agencies in the United States. The United States is perhaps uniquely complicated in having numerous federal, state and local-level agencies involved in reproductive health and population policy. Three federal agencies play leading roles in the funding, production and implementation of research in population issues: The National Institutes of Health (NIH), the United States Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC).

NIH funds two-thirds of all publicly supported research in the United States [120]. One sector of NIH, the National Institute of Child Health and Human Development (NICHD) focuses specifically on fertility, population, contraception, pregnancy, delivery, infant mortality and human development [121]. NICHD periodically brings together groups of scientists involved in reproductive health research to determine the direction of future funding and programmatic efforts and prepares periodic special reports to Congress, so that it is sometimes a critical link between university-based researchers and policy makers [122].

Since the mid-1960s the United States has allocated over $4 billion for population activities in developing countries, largely through USAID [107]. The greatest proportion of this assistance has been for providing contraceptives, strengthening family planning programs and indigenous institutions devoted to population activities, and improving the collection and evaluation of demographic data. Indonesia, Thailand, Bangladesh, Mexico and Egypt have all experienced significant fertility declines in the past decade [107, 123], a great deal of which can be credited to USAID support.

United States governmental activities in population and reproductive health are often constrained by domestic political concerns. For example, in 1991 Louis Sullivan, then U.S. Secretary of Health and Human Services, withdrew NIH funding from two large studies on sexuality, one on adolescent sexuality and one on adult sexuality, in part because the studies were opposed by Senator Jesse Helms and Representative William Dannemeyer [124, 125]. In 1984, at an international conference on family planning in Mexico City, the United States issued a Reagan administration policy stating that the U.S. would no longer contribute to the family planning programs of countries in which abortion was one of the methods offered and would no longer fund NGOs that performed or promoted abortion [126]. Because of this policy, U.S. funding was withdrawn from the United Nations Population Fund and IPPF. This policy was reversed by the Clinton administration in 1993 [127].

Despite the weight of bureaucracy and constraints of politically motivated policies, innovative reproductive health research is being produced by the staff of federal agencies. For example, Cynthia Ferre, Epidemiologist of the Centers for Disease Control and Prevention, is the Project Officer on two ethnographic studies of African-American women's pregnancy and childbirth experiences [128]. The CDC contracted with Susan Scrimshaw, Professor and Associate Dean of the School of Public Health at the University of California at Los Angeles, to lead one of these studies [129]. Ferre and her colleagues at CDC realized that there continues to be a persistent gap in infant mortality, maternal morbidity and mortality, birth weight, and other measures of health between African-Americans and others in the United States. They felt that the known risk factors—largely demographic variables such as age, socioeconomic status, occupation and education—did not fully account for the differences. The CDC staff brought together a collaborative group, of academics, activists and African-American community leaders, to help develop a new research agenda. The study designed by Scrimshaw and her colleagues, within the framework worked out by the CDC, is important in that it attempts to understand the intraethnic diversity in the African-American community, rather than looking at 'race' as a homogeneous variable. The use of ethnographic methods and community participation is part of an effort to generate a new set of hypotheses about and to better understand the contexts which lead African-American women and their infants to experience disparities in health outcome. The advantages of a collaboration such as has taken place in this study are that:

(1) it draws on the methodologically rigorous and innovative work of university-based social scientists;
(2) being commissioned by a federal government agency it has a greater chance of affecting policy, or at least being read by policy makers; and
(3) it includes activists and community leaders, both in the early planning stages at CDC and in the community participation of the data collection and interpretation, so that members of the affected community know about the study and have a stake in its outcome.

(7) Multinational agencies

A number of United Nations agencies have programs that involve reproductive health and population activities. These agencies include:

(1) the United Nations Population Fund (UNFPA), whose primary focus is support for family planning programs;
(2) the World Health Organization (WHO), which has programs in Safe Motherhood, the Global Programme on AIDS, and the Special Programme of Research, Development and Training in Human Reproduction;
(3) the World Bank, which is primarily devoted to fostering socioeconomic progress in developing countries, but has also taken a leadership role in key reproductive health issues such as maternal mortality [130]; and
(4) the United Nations Children's Fund (UNICEF), which addresses reproductive health and population concerns that directly affect the lives and well-being of the world's children [131, 132].

A BRIEF HISTORY OF POPULATION CONTROL

Toward the end of the 1950s, international awareness focused on two factors: the world's population was rapidly increasing and developments in fertility control had reached the point where it was becoming possible to control population growth [133]. A 1962 United Nations resolution, "Population Growth and Economic Development," recognized that the poorest people in the least developed nations had the highest fertility. In recognition of the demographic transition that European populations experienced during industrialization, policy makers of this era thought that widespread adoption of population control measures could 'jumpstart' economic and social progress. In other words, poverty could be overcome if only the poor would control their fertility.

