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# A Decade After Cairo: Women's Health in a Free Market Economy

The Program of Action that came out of the 1994 UN International Conference on Population and Development (ICPD) held in Cairo was the first and most comprehensive international policy document to promote the concepts of reproductive rights and reproductive health.

Its major recommendation – that population programs should provide integrated reproductive health services rather than just family planning – reflects the organizing and lobbying of women's health groups around the world, and the Program has undoubtedly been a useful lobbying and advocacy tool for women's health activists internationally.

One decade later, however, maternal mortality worldwide remains high. Some 600,000 women die each year, 95 per cent of them in sub Saharan Africa and Asia. Eighteen million are left disabled or chronically ill because of largely preventable complications during pregnancy or childbirth. These figures indicate that many women do not have access to essential and emergency obstetric care, let alone access to more comprehensive reproductive health services.

Indeed, more generally:
i) Health services in many countries are in terminal decline;
ii) The underlying conditions that determine women's health and their ability to make decisions about their childbearing are deteriorating;
iii) Fundamentalisms opposing women's rights are on the rise; and
iv) Malthusian thinking that attributes social and environmental problems to the number of children to whom women give birth is as ingrained as ever in development institutions, donor agencies and government departments.

These four trends can be attributed in large measure to the implementation of neo-liberal economic policies over the past two decades, first by means of structural adjustment programs and more recently by international trade agreements. Such policies have helped to prevent the more progressive aspects of the Cairo Program of Action from being implemented.

More critically, however, the Program of Action, and the political organizing that accompanied it, did not challenge this neo-liberal framework sufficiently. In fact, it endorsed it in several respects.

**A Few Health Services for the Few**

Ten years ago, many lobbyists calling for population programs to provide comprehensive reproductive health services seemed not to

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notice that influential policy makers were advocating cuts in public health services, the introduction of "user fees" for the public services that remained, and incentives for the "free market" in the health care sector. These developments have had important implications for reproductive health politics.

Much of the Program of Action simply followed the prescriptions outlined in the World Bank's 1993 World Development Report, *Investing in Health*, which openly advocated one limited and under-funded health care system for the poor ("essential clinical services"), and another high-tech one for those who can or will pay.

The Program's free-market and neo-liberal approach to implementation undermined its groundbreaking principles and goals of gender equality, women's empowerment, and reproductive and sexual health. Governments may now subsidize family planning as part of the essential clinical services they provide, but do not pay for doctors, nurses or midwives.

Several studies from Ghana, Swaziland, Zaire and Uganda suggest that the introduction of user fees for public health services is often followed by dramatic drops in women's use of health care services, an accompanying rise in maternal and infant mortality rates, and a drop in the use of services to treat sexually transmitted diseases.

The Malaysian women's group, Arrow, concludes that "government and civil society actors trying to implement the Cairo recommendations are working at odds with donors and governments striving to cut health costs."

Many women's groups are now well aware that the processes of "health sector reform" are affecting women's access to health services. Yet calling upon policy makers to integrate reproductive health services into what remains of national health systems leaves unchallenged the interests and forces directing current health sector reforms and their connections with global financial and trade interests.

**Neo-Liberalism's Impacts on Health**

Neo-liberal economic policies have affected not just women's access to health services but also the determinants of their health more generally. A large proportion of maternal and infant deaths in India, for instance, are attributable to undernutrition, anemia, and infectious and communicable diseases, which are in turn attributable to poverty and a lack of food, not to a lack of contraceptives.

Women's reproductive rights cannot be achieved unless other fundamental rights – to food, work, freedom of movement and education, for instance – are met. This means that the impact of socio-economic policies on women's lives has to inform any politics of reproductive rights.

By the time of the 1994 ICPD, the effects of the structural adjustment programs introduced in the 1980s and 1990s were evident. Lifting price controls, freezing or lowering wages, devaluing local currencies, reducing subsidies on basic essentials and encouraging countries to produce food and goods for export rather than domestic consumption all made ordinary people less able to obtain food, transport, education or health care.

In the decade since the Cairo ICPD conference, the agreements of the World Trade Organization (WTO), together with a multitude of bilateral, regional and multilateral free trade agreements, have been implemented to varying degrees throughout the world. If the World Bank has become the most influential institution in terms of health policy and health systems, the WTO has arguably become the most important in its impact on the conditions for health.

Many of these trade agreements require countries to allow competition in health care, water, education and energy services, opening up the way for the commercialization and privatization of public services. The privatization of water supply has become a key trade issue. Because of their responsibilities in the household, women tend to have a higher dependency on access to clean sanitation and drinking water. Recent outbreaks of cholera in South Africa and Latin America have been linked to the privatization of the local water supply.

In countries where average wages dropped and unemployment increased, more women and children entered the paid workforce to

increase household incomes. Many of the new jobs created in export industries, however, were unskilled and low-waged. Many women became more exposed to machine-related accidents, dust, noise, poor ventilation, exposure to toxic chemicals and sexual abuse, all of which can affect reproductive health, leading to miscarriages and poor fetal health.

