

INTRODUCTION

As Thomas Kuhn¹ noted, paradigm shifts in science are fiercely contested, and stem from a build-up of discoveries and new knowledge that changes the fundamental theoretical underpinnings of a scientific discipline. Paradigm shifts in public policy are equally contested, but are usually related to a shift in political power structures and/or policy goals as a result of mounting pressure from diverse coalitions and actors. At the beginning of a paradigm shift in public policy, when the first definite steps in a new direction tip the balance away from traditional paths or structures, those who advocated for the shift are jubilant. A momentous victory has been won, and it seems certain that the next steps will follow inevitably in the new direction. The enemy—outdated and hidebound tradition—has been defeated, and momentum is on the side of innovation. In those initial heady moments, few foresee the obstacle course that lies ahead to maintaining the new direction, translating it into concrete changes, and overcoming resistance to change at all levels in society. The International Conference on Population and Development (ICPD) in 1994 was such a moment for global population policy, as the overall goals shifted from fertility reduction and population control to comprehensive reproductive health and well-being, women's empowerment, and reproductive rights.

When such paradigm shifts start at the global policy level, the new general goals subsume diverse issues. For example, the goal of women's empowerment entails attention to issues such as discrimination against women in education and employment, gender-based violence, female genital

mutilation (FGM), and early marriage. Following the shift in overall goals, the next challenge is to promote attention to these more specific issues, so that UN and donor agencies, civil society organizations, and leaders in governments will translate these important policy gains into changes in international and national laws, policies, and programs.

This challenge is not a simple matter, because important advances often lead to backlash and resistance of equal or greater proportions. In the case of sexual and reproductive health, there are well-financed organizations supporting the backlash globally. While the most publicized face of the backlash occurs in UN meetings such as the “ICPD+10” meetings in 2004, less evident but equally intense resistance occurs within agencies, governments, and at the community level. Finding ways to overcome or circumvent this resistance is a major task for advocacy groups and for sexual and reproductive health programs.

Meeting this resistance requires a process of political and cultural change in organizations and communities; until that happens, the new laws or policies remain rhetoric that have not yet become reality. For example, both the UN system and many governments now have clear policies against gender and racial discrimination, and yet behaviors, attitudes, or traditions that discriminate against women and/or ethnic minorities are present in most countries. Additional examples are all too easy to identify. Advocates in many countries have worked with national decision makers to secure the passage of new laws against gender-based violence, FGM, or early marriage. However, flouting of these laws will continue to be widespread until communities undergo cultural change that increases support for these new norms. Worldwide, there are many successful examples of bringing about the necessary cultural changes in institutions and communities. However, traditional cultural frameworks and beliefs are deep-rooted and often operate subconsciously. Therefore, attempts to change them have to be participatory and require a long-term view. Combating discrimination in institutions and communities entails bringing the discriminatory norms and practices to the surface, subjecting them to conscious scrutiny in the light of day, and then promoting cultural change.

There are multiple cultural, intellectual, and political processes at different levels in a given society or in the global policy arena that stimulate a paradigm shift. No matter which sector in society takes the lead in a paradigm shift—whether political elites or “mass culture”—the work of translating new principles into concrete policy or behavioral changes at different levels of society is littered with obstacles and setbacks as the lead sector attempts all means at its disposal to turn the tide. Sometimes influential organizations—corporations, foundations, universities, NGOs, or government agencies—promote a new policy goal supported by a progressive (or conservative) minority; they might or might not have sufficient influence on others to bring the rest of society on board. Sometimes global or national policies

lag behind civil society attitudes and behaviors, especially when the policy relates to widespread practices that contravene the teachings of influential religions. The so-called sexual revolution in Europe and the United States in the 1960s is a good example of this type of shift, as is the case of divorce in Chile, discussed in Chapter 1.

The four studies presented in this book examine this obstacle course to social change, post-ICPD, in Latin America. Two of the studies focus on advocacy initiatives and/or organizations. They aim to illuminate the facilitating factors as well as the obstacles to advocacy for policy change to fulfill the human right to sexual and reproductive health, both in the national context and within advocacy organizations. The next two studies highlight the successful yet short-lived experiences of two programs in Peru and Chile in the late 1990s in the health and education sectors respectively. The programs translated human rights principles of reproductive rights, gender equity, and citizen participation into concrete program models, while encountering obstacles that ultimately brought about their demise. All four studies suggest ways forward for advocacy groups, schools, and health services.

