INTERNATIONAL REPRODUCTIVE HEALTH:

A PERSPECTIVE ON RESEARCH, POLICY, AND PRACTICE

By

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A Thesis

Presented to

The Faculty of Humboldt State University

In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts

In Social Science

(May, 2011)

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ABSTRACT

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This thesis provides a lens through which to view the field of international reproductive health in order to better understand where it stands today, how it evolved to its current state, and the directions in which it is going. This research explores how systems of power, privilege, and oppression intersect with networks of states and their agencies, international institutions and organizations, donor and funding organizations, non-governmental organizations (NGOs), the medical-industrial complex, social and scientific research, educational systems, and the media. These networks produce, reproduce, shape, share, and distribute knowledge about reproductive health, which greatly influences dominant discourse, policies, practices, and decision-making from the international to the individual level. I propose that there is an epistemic vortex, *Reproductive Health International*, that fosters a global view of and approach to reproductive health, but also generates different manifestations and meanings as it encounters local actors. This metaphor reflects the complexities of reproductive health research, the development of international reproductive health policies, and the way in

which reproductive health strategies are put into practice. My research framework has three main roots: (1) postcolonial intersectional ecofeminism, which challenges all systems of power, privilege, and oppression, (2) political ecology, which critically evaluates the political and social aspects of ecological theory and practice, and (3) reproductive justice, which seeks reproductive freedom through advocacy, resistance, and action. I show how the Reproductive Health International vortex operates by examining case studies in the Philippines and Bolivia where I illuminate how hegemonic discourse has been used to justify interventions by the international community and examine the agendas of influential global and local actors who encounter international reproductive health policy and practice. This study reveals the complexity inherent in the production of knowledge about reproductive health, which is essential to our understanding and ability to re-craft a more just reproductive health paradigm.

ACKNOWLEDGEMENTS

I would like to thank my awesome committee, my loving partner, my supportive family and friends, and my “peeps” in the Environment and Community Program. This thesis would not have been completed without you all.

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INTRODUCTION

International reproductive health research, policy, and practice are influenced by a multitude of factors from international development policy to autonomous decision-making. Long standing social systems of power, privilege, and oppression (such as patriarchy, racism, classism, and colonialism) and the globalization of neo-liberal capitalism, affect these factors at every level. Reproductive politics is a field that can be viewed as both a source and symbol of empowerment and liberation, and also as an imposition of oppressive social ideologies. This thesis provides a lens through which to view the field of international reproductive health in order to better understand where it stands today, how it evolved to its current state, and the directions in which it is going. My hope is that the perspective presented here will help to re-craft a more just reproductive health paradigm.

This research examines how systems of power, privilege, and oppression intersect with networks of states and their agencies, international institutions and organizations, donor and funding organizations, non-governmental organizations (NGOs), the medical-industrial complex, social and scientific research, educational systems, and the media. These networks produce, reproduce, form, inform, share, and distribute knowledge about reproductive health, which has an influence on dominant discourse, policy-making, and decision-making from the international to the individual level. This study reveals the complexity inherent in the production of knowledge about reproductive health, examines the agendas of influential global and local actors who encounter international

reproductive health policy and practice, and illustrates measures that have been, and can be, applied to achieve reproductive justice and freedom.

Following David Fairhead and Melissa Leach (2003) [1], I propose that there is a *Reproductive Health International* (RHI), an epistemic vortex that fosters a global view of and approach to reproductive health, but also generates different manifestations and meanings as it encounters local actors. This metaphor reflects the complexities of reproductive health research, the development of international reproductive health policies, and the ways in which reproductive health strategies are put into practice. The diagram of the RHI vortex below (Figure 1) is visually simple, but it points to a complex reality for international reproductive health.

[1] See their book, *Science, Society and Power: Environmental Knowledge and Policy in West Africa and the Caribbean* (2003).

