A Global Affairs Commentary

August 14, 2002

The Far Right, Reproductive Rights, and U.S. International Assistance: The Untold Story

By Jodi L. Jacobson and Rupsa Mallik, Center for Health and Gender Equity

In late July, President Bush cut off funds to the United Nations Population Fund (UNFPA), deeming it guilty by association for abuses within China's one-child family program, despite findings by the administration's own investigative team that no such links exist. Yet while all the focus of public debate is on China and UNFPA, crucial issues about U.S. policies and the politics of reproduction in developing countries continue to be overlooked.

Coercive policies and practices—including the use of targets, incentives, and disincentives—are a legacy of the era of the "population bomb." These practices continue in a number of countries today, and in many cases, Washington's own policies are at least partly to blame. And while the premise of cutting funds to UNFPA is concern for women's rights, the administration and its conservative allies in Congress are working through the legislative and appropriations process and through more covert tactics in a number of countries to undermine the very health services on which millions of women depend for basic care. The irony is that these efforts, coupled with mounting political pressure in many populous countries to cut birth rates farther and faster, increase the likelihood that more women will be subject to heavy-handed approaches to reducing births in the long run.

Throughout the 1960s and 70s, mounting fears about the effects of rapid population growth on poverty, the environment, and international security led to a focus on reducing birth rates throughout the world. National family planning programs were established in many populous countries, including Bangladesh, China, India, Indonesia, Kenya, Mexico, and Peru. Where social conditions were conducive and individual and social goals coincided, birth rates fell relatively quickly. But where demographic objectives were out of sync with individual preferences, fertility declined much more slowly, if at all.

To hasten fertility declines, donor nations invested heavily in family planning programs. The U.S. Congress, for example, concluded that "population control" was necessary to preserve order and stability in developing countries-and thus protect U.S. interests. Annual appropriations grew rapidly and the United States quickly became the leading donor in this area. U.S. influence in some programs grew markedly. Over a 25-year period ending in the mid-nineties, for example, the U.S. contributed one-fourth of all funds for Mexico's family planning program.

As investments increased, governments simultaneously put increasing pressure on these programs to show results. The U.S. Congress developed stringent reporting requirements for the United States Agency for International Development (USAID), requiring USAID to demonstrate how funding translated into increasing contraceptive use, numbers of births averted, and lower birth rates overall.

As a result of the pressure to perform, "choice" became a relative concept in many programs. In the 1980s, for example, providers in Indonesia were initially trained to insert Norplant, but not to remove it, leaving women who suffered side effects or changed their minds without recourse, and eventually tainting the method itself. During the 80s and 90s in Mexico, large numbers of women delivering babies in government maternity hospitals were sterilized without consent, a practice that continues in at least some states today. In Bangladesh, India, Mexico, Peru, and elsewhere, women were

FOREIGN POLICY IN FOCUS

encouraged to “choose” sterilization and IUDs over other “less effective” methods. Food, money, and other incentives were used along with disincentives in a carrot and stick approach, especially in marginalized communities. Pressure was put on health care providers, whose salaries and even jobs sometimes depended on the numbers of new users recruited.

The historical tension between individual needs and demographic goals created a striking paradox that persists today: Family planning services were and are desperately needed by women seeking to control their fertility safely and effectively. Indeed, increased access to a wide range of reproductive health services is quite literally a life and death issue in places where complications from pregnancy and delivery, unsafe abortion, and HIV are the leading causes of illness and death among women in the prime of their lives. Yet from their inception, these services became the conduit for a political agenda that had less to do with women’s needs than it did with the achievement of demographic goals.

In the early 90s, nongovernmental organizations from every region worked to forge international agreements, such as the Program of Action of the 1994 International Conference on Population and Development, that called for a shift toward a focus on promoting women’s health and rights. Since that time, national policies in many countries have changed dramatically. And both bilateral and multilateral donor agencies such as USAID and UNFPA have worked strenuously to retool and provide both leadership and technical assistance to countries struggling to implement new approaches. Not surprisingly, changes on the ground have lagged behind in part because problems created over a period of forty years can not be changed overnight, in part because of conflicting political agendas, and in part because a population control agenda is re-emerging in some countries.