To set the stage for reading these studies, this introduction will describe in more detail the shifts in the mid-1990s in the population field. Following will be a brief description of each study. Chapter 5, the conclusion to this book, will discuss the crosscutting issues in the studies: contested sexual and reproductive health issues, democratization and citizen participation, organizational change processes, and project versus program approaches.

THE TRANSFORMATION OF THE POPULATION FIELD: INCORPORATING HUMAN RIGHTS AND GENDER ISSUES

Leading Up to ICPD

Many advances in policy, international law, global social movements, and research related to population, health, human rights, and gender issues led up to ICPD during the two decades that span from the first UN Conference on Population and Development in 1974 to the watershed moment of ICPD in 1994. Four important trends leading up to ICPD will be discussed here. First, the definitions of reproductive health and of reproductive rights that formed the guiding axis of the ICPD Programme of Action were based on two principles of health embodied in the first paragraphs of the World Health Organization's (WHO) constitution. The first WHO principle defines "health" as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," thus leading to broader, more comprehensive approaches to health that include, but are not limited

to, the field of medicine. The second principle embodies “the enjoyment of the highest attainable standard of health” as “a fundamental right of every human being without distinction of race, religion, political belief, economic or social condition.”² Almost thirty years later, the International Covenant on Economic, Social, and Cultural Rights (1976) further affirmed a comprehensive rights-based framework for health that addresses the social and economic determinants of ill health and inequities in the enjoyment of health.

Second, during the same two decades, the worldwide expansion of activism in favor of women’s rights constituted another potent influence on the population field. During the International Women’s Decade from 1975 to 1985, women’s activists from all continents met at “NGO Forums” at three UN conferences. The growing international women’s health movement was particularly active at these conferences. When these women’s organizations examined the premises underpinning population control programs, they observed that the overriding goal of fertility control led to coercive practices, disregard for women’s health, and lack of concern for women’s right to full informed choice in reproductive matters. Prominent examples were the coercive sterilization programs (targeted at both men and women) in India, and family planning experiments that introduced new contraceptives without sufficient evidence on health risks, such as the widespread marketing in the early 1970s of the unsafe IUD—the Dalkon Shield—which caused alarming numbers of cases of infection, infertility, and death worldwide.

Third, opposition to the prevailing paradigm of population control came from the socialist and communist political tradition, whose adherents objected strongly to the standard argument that unchecked population control was causing widespread poverty in developing countries. They pointed to inequities in the world economy and national economies as the main driving force behind poverty, and levied charges of genocide and imperialism against Northern politicians seeking to reduce the numbers of their dark-skinned neighbors to the South. This trend in the opposition dominated the debates at the First World Conference on Population and Development in Bucharest in 1974.

Fourth, in the environmental movement—traditionally allied with population control agencies—dissenting voices began to point to consumption patterns in industrialized low-fertility countries rather than rising numbers in high-fertility countries as the main culprit in global environmental degradation.

In summary, progressive trends in the UN system, in international human rights law, in the women’s rights and environmental movements, and among socialist countries and leading intellectuals converged in the 1970s and through the 1990s to undermine the paradigm of population control.

However, research within population organizations and agencies also contributed to the shifts ushered in by ICPD. Researchers in the population field

noted that in many countries, simply supplying family planning services did not lead to use of contraception, and began to examine the barriers to “demand” for family planning. The more demographers and other social scientists examined the dynamics behind women’s patterns of high fertility, the more they found poverty, gender issues, cultural valuation of high fertility, fear and distrust of the medical establishment, and lack of social security systems as the driving forces. The association between increased educational levels for women and lower fertility was established by numerous studies. The Population Council was in the vanguard of efforts to introduce the “users’ perspective” in concepts of quality in family planning programs, in order to afford women respectful treatment and full informed choice, and in the process, improve demand.³ Several other major population agencies—including USAID—experimented with programs designed to raise women’s status while providing access to family planning education and services, to see whether raising status affected demand.⁴ In other words, from within the population field, the realization of the need for a more rights-based and comprehensive approach was growing.