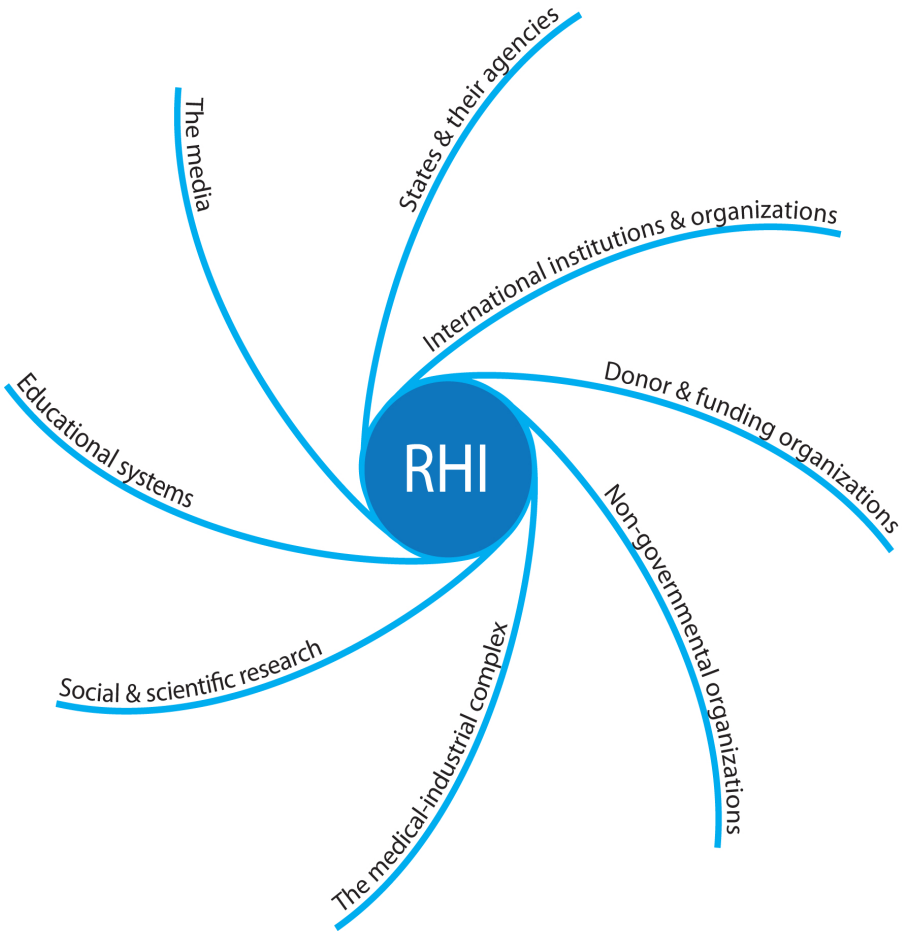

Figure 1: The Reproductive Health International (RHI) vortex[2]

[2] Image by Oneness Creations (www.onenesscreations.com)

Political ecologists, Fairhead and Leach, argue that knowledge about tropical forests, and the relationship between people and forests, has been globalized and filtered through a matrix of social systems (e.g., sexism, racism, classism, colonialism, and capitalism) and institutional networks (e.g., science, academia, educational systems, media, governments and their agencies, intergovernmental organizations, donor foundations, and lending organizations). This interconnected matrix amounts to a vortex they call "Tropical Forest International," which creates an internationalized spin on the "production of knowledge about tropical forests" and "shapes what we know about the environment and tropical forests (and what we don't), and the ways in which debates are conducted and manifested" (Fairhead and Leach 2003:26).

The vortex is a valuable metaphor that captures "something of the growing global coordination of science and policy, without orchestration by any particular international organisation, state or located institution" (Fairhead and Leach 2003:26). They state that there are

> certain trends in the treatment of forest and biodiversity issues in the nexus of international conventions, the United Nations, and other international organisations, multilateral and bilateral donors, trans-national corporations, international NGOs, international research centres and the research community more widely. [They] make the case that the sheer mass of organisations and the networks (and rivalries) which link them generates a dynamic of its own. This has the quality of a vortex into which people and organisations involved with research or policy—nationally as well as globally—are drawn whether through obligations to internationally negotiated regimes, funding, interest, the need for work or to have contemporary relevance, or as the audience for critique. [Fairhead and Leach 2003:26]

The vortex is a useful metaphorical tool to describe and analyze how knowledge is shared and policy is formed and put into action at multiple levels by networks of global and local actors.

Although this epistemological vortex has hegemonic and homogenizing qualities, its impacts on practices are dynamic and variable. Fairhead and Leach "treat 'science' and 'policy' as constellations of component practices and procedures enacted by people and institutions, but also used to structure their choices" (Fairhead and Leach 2003:17). The people and institutions that interact with the vortex do so in different ways and with varying degrees depending on diverse factors such as temporal and spatial localities, regional cultural and social norms and values, and relationships negotiated between local and global actors. In their research, they use grounded examples to illustrate that the realities of tropical forest management strategies paint a different picture than the dominant discourse promoted by Tropical Forest International and, ultimately, advocate for a paradigm shift to accommodate their findings (Fairhead and Leach 2003).

In this thesis, I apply the RHI lens to carefully selected case studies in the Philippines and Bolivia, and critically analyze how international reproductive health ideology and policy hit the ground. Following their research, the perspective presented in this paper provides "a lens through which to discern how national and local social relations of science and policy have been shaped by international animation, and how this process re-shapes broader society" (Fairhead and Leach 2003:11). Applying the vortex metaphor to a comprehensive analysis of international reproductive health enables one to

grasp the growing complexity of the field and understand its role as a subject of study and an instrument of globalization. The RHI vortex diagram below (Figure 1) is visually simple, but it points to a complex reality for international reproductive health. Failure to recognize the widespread power and influence of the RHI vortex on research, policy, and practice impedes our understanding the field of international reproductive health. We need to critically evaluate the interactions of the actors, agendas, and discourse within this vortex, as well as how the vortex is both welcomed and resisted. This is essential to our understanding and shaping of a more just reproductive health paradigm.

I employ a feminist standpoint epistemology and explain my personal and particular reasons for conducting this research, and the reasons I chose the epistemologies, methodologies, and methods used. Sharlene Nagy Hesse-Biber, Patricia Leavy, and Michelle L. Yaiser write,

> by disclosing *why* sociologists [or social scientists] study a topic, and the decisions that went into conceptualizing research design, one gains a better understanding of the varied issues pertaining to the topic and how one can continue to create reflexive research projects (research that is attentive to the complexity of power relations) in order to create larger amounts of contextualized knowledge. [Hesse-Biber, et al. 2004:13]

Drawing on the tradition of feminist research, I assume the existence of systems of power, privilege, and oppression in our society, which function to benefit some and subjugate others. Even though these socially constructed systems are not tangible, they have very real, and sometimes harmful and violent, manifestations and consequences. I acknowledge that my perspective is partial given my particular social location at this

time. I view this research as a documentation process and my hope is that others will contribute their perspectives and ideas about this research in the future.