Many women left their homes in huge numbers to find work as nannies, domestic help or sex workers. In many countries, women turned to prostitution, making them more vulnerable to sexually transmitted diseases. Many commentators now link the increasing commodification of sexuality, trafficking in women and girls, and prostitution with the neo-liberal economic agenda, as women and girls have fewer and fewer options to earn livelihoods. All of these processes facilitate the spread of HIV and AIDS, thus undermining women's reproductive health and rights still further.

Despite its groundbreaking advances, the Program of Action failed to address macroeconomic inequities and the inability of prevailing neo-liberal, market-oriented approaches to deliver reproductive and sexual health for the vast majority – the commercial sector is just not interested in delivering services to those who can't afford to pay for them.

Reproductive health and rights – and indeed health in general – require broad, multisectoral approaches rather than single interventions. In practice, however, reproductive health is still translated narrowly as family planning, although now with HIV/AIDS treatment and prevention tacked on.

**Resurgent Fundamentalisms**

One reason that many women's health groups paid less attention towards assuring the structural and macroeconomic conditions for women to exercise their rights was because they were aiming instead to counter the impacts of religious fundamentalisms on women's rights and self-determination. But a decade later, both economic and religious fundamentalist and traditionalist interests have gained ground in both North and South.

As neo-liberalism has impoverished and excluded more and more people, so it has generated more and more support for religious fundamentalisms, which are thus strengthened in their goals of subordinating women. Women's health groups are struggling today not only to ensure the provision of integrated reproductive health services but even to retain some of the Program of Action's progressive language and concepts. The United States, for instance, has called for many of the key concepts and all language referring to reproductive health services, reproductive rights and sexual health to be removed altogether. The Women's International Coalition for Economic Justice link the attempted dismantling of the reproductive rights agenda to today's intertwined fundamentalisms – the "fundamentalism" of the market, and ethnic and religious fundamentalisms.

**Malthusian Thinking**

A final trend that has blocked women from exercising their reproductive rights is the persistence of Malthusian or population thinking within a range of development institutions and policies, echoing the neo-Malthusian subtext that runs through much of the Program of Action.

No matter how progressive or feminist-sounding population policies and institutions may have become, population theory and practice are still deeply entrenched within many government, academic, NGO, and even women's organizational, circles. They have deep and pervasive effects upon women's lives and health in other areas besides population policies.

Population thinking continues to underlie mainstream development and economic policies, for instance – policies that have made more people surplus to economic requirements. Immigrants, the elderly and the disabled are now added to women, the poor, indigenous peoples and people of color that Malthusianism has traditionally targeted.

Claims that burgeoning numbers of immigrants steal jobs, are parasites on state welfare, and destroy the environment of countries such as the US, Britain or Australia derive in large part from Malthusian thinking – even though the word "population" itself may seldom be used. Western countries proclaim themselves "full up" (even as the number of children being born drops to below

"replacement level") and argue that they are unable to admit migrants at the same time as they support wars, development projects and climate change that create ever-larger enforced migrations from the South. The belief that these people are "too many" or "overpopulation" has bolstered public antagonism, racism and fear in many places, has fed renewed calls for population control and harsh measures against migrants – and has supported attacks on women's rights.

The challenge today is not just to make demands for reproductive rights and social justice outside of a population framework, but also to challenge the very thinking that underpins many health, welfare, employment, immigration and education policies, to name a few.

**Conclusion**

Groups seeking to implement reproductive and sexual rights for women have to confront macroeconomic, fundamentalist and neo-Malthusian agendas that perpetuate gender, race and class inequalities and that impede the implementation of those rights for the vast majority.

Some women's groups may still find some space within the Cairo framework to negotiate for higher-quality contraceptive, abortion and health services and increased access to economic and educational resources. But when the international women's health movement accepts the population framework, it ends up endorsing a narrow technocratic agenda rather than broader policies of social and economic transformation.

The real political space will remain in alliance with progressive development agencies, social justice environmentalists, and anti-racism organizers. New Zealand lawyer Jane Kelsey points out that "If the architects of structural adjustment are pooling their experiences . . . to help them impose their agenda on the rest of the world, those who want to stop them should do the same." Kelsey admonishes activists to "take economics seriously" because:

"There is no boundary between economic, indigenous, social, foreign, environmental or other policies. Those who focus on narrow sectoral concerns and ignore the pervasive economic agenda will lose their own battles and weaken the collective ability to resist."[i]

Kelsey concludes that activists need to "rethink identity and alliances – combine a critical analysis of economic, political, cultural and social models of the past with a forward-thinking vision of what a socially just future might look like."[ii]

This is the task before the international women's health movement.

*This paper is an edited extract of "A Decade After Cairo: Women's Health in a Free Market Economy", by Sumati Nair and Preeti Kirbat of Women's Global Network for Reproductive Rights (WGNRR) and Sarah Sexton of The Corner House, CornerHouse Briefing 31, www.thecornerhouse.org.uk; www. wgnrr.org*

[i] Jane Kelsey, *Economic Fundamentalism,* Pluto Press, London 1995, p.372.
[ii] Ibid