In the 1990s, two United Nations conferences preceded and followed ICPD, and both significantly increased the legitimacy of efforts to advance women’s rights based on the Convention on the Elimination of All Forms of Discrimination against Women, which entered into force in 1981. The consensus agreements in the World Conference on Human Rights in Vienna in 1993 and the Fourth World Conference on Women (FWCW) in Beijing in 1995⁵ made important advances in global policy, including greater recognition of women’s rights as human rights and of “domestic” violence against women as a violation of women’s rights. ICPD transformed the population field through its focus on women’s rights, incorporating “women’s empowerment” into the central agenda of population and development programs.⁶ All three conferences included an unprecedented level of civil society organizations’ (CSOs) involvement, both in official meetings and in parallel NGO Fora.⁷ This involvement and the policy changes promoted by CSOs were inextricably linked to the broader social changes advanced by democratization movements from the late 1960s through the 1990s: respect for human rights, acceptance of diversity, elimination of discrimination, and promotion of citizenship and empowerment.

The 1994 ICPD Programme of Action put human beings’ welfare and rights at the center of all development and population policies. ICPD focused on three basic guiding principles: comprehensive sexual and reproductive health, women’s empowerment, and respect for individuals’ and couples’ reproductive rights. In 1995, the Beijing Platform for Action included a fuller range of issues central to women’s empowerment and rights, and in its language even advanced slightly in the area of rights to sexual health, defined by ICPD (7.3) as “the enhancement of life and personal relations,

and not merely . . . care related to reproduction and STDs.” The Platform for Action further elaborated:

96. The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences.⁸

The term “sexual rights” has never made its way into any conference consensus agreement or international human rights treaty, but the ICPD Programme of Action states that the concept of “reproductive health” includes sexual health. By that same logic, “reproductive rights” includes the right to information, education, and services related to both reproductive and sexual health.

Obstacles to Implementing ICPD Principles: Resistance and Confusion

As mentioned above, a strong backlash and resistance to one or more of the main ICPD principles is perhaps the most important obstacle to converting the principles into concrete changes in national programs and policies. Commitment to gender equity and to fulfillment of human rights is necessary to protect health, but these principles often run counter to the dominant norms in a given culture. The first two chapters illustrate how advocacy for legal divorce and safe, legal abortion to reduce maternal deaths run into political resistance arising from dominant religious and cultural norms. In Chapter 3, Consorcio Mujer’s focus on users’ rights and participation went against the grain of traditionally hierarchical Peruvian health services. In Chapter 4 on the JOCAS in Chile, the uncensored free expression of the students in a participatory sex education program erupted into the public domain through the media, igniting public controversies and political pressures from religious leaders to shut down the program.

Another important source of resistance was and is bureaucratic. Reorganization in bureaucracies is often chaotic and conflictive. Managers of vertical programs in government or international donor agencies—maternal-child health, family planning, STIs, and in the 1990s HIV/AIDS—have jobs and budgets to defend. Attempts to unite two or more programs under one umbrella to create a comprehensive sexual and reproductive health program can unseat senior officials, create lay-offs, and cause logistical headaches. Not surprisingly, even within population agencies that officially endorsed ICPD, many senior managers were resistant to the loss of an exclusive focus on family planning.

Another obstacle arises from uncertainty about how to implement ICPD principles. Any new and pioneering direction has no road map to follow. Those who support the new paradigm in theory still need to figure out how to integrate these principles into their policies and programs. How does one transform the fundamental philosophy and goals behind a program? Is it a different configuration of services and activities? If so, which ones? How do work plans and procedures change? If the needed change is attitudinal among staff, how do we bring that about? How does one deal with resistance from one's own staff, from other stakeholders? Do we need new incentives and performance indicators? What are the budgetary implications? How can we be more comprehensive within the same budget? Reproductive health includes so many issues; how can we prioritize? How does one measure success?

Attempting to answer these questions, program after program reinvented the wheel when experimenting with integration of the principles accepted at ICPD. In many countries, family planning programs changed their label to "reproductive health," but did little different except for adding single services such as cervical cancer screening. Decision-makers in many agencies either actively resisted or threw up their hands in bewilderment when asked to incorporate a "gender perspective" or a "rights-based" approach.