My theoretical approach has three main roots: (1) postcolonial intersectional ecofeminism, which challenges all systems of power, privilege, and oppression; (2) political ecology, which critically evaluates the political and social aspects of ecological theory and practice; and (3) reproductive justice, which seeks reproductive freedom through advocacy, resistance, and action. These viewpoints are specifically and actively oriented to resist the proposed RHI paradigm, and to support a paradigmatic shift, which includes the development of an alternative and comprehensive approach to reproductive health.

In the chapters that follow, I will outline my theoretical approach, describe the RHI vortex, and present two case studies where RHI is examined in the Philippines and Bolivia. First, however, I define crucial terms and explain the justification for this research.

Agenda-Setting Power and the Authority to Define Reproductive Health

Reproductive health is a dynamic concept that means different things to different people in different places at different times. Marcia Inhorn, an anthropologist, surveyed and summarized twelve "major messages" from over 150 ethnographies focused on women's health with the intent of bringing light to "a particular set of insights that are important, timely, and quite different from the women's health research agenda currently

being promoted within biomedical and public health circles" (Inhorn 2006:346). The principal message expressed is "the power to define women's health" (Inhorn 2006:348). She writes,

> Women are rarely the ones to set the boundaries of the discussions surrounding the identification and definition of their health problems. Women's health, as a discursive field, is usually defined by others. [Inhorn, 2006:348]

The definitions of what constitutes "reproductive health" and "women's health" that dominate the discourse have been "largely forwarded by the Western biomedical and public health establishments," therefore their concerns reflect the rather narrow Western professional definitions and interests (Inhorn 2006:345).

For example, the National Institutes of Health (NIH) within the U.S. Department of Health and Human Services is the government agency responsible for funding health-related research, including clinical trials.[3] Their reproductive health research agenda and approach to knowledge production have changed over time reflecting societal changes and social pressures, while remaining a powerful institution with much influence on policy and practice. In the 1960s and 1970s, feminist concerns about women's experiences with the medical system resulted in a broader national research agenda that encompassed "a more comprehensive definition of women's health" than the previous focus on gynecology and obstetrics (NIH 1999:167).

[3] The various NIH institutes, centers, and offices that include reproductive health on their agendas include the Office of Research on Women's Health, the Center for Population Research, the National Institute of Environmental Health Sciences, and the Eunice Kennedy Shriver National Institute of Child Health and Human Development.

A 1991 NIH Report, "Opportunities for Research on Women's Health" (also known as the Hunt Valley Report), "emphasized the need for interdisciplinary work to study the effect of social context on women's health" (NIH 1999:167). Applying this new framework, the NIH released their "Agenda for Research on Women's Health for the 21st Century" in 1999 and listed a dozen top priorities in women's health, one of which was reproductive health (NIH 1999). Although the overall goal was to forward inclusive, interdisciplinary, and socially responsible research, Inhorn writes that "the NIH has defined women's health research priorities in strictly medical and public health terms" reflecting "a fragmented view of women's health and women's bodies" and "furthermore, it almost entirely neglects the sociocultural matrix in which women's ills develop, including the context of poverty, patriarchy, and other life stresses… The research agenda was clearly not a reflection of what U.S. women themselves perceive to be their major health problems" (Inhorn 2006: 349). This compartmentalized and patchy view has a great effect on the research agenda, the knowledge produced, and the policies and practices enacted as a result.

There are many ways in which reproductive health strategies and policies affect women and men all over the world. There are also many perspectives, interpretations, and definitions of *reproductive health*, as well as of *reproductive justice* and *reproductive freedom*. The way in which reproductive health is defined has a huge impact on how we conceptualize it and how, and to what extent, it is addressed in policy and practice.

I use *reproductive health* to refer to the health and wellness of one's reproductive anatomy and physiology during all stages of life, the institutional system of reproductive

medicine and its personnel, and the discipline and field of study. It also refers to one's overall well-being, including having access to quality health care and the rights to be informed and make informed decisions within one's particular context. These biological and social aspects of reproductive health are intimately intertwined and should not be thought of as separable.

To Sandra D. Lane, a *reproductive health focus* is a "comprehensive approach to women's health and well-being, that includes fertility and infertility, contraception, abortion, childbearing, maternal morbidity and mortality, sexuality, sexually transmitted diseases, menstruation and menopause" (Lane 1994:1303). The scope of reproductive health could be further broadened to include breast health, as well as holistic mental, emotional, psychological, and social health. There are many social justice aspects of reproductive health that could also be factored into this dynamic concept, such as social positionality, identity, politics, economics, and the relationships we have with other people and the ecosystem.

Reproductive freedom can be understood as the right to freely shape one's own reproductive health and childbearing. Sadly, there are too many examples of how reproductive freedom has been and still remains compromised. According to the Society for Menstrual Cycle Research, a nonprofit interdisciplinary research organization, informed choices about one's reproductive health are "only possible when reliable, accurate, and comprehensive information is widely available" (Kissling 2009). However, this information needs to be contextualized and routinely interrogated if true reproductive freedom is to be achieved.