The correlation of high fertility with poverty may not indicate direct causation, however. John Ratcliffe [52] suggested that rather than being poor because they have many children, people may have many children because they are poor. He cites the example of Kerala state, India, where social justice reforms including land reform, increased education and availability of health services were followed by decreases in infant and child mortality and only then by declining fertility. While not necessarily advocating social justice, others have claimed that economic development could be a better contraceptive than programs aimed specifically at population control.

Underlying the altruistic concerns expressed by the West about the alleviation of poverty, however, was another more self-interested worry of Western governments derived from Malthusian [134] notions of the tragic consequences of unchecked population growth. In 1965, for example, President Lyndon Johnson's State of the Union message called for funding to "seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources" [135, 136]. The United States began funding population control activities through USAID in 1965 [107] and in 1967 UNFPA was established to coordinate the growing international funding and transfer of contraceptive technology to developing-country population programs [137].

Cold War fears about rapid birth rates furthering the potential spread of communism also inspired the funding of overseas population activities by the United States. A 1974 memorandum drafted by Henry Kissinger, then Secretary of State and Director of the National Security Council, called for support for population control in countries of political interest to the U.S.: Bangladesh, Brazil, Colombia, Egypt, Ethiopia, India, Indonesia, Mexico, Nigeria, Pakistan, the Philippines, Thailand and Turkey [138, 139]. The United States' experience in Vietnam further aroused fears of communism emerging in societies with large dissatisfied peasant populations. Population control efforts based on this political agenda, however, convinced many people in the developing world that such policies were a form of genocide.

Ecological factors continue to be the explicit concerns in current population debates. During the 1991 Earth's Summit in Rio de Janeiro the United States stressed overpopulation as a cause of environmental degradation [138] and a recent issue of *Population Reports* calls for a "Decade for Action" on the environmental problems caused by population growth [140]. Without minimizing the environmental crisis facing our planet, it is critical to point out that as Dr Malini Karkal, consultant to the World Health Organization, has said, "One birth in the United States is the 'ecological equivalent' of twenty-five [births] in India" in terms of consumption of valuable resources [138, p. 15].

Despite the self-interested motives of the industrialized donor nations, their support has contributed to slowing the world's population growth, which most observers agree is an important goal [141]. Family planning programs have been established in

most countries world-wide and in many countries even poor rural women have access to modern contraceptives [142]. Although the world's population has now reached 5.5 billion and increases at 90 million per year, recent studies indicate that independent of social and economic factors, family planning programs have significantly reduced fertility in developing countries [54, 143]. Since the mid-1960s social, political, and economic changes—*and access to modern contraception*—have caused a decline in the average number of children per woman in the developing world from six to four [143, 144].

From the earliest days in the population movement there has been confusion about the potential beneficiaries of population programs. Are they individual women and their families or nations? In 1965, for example, Sir Dugald Baird, then Regius Professor of Obstetrics and Gynaecology in Aberdeen, Scotland, arguing from an individual rights perspective, wrote that "freedom from the tyranny of excessive fertility" be added to the four other basic human freedoms elaborated by President Roosevelt in the 1940s [142, 145, 146]. The 1968 U.N. Teheran Declaration on human rights echoed this sentiment by declaring that families have a basic human right to chose the number and spacing of their children [3]. This view of access to contraception as empowerment for the individual harkens back to an earlier generation of feminists, notably Margaret Sanger and Emma Goldman, who, according to Ruth Dixon-Mueller, saw birth control as a means by which women might oppose "male tyranny" and "serve as a weapon [for the poor] in the struggle against capitalist exploitation" [3 p. 38].

In spite of some support for the rights and needs of family planning clients, however, the metaphor of population control guides much of the population rhetoric [147, 148]. There are three major problems with the population control metaphor. First, in some cases it can lead to thinking that normalizes coercive policies, notably China's one-child policy [149], legislative policies in Singapore and, for a brief time in India [142]. Coercive policies need not be aimed at limiting population growth, but can instead be pronatalist. Among the harshest state-imposed population policies in recent times were those of the Ceausescu regime, which until overthrown in 1989 outlawed all methods of family planning and abortion in Romania [150]. Government-enforced regulations can, of course, work. Evaluations of China's fertility decline, for example, have found deliberate control to be the major factor inhibiting fertility [151]. In most other countries, however, to a greater or lesser degree, decisions about family planning are viewed as individual, or family level, choices.