In Latin America, the pilot programs pioneered by feminist organizations in the 1980s and early 1990s constituted a promising source of guidance, because they pre-figured the principles agreed on at ICPD and FWCW of comprehensive sexual and reproductive health, women's empowerment, and respect for women's and reproductive rights. However, these feminist efforts tended to be short-lived projects, or small-scale programs that were hard to "scale up," that is, to bring to a national or regional level with mass coverage at a reasonable cost.

Reproductive and sexual health advocates and program managers have been engaged in this dual challenge of advocacy to counter resistance and guidance to assist implementation ever since ICPD. There have been many successes. Most recently, the countries of the world resoundingly reaffirmed the Programme of Action in the ICPD+10 meetings in 2004, despite intense lobbying by the U.S. delegation and a handful of other countries. However, within agencies and organizations, whether due to failure to buy into the new principles or confusion about how to proceed, or both, delays and resistance are rife in the organizational change process. Often, the two obstacles are related. The answers to the questions that arise are complex enough that confusion is an easy excuse for failure to act. Initial steps to implement rights-based approaches can incite resistance among the staff, leading managers to decide to abandon the effort. Many decision-makers use the new consensus rhetoric, but are not completely convinced of these new principles. In this situation, it is convenient to focus on the difficulties, complaining that

the process of implementing these principles is too complex and costly, or too difficult to grasp.

However, the confusion is real, not just a pretext; it must be addressed. We are all “bush-whacking” in uncharted territory and the way ahead is not always clear. Both the convinced and the unconvinced express the need for “tools,” “guidelines,” “indicators,” and “road maps” to help them implement the principles embodied in these new phrases: “gender perspective,” “rights-based programming,” “sexual and reproductive health,” or “male involvement.”

Efforts to address these two obstacles to implementing ICPD—resistance and the need for guidance—form the two axes for this book. Putting ICPD principles into practice in programs usually requires both advocacy with decision-makers and experimentation with new models and strategies at the program level. Ongoing staff training and new incentives are necessary in order to effect the sustained transformation.

DESCRIPTION OF THE STUDIES—FOCUS AND METHODOLOGY

These studies analyze experiences in countries in the Southern Cone and Andean Region of Latin America, where the author lived and worked from 1992–1998. Corresponding to the main types of challenges post-ICPD, the four chapters fall into two categories: (1) studies of the political and organizational dynamics of sexual and reproductive health advocacy, and (2) studies of innovative experiments in implementing ICPD principles along with the rights-based mandate to enhance the participation of young people and women in the programs that affect their lives.

The Advocacy Studies

Chapter 1: The “Double Discourse” on Sexual and Reproductive Rights. This study analyzes the cultural and religious norms that pose formidable obstacles to sexual and reproductive health advocacy in Latin America. The article argues that societies accommodate conflicting views on sexuality and reproduction with a “double discourse system” that causes a disjunction between the public and private spheres. Official speech and policies on sexual and reproductive health must be based in religious dogma, leading to failure to protect the health of a country’s inhabitants. On the other hand, governments tolerate unofficial and often illegal mechanisms that expand private sexual and reproductive choices, so long as they stay out of the public eye. These unofficial mechanisms for expanded choice are mostly available to the middle and upper classes, leading to inequities in enjoyment of the basic right to health. The examples of divorce policy in Chile and abortion policy in Colombia and Chile are highlighted to illustrate how this “chasm” between

public discourse and private actions operates in practice, and who is harmed by it. The article concludes by discussing the implications of this system for rights advocacy, and provides some suggestions for reducing the political costs of transgression in countries characterized by this system.

The study is mainly based on findings from a literature review that included published sources as well as a corpus of unpublished sources: conference papers, agency-funded evaluation reports, and unpublished theses. The study also draws on the author's reflections on her experiences in the 1980s and 1990s with advocacy initiatives in Latin America. Conversations with colleagues in Chile and Colombia and several readers of first drafts added valuable content to the article.