Reproductive abuse can be most generally defined as the loss of reproductive freedom and self-determination. It is considered abuse when individuals lack the information necessary to make a truly informed decision about their reproductive health. It is also reproductive abuse when women and men are not informed, mis-informed, coerced, forced, or threatened with force to use or to not use reproductive technologies, including permanent sterilization. Reproductive abuse can be used to reinforce and perpetuate multiple systems of power, privilege, and oppression based on gender, race, class, age, religion, sexual orientation, citizenship status, immigrant status, language ability, ability/disability status, and incarceration status. Individuals and groups of people are targeted for reproductive abuse based on their position within these systems.

Justification for this Research

This topic of study is crucial for many reasons. We need to remain critical of reproductive health knowledge production and strategies, and attentive to issues of reproductive justice, freedom, and abuse. I would argue that reproductive abuse is equivalent to war and genocide. Population control policies and strategies are political acts of direct and indirect violence against perceived threats to, and enemies of, the status quo and those in powerful and privileged positions. Farida Akhter writes, "war is essentially a population policy, or to look from the reverse side, population policies are essentially war policies aiming to terminate the people considered as enemy" (Akhter 2003:328). Strategic population control policy is for all intents and purposes war policy,

where the weapons are pharmaceutical concoctions and sterilization procedures, which may be characterized as covert forms of violence, but violence nonetheless.

I know from personal experience, the experiences of those close to me, and my experience gained from working in the field providing reproductive health care, that deciding to use or not to use contraception or other reproductive technologies are very personal and significant decisions in one's life. Modern contraceptive and childbirth technologies can be positive and empowering, but can also cause serious and harmful health effects. Many influential factors contribute to what one knows about reproductive health and what options are accessible and appropriate. I explore how these factors are influenced by RHI and how we can resist and overcome them when necessary. Overall, I want this research to be used as a catalyst for a reproductive health paradigm shift and overall progressive social change. I hope it is used as a tool of empowerment for all to gain complete and total reproductive justice and freedom.

THEORETICAL FRAMEWORK

Three main perspectives inform the theoretical framework for this research: postcolonial intersectional ecofeminism, reproductive justice, and political ecology. This foundation allows me to weave together an argument that draws from the insights of all of these viewpoints regarding reproductive health, which is a necessary strategy to uncover the complexity of the RHI vortex I am proposing. Throughout, I also include aspects of an advocacy approach, because my topic is inherently political and social change-oriented, and a pragmatic approach, because my research will be problem-centered and pluralistic.

Postcolonial Intersectional Ecofeminism

Postcolonial intersectional ecofeminism pays specific attention to the interconnectedness and interrelatedness of numerous existing social systems of power, privilege, and oppression. Audre Lorde defines these systems as such:

> *Racism, the belief in the inherent superiority of one race over all others and thereby the right to dominance. Sexism, the belief in the inherent superiority of one sex* [or gender] *over the other*[s] *and thereby the right to dominance. Ageism. Heterosexism. Elitism, Classism.* [Lorde, 2007:704]

I adapt her definition to also describe heterosexism, ableism, colonialism, and anthropocentrism. Intersectional feminists understand that systems of power, privilege, and oppression are intertwining and mutually reinforcing, and impact all social relations

and institutions, including our interactions with the physical environment (Crenshaw 1991:1244; Andersen and Collins 2007:5; Kirk and Okazawa-Rey 2007a:5-6,16; hooks 2007:712; Rothenberg 2007:121; Warren 2000).

Patricia Hill Collins refers to these interlocking systems of oppression as a "matrix of domination" (2000:18, 23). bell hooks uses the phrase "white supremacist capitalist patriarchy" to describe how this matrix is part of our political world, "functioning simultaneously at all times in our lives" (Jhally 1997). hooks advocates that we should work collectively in solidarity to think critically and expand our awareness of interlocking systems of domination and the "ways we reinforce and perpetuate these structures" (hooks 2007:715).

In order to begin deconstructing these systems, we have to both dismantle oppression and disrupt the unequal distribution of power and privilege together. Essentially, *privilege* is unearned and unfair advantage over Others. There can be no privilege without oppression. Andrea Ayvazian describes oppression as "the combination of prejudice plus access to social, political, and economic power on the part of the dominant group" and argues that David Wellman's definition of racism as "a system of advantage based on race" can "be altered slightly to describe every other form of oppression" (Rothenberg 2007:724). Beverly Daniel Tatum argues that Wellman's definition is useful because it goes further than thinking of oppression as a form of personal prejudice, but as "involving cultural messages and institutional policies and practices as well as the beliefs and actions of individuals" (Rothenberg 2007:126). This way of thinking about racism emphasizes the cultural, systemic, and institutional nature

of relationships of power, privilege, and oppression, and how society informs and influences individual beliefs and behavior.

Since the established systems of inequality privilege some over others, the experience of dominated and oppressed people, and the realities of non-human nature, are marginalized, devalued, omitted, erased, silenced, and exploited by those in power. At the same time, institutional privilege enables those benefiting from the system the ability to overlook or ignore the benefits they receive because the inequalities are normalized and unquestioned. Allan Johnson refers to this phenomenon as the "luxury of obliviousness" (2001:24). According to Gwyn Kirk and Margo Okazawa-Rey, privilege is "the process of accruing benefits and power from institutional inequalities" in which "members of dominant groups generally have built-in economic, political, and cultural benefits and power, regardless of whether they are aware of, or even want, these benefits" (Kirk and Okazawa-Rey 2007a:5). With privilege also comes cultural authority, agenda-setting power, and ideologies of entitlement, all of which work to maintain the status quo and institutional inequality.