A second problem with a population control approach is that, even in countries without coercive official policies, it can lead to ethical violations, because rights of individuals are viewed as less important than the goal of fertility limitation. A 1991 letter from USAID's Office of Population to IPPF, for example, urged against "unnecessary laboratory tests," pelvic and breast exams, and "conservative medical thinking" in deciding issues of safety for women clients of family planning clinics [138, p. 15]. Another example, the continued marketing of the Dalkon shield after serious questions had been raised about its safety, shows that in the promotion of contraceptive methods, women's health does not always have priority [152, 153]. Also questionable is the promotion of family planning through incentive payments to 'acceptors,' who may be influenced by the payments to undergo procedures or take drugs that they would not otherwise have chosen [154, 155]. Ellen Chesler, a director of the International Women's Health Coalition, points out that female sterilization is the most common fertility control method in the developing world, accounting for 40% of users of modern contraception [156]. While acknowledging that many women prefer, and welcome, the permanent end to childbearing that sterilization achieves, Chesler and other feminists argue that poor women may be "quietly coerced" into accepting sterilization without fully understanding, or being offered, alternative methods [156, p. 33].

Eugenics, the notion that 'scientific' principles can improve human populations through better breeding, is in many ways the ethnoscience of the West. Eugenics ideas underlie some population control practices that are directed toward special categories of women, including those who are disabled, members of ethnic minorities, or poor. In the United States, subsequent to a 1927 Supreme Court decision supporting the sterilization of mentally retarded individuals, over 60,000 were surgically sterilized [157]. Although current U.S. policy provides greater protection for the rights of the mentally retarded than in decades past, South Africa in 1975 passed legislation allowing therapeutic sterilization of the mentally retarded [158]. From 1975 to 1989 1817 such women were sterilized. Evidence indicates that Native American women have been sterilized without their full knowledge or consent [159]. By the mid-1970s, one third of Puerto Rican women of reproductive age had been sterilized, which was the highest recorded incidence in the world [160]. Although Puerto Rican health officials claim that these sterilizations have been voluntary, critics argue that this represents "a form of cultural genocide or class warfare" [160, p. 252]. Similarly, Norplant, the new five-year subdermal contraceptive implant, has been used coercively in some cases. In 1991, a California judge ordered convicted child abuser Darlene Johnson to have Norplant inserted [161] and a similar ruling occurred in 1993 in Illinois [162]. A recent volume addresses the safety, acceptability and ethics of Norplant in several countries [163]. Two of the contributors to this volume, writing about Indonesia and Egypt, describe numerous instances in which women have had great difficulty in getting Norplant removed

before their five years had ended [62, 164]. Of course many women, and men, want permanent sterilization, and many women like the contraceptive benefits of Norplant. The problem is not with the methods themselves, but with formal and informal policies that give the decision-making power to someone other than the individual in whom they are used.

A third problem with a population control approach is that, except where coercive policies are strictly enforced, policies based on population control do not work as well as those that seek to meet the needs of clients. Judith Fortney's argument clearly makes this point:

> Governments have many reasons to promote family planning programs in their countries. And women/couples/families have many reasons to want to use family planning. But the reasons are not the same. Couples do not choose to use contraception to protect the environment; they want contraception to protect the mother's health, to devote more attention to fewer children, to ensure that their children get enough to eat and have clothes to go to school and so on. "Population control" arguments are not very compelling among the potential clients of family planning clinics, and may even have set back progress in use of family planning services [165].

Population control as a conceptual framework often focuses on attempting to convince women to use contraceptives. Approaches that are 'woman centered,' in contrast, focus on satisfying family planning clients. Evaluations in a variety of countries indicate that the major factors in successful family planning programs—having a wide range of choices of contraceptive methods and convenient, accessible service—are those that focus on individual clients and their families [142]. It is evident from an examination of highly successful projects, such as that of the Bangladesh Women's Health Coalition, that respectfully meeting the needs of individual women can also be the basis for effective family planning programs [166].

WHY REPRODUCTIVE HEALTH?

In response to the types of abuses outlined above, a few feminists appear to reject most international population programs [167] or even most contraceptive and reproductive technology [97]. Other less extreme responses include scholars who focus on bioethics and the rights of family planning clients. A growing body of literature specifically addresses the ethics of family planning, much of it responding to the abuses of the population control approach [168, 169]. Inspired by this movement, IPPF has outlined 10 rights of family planning clients—the rights to safety, information, access, choice, privacy, confidentiality, dignity, comfort, continuity and opinion [170].

Toward the end of the 1980s staff of the Ford Foundation, the IWHC, the Population Council, and the WHO conceptualized a "reproductive health" approach that could replace the limited, and potentially abusive, "population control" approach [4–8]. This approach places "women at its center" and can, its authors argue, "considerably strengthen the achievements of existing family planning and health programs, while helping women to attain health, dignity, and basic rights" [5, p. 1]. Precisely what would be included in a fully developed reproductive health agenda is still being negotiated among feminists. Disagreement exists about whether reproductive health is sufficiently comprehensive, and exactly what it should include. Some scholars call for a women's health focus that would address such non-reproductive concerns as breast cancer and violence against women and not represent women solely as potential reproducers [171, 172].