Chapter 2: NGO Advocacy Networks in Latin America. This study analyzes the experiences during the 1990s of thirteen Latin American regional and national networks of nongovernmental organizations that advocate for sexual and reproductive rights and women's rights.

The questions guiding this study arose from the author's reflections on her experiences with these networks while working at the Ford Foundation. The networks had trouble constituting themselves as actors with a public voice in the national arena, and the study aimed to analyze the reasons for their difficulties. The questions relate to the relationship between the political advocacy role of these networks and their governance structure, facilitating factors or obstacles to their advocacy, and the most appropriate advocacy strategies for such networks.

The study highlights several dilemmas. Feminist networks reacting against authoritarian structures often strive for consensus decision-making and nonhierarchical structures, limiting their ability to take decisive action on controversial sexual and reproductive health advocacy issues. Analysis of problems related to membership, decision-making, and leadership structures provides some helpful insights for other advocacy networks. The effect of financial pressures on struggling NGOs limited their ability to take controversial stances, as did expansion of membership to enhance diversity. The chapter discusses and analyzes the successes of these NGO networks and the problems they faced, leading to suggestions for other advocacy networks in the often-contentious spheres of sexual and reproductive health and rights.

The study draws on an extensive literature search on networks, the women's movement, and political coalitions, as well as the author's personal experiences as a donor to the networks. These sources are complemented by in-depth semistructured interviews with five regional and eight national networks; some of these are group interviews, and others individual interviews with the network coordinators. National networks from Chile, Peru, Colombia, and Mexico were interviewed. Networks of grassroots, provincial (outside of the capital) or rural organizations are not represented in the study.

The Program Case Studies

These programs in Peru and Chile experimented with rights-based approaches based on goals of women's and young people's empowerment. The interventions challenged the traditional hierarchical systems of Peruvian health clinics and Chilean schools, while promoting women's and young people's access to vital health information and services. In different ways, both programs aimed to change the culture of the institutions where the intervention took place.

Chapter 3: "Let's Be Citizens, Not Patients!" This study of the *Consortio Mujer* program in Peru analyzes the experiences of a consortium of women's movement organizations in an innovative four-city experiment that promoted respect for users' rights through involving women's community organizations in evaluation of quality of public health services. The consortium explicitly promoted a model of women's citizenship that countered the traditional paternalistic, and often abusive, model of provider-client relationships in the health services in Peru. The consortium conducted needs assessments of quality of care, involving both health providers and community women. These assessments fed into training workshops on quality of care and users' rights for both health providers and community members, and the development of proposals for quality improvements for each health center. The project aimed to achieve a more equal sustained relationship between the two groups through the establishment of Users' Committees among community organizations, and Quality of Care Committees in the health centers.

The study illustrates the tensions and dynamics that arise between community members and health service providers when women strive to become "citizens, and not patients," exercising community oversight of health services. The findings suggest some factors that would facilitate similar efforts in other locations, and help create sustainable channels for dialogue between health services and the communities they serve.

In the Peruvian study, the author conducted semistructured interviews with the NGO coordinators, leaders of the participating women's organizations, and health professionals at the six project sites during a two-week period in December 1998. These interviews are complemented by subsequent conversations with the *Consortio Mujer* leaders during subsequent trips to Peru in 1999 and 2000, notes from an observation of an all-day meeting in Piura in 1997, and visits to all the other five sites between 1994 and 1997 while the author still worked at the Ford Foundation. These sources of data are complemented by literature on the health system in Peru at the time of the study, and studies published by Peruvian women's NGOs.

Chapter 4: "Conversations and Controversies: A Sexuality Education Program in Chile." This study describes a government-sponsored sex

education program in Chilean schools and communities: the “Conversation Workshops on Relationships and Sexuality,” or JOCAS (the acronym in Spanish). The case shows how a participatory program with empowerment goals for adolescents adapted to a socially conservative context when faced with intense public controversy, and scaled up to include half (600) of all of the secondary schools in Chile. The program consists of the promotion of informal and uncensored conversations among students, and then among students and parents, complemented by contact with community resource people who answer students’ questions on sexual and reproductive health issues. The study highlights the strengths as well as the limitations of this highly decentralized and participatory model. It analyzes factors limiting parent participation and suggests possible mechanisms to ensure students’ access to comprehensive sexual and reproductive health information in locally controlled schools. Finally, the study examines the political dynamics and tensions that contributed to the demise of the program.