Identities formed by and within these systems are fluid, multi-layered, and interlocking, and, therefore, individuals can be systematically privileged and oppressed simultaneously and differently throughout their lives (Kirk and Okazawa-Rey 2007b). One's complex social position is not static, but changes throughout a lifetime temporally and sometimes spatially. In other words, an individual's perspective is partial and subjective given one's particular social location at any point in time. Intersectional feminists believe that by exposing and analyzing the interconnectedness and

interdependence of systems of inequality, we will be able to deconstruct and dismantle them, and move toward creating a more just world for all.

Ecofeminists see social systems of power, privilege, and oppression as also being intimately connected with the oppression and exploitation of non-human nature. According to Karen Warren's ecofeminist philosophy (arguably an intersectional feminist paradigm), unwarranted domination over and subordination of women, other human Others, and non-human nature are upheld by oppressive conceptual frameworks, which function to explain, maintain, and "justify" oppressive, value-hierarchical, binary relationships that sanction the unjustified advantage of some over others (Warren 2000:46-7). This allows for a rationalized logic of domination, which "assumes that superiority justifies subordination" (Warren 2000:47). Within the interlocking systems of power, privilege, and oppression, dichotomies are constructed between "people and the environment, the individual and society, production and reproduction, and sexuality and procreation" (Mies and Shiva 1993:281). These social constructions have very real and tangible consequences, and are clearly evident when examining the issues surrounding reproductive health and justice.

One of the core tenets of ecofeminism is the acknowledgement that environmental issues are women's issues because women are disproportionately affected by, and blamed for, environmental degradation. Examples of this connection are abundant (Warren 2000:1-16). In the Global South, for instance, women in rural, subsistence-oriented agrarian societies are usually responsible for providing sustenance for their families and communities, and are usually dependent on local natural resources to do so. Socially

constructed and institutionalized gender roles prescribe that women do the majority of subsistence practices like collecting water and fuel, and growing and gathering food (Warren 2000:9, Shiva 2005:17). If the local natural environment has been exploited as a result of colonialism or neo-liberal globalization, it can become very difficult for these women to sustain themselves, their families, and their communities.

Furthermore, the connections between the oppression of women and the environment become clear when one analyzes how women have been unjustifiably blamed and punished for environmental degradation and so-called "overpopulation". Significantly more population control strategies are targeted at women than men, as Malthusian and neo-Malthusian ideologies permeate hegemonic population-environment and international reproductive health discourse where women are routinely seen as responsible for producing additional consumers of limited natural resources.[4] These strategies often result in reproductive abuse and injustice toward women and are not limited to the "Third World" (Hartmann 1995:55).

According to Ynestra King, ecofeminism's "challenge of social domination extends beyond sex to social domination of all kinds, because the domination of sex, race, and class and the domination of nature are mutually reinforcing" (Smith 1997:21). Andy Smith writes, "most ecofeminist theorists argue that there is no primary form of

[4] The basic tenets of Malthusian-influenced perspectives are that the human population is growing faster than the supply of natural resources available to support it, and that human populations, especially rapidly growing ones, inevitably cause environmental degradation. Population growth and environmental destruction are often posited as the leading causes of human suffering, leaving out core questions regarding access to land, resources, capital, education, health care, and opportunities to support oneself and one's family within the current social system.

oppression, as all oppressions are related and reinforce each other" (Smith 1997:21). In this way, ecofeminism can be considered an intersectional feminist methodology.

I also apply a postcolonial theoretical framework, drawing particular attention to Western colonialism and neoliberal capitalism in my analysis of international reproductive health. Mack-Canty writes, "the "post," in postcolonialism, does not indicate that colonialism is over but, rather, that colonial legacies continue to exist," in the form of neocolonial phenomena such as "the capitalist global economy, development projects in the Southern Hemisphere, and events such as environmental racism in the United States" (Mack-Canty 2004:164-5).

This thesis follows the tradition of postcolonial critique as it challenges representations of an "international reality" and an "international existence" that attempt to characterize an objective perspective on reproductive health. These globalized representations ultimately "remain grounded in Western institutional and discursive practices so as to reflect and affirm parochial structures of power, interest, and identity" (Grovogui 2002:33). Chandra Talpade Mohanty promotes a "feminism without borders" (2003), a "transnational multicultural feminism" that would "avoid false universalisms and involve ethical and caring dialogue across differences, divisions, and conflicts" (Kirk and Okazawa-Rey 2007b:17).

From a postcolonial, intersectional, ecofeminist perspective, international reproductive health is an integral part of a multi-layered collage of social interactions and relationships that intersect with politics, economics, and dynamic personal identities. The complexity of one's identity is intensified by postcolonial factors such as nationality,

immigration status, and the relationships between nation states. Sankaran Krishna explains that "identity is seen as a constantly dynamic and performative practice, as something based in part on a historical inventory that that memorializes past encounters but also something that changes with dazzling speed within a single movement" (2001:171). Maria Mies and Vandana Shiva write, "to isolate the individual sexual and reproductive behaviour from the social fabric can only be harmful to women, in the South and the North" (1993:293). For example, Mohanty writes, "since the relationships of women of color to white men are usually mediated by state institutions, [one] can never define feminist politics without accounting for this mediation" (2003:54). In other words, a postcolonial, intersectional ecofeminist critique on reproductive health requires an analysis that includes elements on individual, community, institutional, national, and global levels, and an understanding that these elements are fluid and dynamic.