In 1995, for example, the Government of India sought to do away with its notorious target-based family planning program by creating the “Target-Free Approach,” intended to create a system focused on individual choice and quality of care. But many states never really became target-free, due to lack of commitment to and funding for needed changes in programs, and lack of alternative means of evaluating the performance of health workers, among other things. Poor quality of care and questionable practices remain a problem in several states. This scenario has been repeated in Peru, where under President Alberto Fujimori, the government focused on achieving demographic objectives by aggressively increasing the use of modern contraceptives. Targets were set in which health care workers were required to fulfill numeric quotas for sterilization, legalized in Peru in 1995. This approach led to the same types of abuses of choice and consent that have been evident in India, Mexico, and other countries.

Strenuous efforts to improve services are being made by international agencies such as UNFPA, USAID, and innumerable national and international NGOs, but these have been persistently undermined by the recurrent funding cuts sought by conservatives. Multilateral institutions, frequently viewed by recipient governments as more independent than bilateral donors, can act as a more effective counterweight to coercive measures. Last year, in the state of Gujarat, India, for example, the government considered stringent measures aimed at promoting two-child families. In field visits conducted last fall, sources both within and outside the government repeatedly told us that UNFPA played a singular role in lobbying for critical changes to the policy that focused on individual rights.

Problems in these programs are a reality, but given the urgent need for reproductive health services worldwide, they are far from the whole story. Yet the conservative right here and abroad have nonetheless joined forces to undermine reproductive health programs in every way possible, using human rights as a foil for their efforts, while making no commitment to improving women’s health or taking meaningful steps to eliminate coercion. In effect, the right has merely replaced one anti-woman political agenda with another.

Each year, for example, conservatives in the U.S. Congress seek new ways to limit funding for family planning by insisting on onerous procedures such as “metering,” in which funds appropriated by Congress were literally meted out to USAID in increments so small that programs could not function properly. Congressman Chris Smith, who has made a career of bashing health programs, recently visited Peru where he and his staff have been working doggedly behind the scenes to undermine access to emergency contraception and to the equipment needed to treat life-threatening infections in women with complications from unsafe abortions.

In addition, laws passed in recent years by the U.S. Congress under the guise of preventing coercion instead are routinely used as a tool to further undermine programs in ways that are likely to increase it. In 1998, for example, Congressman Tiahrt, who

earlier had tried and failed to completely eliminate U.S. bilateral funding for family planning, attached an amendment to the 1998 appropriations bill that calls for withdrawing funds from any country in which violations can be found. Since then, the Tiahrt Amendment has been used by conservatives to mandate cumbersome monitoring and reporting by USAID, and to justify sending missions abroad to investigate abuses for the purposes of cutting funds altogether.

Such absolutist measures are both dangerous and counterproductive. First, they unquestionably make it harder for donor agencies to openly address problems where they exist for fear of losing funds altogether. This happened in Mexico where, throughout the 90s we and our colleagues in Mexico persistently raised concerns with the government and donors about violations of informed choice and changes needed to address these. At the same time, however, Congressman Smith was forging alliances with the Catholic Church in Mexico, an institution not known for its avid support of family planning. Concerns about political harassment by the conservative right in the U.S. Congress and the Church in Mexico coupled with irrefutable evidence about violations led the major players first to adopt a series of superficial remedies for promoting informed choice, and second to withdraw U.S. funds from the program altogether so as not to endanger funding for other programs. The end result: Little has since been done to remedy a situation created jointly by both countries.

Such tactics also further undermine women's rights by reducing the resources available to those agencies most able to provide high quality services directly to women while offering desperately needed technical assistance to larger-scale government programs. Finally, they threaten the stability and clout of those in the greatest position to counter the resurgence of coercive policies. In this regard, defunding UNFPA demonstrates as little logic as forbidding independent election observers to remain in countries where vote fraud is rampant.

A better approach would be to acknowledge that needed changes are going to be made only incrementally even in the best of circumstances, to distinguish between incident and pattern, and to continue funding programs while monitoring progress on informed choice and quality of care. Eliminating coercion while promoting women's health and rights will simultaneously require a dramatic increase in funds to expand and improve reproductive health programs worldwide and an unfailing commitment to providing a wider range of needed services. Finally, this agenda requires an acknowledgment that having helped create the situation in the first place, the U.S. has a moral and ethical obligation to help change it. In the annual battles to cripple UNFPA and persistently attack USAID, the conservative right in the United States has shown no inclination for such an agenda.

(Jodi L. Jacobson <jjacobson@genderhealth.org> is Founder and Executive Director and Rupsa Mallik is a Program Associate at the Center for Health and Gender Equity in Takoma Park, Maryland (online at www.genderhealth.org).)