The JOCAS experience illustrates how controversies surrounding adolescent sexual and reproductive health programs wear down political will. This experience is repeated in diverse forms in almost every country, finally resulting in a nearly worldwide failure of governments to fulfill their obligation to protect the health of vulnerable young people.

For the study of the JOCAS, the author conducted face-to-face and telephonic semistructured interviews with professionals and government officials closely involved with the design and implementation of the JOCAS from mid-1998 through 2003. In 1998, the author observed one JOCAS training session involving teachers, parents, and students from several schools. Numerous e-mail exchanges with these professionals supplemented the interviews, as did review of evaluation reports, manuals, and newspaper articles.⁹ Although none of those interviewed by the author were at the school level (students, teachers, administrators, or parents), the study draws on earlier evaluations that interviewed and surveyed school-level stakeholders. Through her program at the Ford Foundation, the author supported the evaluation study of the first thirty pilot schools in 1995 and 1996, and attended meetings related to the JOCAS in the period from 1995–1997.

RUNNING THE OBSTACLE COURSE

Globally and within most countries, there is progress in fulfillment of the human right to sexual and reproductive health. In 2005, from the author’s vantage point in the United States, these rights seem particularly threatened, but the countries of the world resoundingly defeated the U.S. administration’s efforts to roll back the ICPD agreements in the ICPD+10 meetings in 2004.

Revealing the point of view of participants, these studies shed light on attempts to address both the resistance fulfilling the basic human right to

sexual and reproductive health and the need for guidance in how to do so. The lessons from the experience of these advocates and programs in Latin America should help others to turn the rhetoric of ICPD into the reality of policies and programs. Progress on fulfilling sexual and reproductive rights will always suffer setbacks and obstacles, many of which are placed on the course by well-organized and well-financed conservative groups. Nonetheless, in this obstacle course, the overall direction of the runners is forward. May this book contribute to their progress.

NOTES

1. Thomas Kuhn, *The Structure of Scientific Revolutions*, Chicago: University of Chicago Press, 1962.

2. Original text of the WHO constitution accessed on October 21, 2005: http://w3.who.org/LinkFiles/About_SEARO_const.pdf. An interesting discussion of amendments since 1948 can be found in: Dr. U Than Sein, "Constitution of the World Health Organization and Its Evolution," *Regional Health Forum*, Volume 6, No. 1, 2002; accessed on October 21, 2005: <http://w3.who.org/rhf/rhf6-1/7whoconstitution.htm>.

3. See Judith Bruce 1990. Her framework was disseminated widely, leading to a body of literature on the subject.

4. See Helzner and Shepard 1990 and 1997. The experiments suffered from various design flaws, including too short a time frame and too few participants, and so they did not contribute to the literature on the link between women's status and fertility patterns.

5. The Vienna Declaration and Programme of Action A/CONF.157/23, July 12, 1993; accessed in June 2005: [http://www.unhchr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En?OpenDocument](http://www.unhchr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En?OpenDocument); The Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, September 5–13, 1994, UN Doc. A/CONF.171/13; accessed in June 2005: <http://www.unfpa.org/icpd/docs/index.htm>; The Platform for Action from the Beijing Conference A/CONF.177/20/REV.1; accessed in June 2005: <http://www.un.org/womenwatch/confer/beijing/reports/>.

6. See the chapter on the international women's movement in Keck and Sikkink 1998, for a comprehensive description of this historical process.

7. The literature on the role of women's and other civil society NGOs in the ICPD and FWCW conferences and in the follow-up conference five years later is vast. The websites of The Women's Environment and Development Organization (WEDO), the Center for Reproductive Rights, the International Women's Health Coalition, ISIS Internacional, the Latin American and Caribbean Women's Health Network, CLADEM, the United Nations Population Fund, and the UN "Women Watch" site all contain useful articles, summaries, and access to other publications.

8. The Platform for Action from the Beijing Conference op. cit.

9. One respondent provided copies of the relevant Chilean newspaper articles from 1996–1997. Sources for other articles are mainly from the Internet.