Reproductive Justice

The *reproductive justice movement* is a collective effort that strives to reclaim the rights of all people to control if and when they want to have children within a context of simultaneously working toward the dismantling of interlocking systems of power, privilege, and oppression. As outlined by Asian Communities for Reproductive Justice, "reproductive justice is the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights" (Ross 2007:4). The intersectional perspective of this movement

takes into account the cultural-historical context of these issues and the current social realities affecting reproductive freedom. The reproductive justice movement offers a new and comprehensive paradigm to analyze and combat reproductive abuse and oppression.

A reproductive justice analysis is intersectional and solution-oriented, and offers an agenda aimed at empowerment within a culturally relevant context. I include all genders in my understanding of reproductive freedom and justice.[5] The reproductive justice framework provides a multi-pronged approach needed to challenge all forms of power, privilege, and oppression, and includes a three-part agenda to fight reproductive oppression: reproductive health (service delivery), reproductive rights (legal advocacy), and reproductive justice (movement building and organizing) (Ross 2007:4). The reproductive justice movement and organizations like SisterSong and the Committee for Women, Population, and the Environment specifically seek to increase empowerment and agency over one's reproductive health, while also resisting oppressive reproductive health strategies that have been used by the state and inter-governmental and non-governmental organizations (Ross 2007:4-5, SisterSong 2007, CWPE 2007a and 2007 b).

Political Ecology

Political ecology is a diverse interdisciplinary field that combines the fields of political economy and cultural ecology to examine environment-society interrelationships. It is informed by political science, non-equilibrium ecology,

[5] This intersectional perspective takes into account the current social reality affecting the reproductive freedom of all people, including those who identify outside of the socially constructed gender dualism.

geography, anthropology, and sociology. Political ecology explores the dynamic dialectical relationship between people and the environment across temporal and spatial localities in a variety of contexts. Roderick P. Neumann states that the central premise of political ecology is "that the human transformation of natural ecosystems cannot be understood without consideration of the political and economic structures and institutions within which the transformations are embedded" (2005:9). Because of the interdisciplinary and inclusive nature of political ecology, researchers employ a diverse array of epistemologies, methodologies, and methods, and bring with them different perceptions of and approaches to human-environment relations.

Within political ecology, scientific knowledge is understood to be socially and subjectively situated, not objective, impartial, or apolitical. Political ecology focuses on the social construction and production of nature, which are both material and discursive. From the perspective of political ecology, the environment and ideas about the environment play an important role in identity formation, social group formation, and social movements, therefore material analyses are not complete without discursive analyses. Political ecology also devotes significant attention to situations of poverty and political, ecological, and economic marginality.

In this thesis, I incorporate aspects of a political ecology perspective by utilizing poststructuralist discourse analysis, historical analysis, and multi-scalar analysis. A poststructuralist discourse analysis will highlight how socially constructed identities of gender, ethnicity, nationality, and economic class impact and shape social and political movements. A historical analysis will reveal the causal "chains of explanation" or

justifications for, and the social-historical contexts of, the justifications for promoting and dismissing different reproductive health policies and practices (Blaikie and Brookfield 1987:46).

The multi-scalar analysis in political ecology is akin to the multi-level analysis within a postcolonial intersectional ecofeminist analysis described above. Examining reproductive health policies and practices in different spatial and temporal localities highlights the disparities of global and local distribution of power and knowledge. It also reveals how science simultaneously produces and reinforces specific narratives and strategies of international reproductive health and governmentality, which influence identity and governable subject formation.

Political ecology methodologies are relevant to this research as they specifically developed as a critique of environmental and natural resource management practices, policies, and institutions. A political ecology perspective calls into question hegemonic discourse upheld by Malthusian and neo-Malthusian ideology that is used to defend assumptions regarding population-environment relationships, environmental degradation, and environmental change.

The varied theoretical strands and perspectives described above shape and deepen our understanding of the complexity and intersectionality of the issues encompassing reproductive health and justice. By using this bricolage-style theoretical approach in the chapters that follow, I interrogate these issues and case studies with the depth of attention and analysis they demand.

ENCOUNTERING AND COUNTERING THE RHI VORTEX

In this chapter, I outline the narrative of the evolution of RHI and examine the relationships between the elements that combine to form the vortex. A brief historical overview of reproductive health will serve to place reproductive health knowledge into its sociocultural and historical context, and within the context of social and scientific research, and national and international policy. Because international reproductive health is a subject of international development discourse, I will examine the emergence of international reproductive health as a field of study, a political issue, and an approach to achieve international development goals. I state the case that in order to develop a more comprehensive and just reproductive health paradigm, we need to acknowledge human evolutionary history, the systematic exclusion of women's perspectives in research, and the obliteration of indigenous knowledge and epistemologies. We also need to recognize and understand how these issues impact political and personal aspects of reproductive health knowledge production, policy, and practice, and contribute to the varying interactions between the RHI vortex and local and global actors.

The Cultural and Historical Context of Reproductive Health Knowledge and Research

It is important to recognize how current international reproductive health research is imbued with patriarchal and colonial ideologies, which has a significant influence on knowledge production, how different epistemologies are valued, and how knowledge is

shared through the media and educational systems. I begin by looking at the evolutionary medicine approach to modern health because it offers a holistic and evolutionary interdisciplinary perspective on reproductive health that transcends the discourse of mainstream Western medicine. The evolutionary medicine approach to reproductive health includes looking at our evolution as a species, our co-evolution alongside other species, and both past and current cultural and biological influences on our reproductive systems and functions. This perspective on health, wellness, and disease offers a striking critique to many contemporary assumptions.