Feminist population scholars have begun to address how a reproductive health approach might be the basis for responsible population policies [3] and what a feminist population policy might look like [173]. In anticipation of the upcoming Third International Conference on Population and Development, to be held in Cairo in September 1994, over 100 women's organizations world-wide have joined in drafting a "Women's Declaration on Population Policies" [174]. This statement outlines fundamental ethical principles, program requirements and conditions that would allow women to control their own reproductive health.

The degree to which this approach will be adopted by multilateral and bilateral agencies, or national family planning programs, remains to be seen. For agencies like USAID, adopting a reproductive health approach would mean substantial program reorientation. Nevertheless, the reproductive health movement has begun to have some influence in a few USAID-sponsored projects, albeit indirectly. For example, USAID funds the Egyptian Clinical Services Improvement Project (CSI), a recently-developed and highly successful organization of family planning clinics [175]. These clinics provide low cost, accessible services that are far superior to the other types of government subsidized (also USAID-funded) services available to lower-income Egyptian women. Quality of care at least, if not women's empowerment explicitly, is now the basis for some USAID-supported projects.

SUGGESTED AREAS FOR FUTURE RESEARCH

Social scientists could play a much larger role in policy-oriented research than they do presently. This work could include examining the influence of various policies on women and factors that lead to the creation of those policies [176]. Abortion, for example, is an area in which there has been relatively little policy-oriented research. Two exceptions to this lack of attention to abortion are Faye Ginsberg's [92] study of the grassroots politics of abortion in Fargo, North Dakota and study that I conducted in Egypt on the macro-level forces (law, religion, Western donor support and economics) that shape women's access to safe abortion [90]. The paucity of social

scientific, especially ethnographic, study on abortion is not because it is an infrequently performed procedure. Induced abortion is one of the most common surgical procedures world-wide. The Alan Guttmacher Institute estimates that there are 1.6 million abortions in the United States each year [114]. World-wide there are between 26 to 31 million legal and 10 to 22 million illegal, or clandestine, abortions.

The recent increase in U.S. state laws requiring a 24 h waiting period to have an abortion performed and parental consent for women under 18 years of age are critical areas for study. Recent newspaper coverage has identified additional issues that could be the basis for scholarly inquiry. For example, the *San Francisco Chronicle/Examiner* reported that a lobbying group called the RCR Alliance was established in 1988 [177]. Formed by a Christian minister from Roanoke, Virginia, the RCR Alliance has targeted anti-abortion advocacy efforts toward Hoechst, the German parent company of Roussel Uclaf, which manufactures the abortion pill RU 486 [177]. A letter sent to Hoechst headquarters by the RCR Alliance claimed to know "the location of Hoechst chief executive officer 'Wolfgang Hilger's vacation home in the Alps'" [177 p. 12]. Another *San Francisco Examiner* article described a group of women who were teaching each other the technique of home abortions, with simple hand-held suction devices, that they might perform in the event of abortion being ruled illegal by the U.S. Supreme Court [178]. This interplay between grassroots activists and national or international abortion policies should receive a great deal more attention.

A second neglected area of research involves women's rights in the area of reproductive health. Reproductive rights has developed as a substantive focus of feminist concern both in the United States and abroad [179] and could be the basis for social science study. Among the most tragic reproductive rights violations has been the sexual enslavement of Korean women by the Japanese military during World War II [180] and the use of rape by Serbian forces against Bosnian women in 1993 [181]. Other areas for investigation include a reported increase in spontaneous abortions experienced by Palestinian women in the Occupied Territories, which may be due to their exposure to the Israeli military force's use of tear gas in small enclosed spaces [18]. Other less dramatic, yet critical, areas for study include women's and girls' access to education and health care, the differential mortality of women and girls resulting from disparities in food and medical care, and domestic violence. The reproductive rights agenda has to date largely been defined by Westerners. This is an area, however, which desperately needs alternative perspectives. Social scientists could contribute in important ways to the analysis of how people in different cultures define rights and values in reproductive health and how these rights are constrained by national policies or cultural expectations.

CONCLUSION

This article has reviewed the background to the policy debates on population control and reproductive health. Feminist efforts to shape the discourse on population policy have evolved from the consumer movement in health and from the work of activist groups. Population control has been a dominant metaphor in international family planning programs since the 1960s. Population control has frequently meant pursuing a single-minded goal of fertility limitation, often without sufficient attention to the rights of family planning clients. This narrow focus has led to some coercive policies, numerous ethical violations, and ineffective family planning programs. Reproductive health is an emerging policy focus, advocated by a growing number of activists and researchers in women's health. A reproductive health framework would provide a broader programmatic focus that could bring needed attention to such issues as sexually transmitted diseases, infertility, abortion, reproductive cancers and women's empowerment generally.

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