The evolution of bipedalism in our species around six million years ago "resulted in fundamental changes in the ways birth occurred," making it significantly more difficult than birth in our closest living relatives (Trevathan 1996:288). As the human pelvis evolved to accommodate walking on two feet and our brain-to-body ratio continued to grow, childbirth was transformed from "an individual to a social enterprise" making isolated births virtually unknown or a rarely achieved ideal (Trevathan 1996:287). From an evolutionary perspective, we have arguably required the assistance of others during the birth process for the survival of our species. Therefore, some form of women's reproductive health care has been vital for millennia.[6]

Although we have built and shared knowledge about birth, conception, and fertility manipulation since ancient times, it was rarely given serious consideration in

[6] When looking toward our evolutionary past, it is also interesting to note the uniqueness of the human female reproductive system within the animal kingdom, and the diversity of phenotypes and functions represented within our species. We have a menstrual cycle unlike any other creature on earth and our experience of menopause (the cessation of fertility) is only shared with pilot whales and a handful of individual primates (Pelvelka and Fedigan 1991). Non-advertised, or "concealed," ovulation is also an interesting feature of the human female reproductive system (Havlícek et al. 2006).

historical and scholarly literature until rather recently. Much has been written and discussed about the positive and negative consequences of authoritative knowledge about birth and reproduction, the social construction of systems to aid in labor and delivery, and the professionalization of these systems (De Brouwere 2007, Shiffman and Garces del Valle 2006, De Brouwere, Tonglet, and Van Lerberghe 1998). Evolutionary obstetrics and midwifery, for example, have been given attention by contemporary medicine. Recent consideration has also been given to the history and politics of midwifery and how midwives have organized both subversively and publicly to legitimize their practices. But even with their current levels of support and growing social acceptance in the form of official licensures and certifications, midwives still face a barrage of resistance from the mainstream Western medical system and midwifery is still considered criminal in many places.

Issues of contraception have also become more mainstream in recent decades and sometimes seem to overshadow the broader picture of what constitutes reproductive health. Therefore, a brief discussion on the history of contraception and fertility manipulation is very relevant here. A survey of scholarly literature on ancient, "traditional," and "indigenous" forms of contraception reveals that it is routinely interpreted as non-existent, unreliable, and ineffective. For example, in 1936, Dr. Norman Himes, an American sociologist, compiled all the research he could find on contraception and published a 500-page volume, *The Medical History of Contraception* (Himes 1970). Although he records countless contraceptive methods used in many different cultures in different times, he dismisses most of them as ineffective, or argues

that knowledge about methods that were effective was "confined largely to the heads of medical encylopedists, to a few physicians and scholars" (Himes 1970:100).[7]

However, more recent research has made it even more evident that our ancestors were indeed knowledgeable about birth, reproduction, fertility, menstruation, contraception, and abortion (Riddle 1991, 1992, and 1997; Raymond 2006; Van de Walle 1997; Schiebinger 2000, 2008, and 2009**)**. John Riddle, a historian, has researched the long human history of contraceptive use (Riddle 1991, 1992, 1997). He documents that these practices were "safe, effective, and commonly used" (Raymond 2006:685), and that ancient people knew the difference between contraceptives and abortifacients (Riddle 1991:7)[8]**.** He argues that knowledge of contraceptives "was primarily transmitted by a network of women working within the culture of their gender and that only occasionally was some of it learned by medical writers, almost all of whom were male" (Riddle 1992:16)[9].

In the end, "the extent to which women throughout history have known about birth-control is an important but ultimately unanswerable question" (Riddle 1991: 24). However, the common assumption of a pervasive lack of reproductive health knowledge

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[7] Also in 1936, a significant contraceptive legal battle was won. As a result of Margaret Sanger's political activism and Dr. Hannah Stone's perseverance, a U.S. federal appeals court ruled in *The United States v. One Package (of Japanese Pessaries)* [1936] that the federal government could not interfere with doctors providing contraception to their patients. Although the decision in this case led the American Medical Association to endorse contraception as a legitimate medical service and a vital component of medical education in 1937, the Food and Drug Administration did not approve the first birth control pill until 1960.

[8] Contrarily, Etienne Van de Walle, also an historian, writes about the extensive use of emmenagogues for "menstrual regulation" in Middle Age Europe and argues that "historical evidence does not permit the conclusion that convenient and dependable means of abortion were available to our ancestors—and were used" (1997:203).

[9] Suzanne Dixon goes as far as to argue that according to her observations, all of the negative comments about abortion in antiquity came from "the public male attitude" (Riddle 1992:10).

and effective reproductive health strategies in cultures of the world today has been used to justify "interventions" from outside groups such as colonial regimes, international agencies, and development groups, which have many repercussions and implications. This will be reflected in the coming case studies of international reproductive health interventions.

Modern Reproductive Health Research and Technology Development Within the Medical-Industrial Complex

The topic of modern women's health and reproductive health is as full of controversy as the varied interpretations of ancient fertility manipulation. When the professionalization of women's health began pushing aside female healers and midwives, "women's bodies came under the control of male professionals who used both their medical knowledge and medical and reproductive technology to reinforce and justify women's subordinate status in society" (Schoen 2005:6). Moreover, the fact that the current medical system operates under a capitalist, for-profit framework presents a very problematic situation for all who depend on it for health care, as well as for the knowledge that is produced and shared from within it.

In 1980, the editor of The New England Journal of Medicine, Arnold S. Relman, M.D., coined the term *Medical-Industrial Complex to* describe "the most important health-care development of the day": "a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit—services heretofore provided by nonprofit institutions or individual practitioners."

(1980:963). He explains how this "private health-care industry of huge proportions could be a powerful political force in the country and could exert considerable influence on national health policy" and knowledge production about health and medical technology (Relman 1980:969):

> Physicians evaluate drugs, devices, diagnostic tests, and therapeutic procedures in the public interest. Their opinions - expressed publicly in articles, speeches, and committee reports - not only influence the practices of their colleagues but carry weight in the councils of government and directly affect the fortunes of health-care businesses. That is why the Wall Street Journal and the financial sections of the major newspapers carry so many news items about medical developments. The medical-industrial complex depends heavily on the favorable public judgments of physicians, individually and collectively. Doctors may not be able to affect the profits of large companies by what they do in their own practices, but they can easily do so through published articles, public statements, or committee reports. [Relman 1980:968]

Therefore, the research frameworks and methods used to conduct medical and clinical studies need to be contextualized and critically analyzed, especially because they are intimately intertwined with profit-seeking ventures and have a powerful and long-lasting effect in terms of policy and medical praxis. For instance, there is no doubt that the discovery and synthesis of human reproductive hormones forever changed our ability to control our fertility. However, the degree to which modern hormonal contraceptives are deemed the most effective and safe methods for women to control their own fertility (Stewart and Gabelnick 2004:610) needs to be deconstructed and put in its proper context. The positionality and influence of the researchers and the methods they use undoubtedly affect the reported and published research about different methods (Trussel 2004:232-3).

In a popular edited textbook, *Contraceptive Technology*, James Trussel, Professor of Economics and Public Affairs and Director of the Office of Population Research at Princeton University, writes,

> the system of drug testing in the United States, which demands that the company wishing to market a drug be responsible for conducting studies to assess its efficacy and safety, provides incentives for the unscrupulous to present less-than-honest results. [2004:232]

In this same text, Felicia Stewart and Henry L. Gabelnick also recognize that the development of systemic contraceptive methods for men is lacking (2004). Besides the challenge of controlling the continual production of sperm in male physiology, "issues like adverse effects, side effects, acceptability, and affordability are more of a powerful constraint [*sic*] now than they were in the 1950s when female systemic methods were devised" (Stewart and Gabelnick 2004:611-2).

Since the US Food and Drug Administration (FDA) approved the first birth control pill in 1960, reactions have been varied. Enovid, developed by Searle, a pharmaceutical company, was the first combined hormonal oral contraceptive approved by the FDA for the specific purposes of preventing pregnancy. For many activist women, including Margaret Sanger, Katharine McCormick, and Emma Goldman, the advent of "The Pill" symbolized women's empowerment, freedom, and momentum for the feminist movement (May 2010). But at the same time, for many others, like Barbara Seaman, Alice Wolfson, and Dorothy Roberts, it symbolized further control of, and experimentation on, women's bodies by the state, science, and pharmaceutical companies.

Elizabeth Kissling, President of the Society for Menstrual Cycle Research and Professor of Communication Studies and Women's and Gender Studies at Eastern Washington University, argues that the legalization of "The Pill" helped to launch the feminist health movement during U.S. Senator Gaylord Nelson's congressional hearings about the birth control pill's safety (2010). Members of an activist collective (D.C. Women's Liberation) attended the hearings and spoke out when the voices and concerns of the millions of pill-users were not heard (Kissling 2010). These activists demanded answers to their questions regarding the withholding of information about negative side effects, the suffering and fatalities of women involved in the clinical trials held in Puerto Rico, and the huge profits made by the pharmaceutical companies.

As a result of these hearings, the FDA required the "inclusion of printed information about risks, ingredients and side effects in pill packets, and eventually in all pharmaceuticals" (Kissling 2010). Since these hearings, the levels of estrogen in oral contraceptives have gradually decreased worldwide from the 150-microgram dose of synthetic estrogen (mestranol) in Enovid to the 20- to 50-microgram doses of synthetic estrogen (ethynil estradiol) in the most widely prescribed oral contraceptive pills today (Eldridge 2010:37).

Although the dosages of hormones in contraceptives continue to drop, the side effects experienced by women who take them, particularly those who are subjects of clinical trials or participants in international development programs, are routinely ignored and deemed insignificant by researchers and policymakers just as they were during the Enovid clinical trials (Kammen and Oudshoorn 2002, American Experience 2002).

Despite the fact that Puerto Rico was partly chosen as the location of the Enovid trials because it would be more difficult for researchers to lose touch with participants on an island (meeting funder McCormick's call for a "cage of ovulating females"), many women dropped out of the study because of side effects (such as nausea, dizziness, headaches, and vomiting) and rumors that the Pill was being developed with eugenic intentions (Eldridge 2010:28, American Experience 2002). The on-site medical director of the study concluded that although the Pill proved to be an effective contraceptive, she thought it caused "too many side reactions to be generally acceptable" (American Experience 2002). Additionally, a control group was not adequately included in the study, and three participants in the trial died during the duration of the study and their deaths were not reported or investigated with autopsies (Eldridge 2010:29 American Experience 2002). Consequently, I consider this to be incomplete clinical data, which runs counter to the evidence-based claims of Western medical praxis.[10]

Research by Virginia Vitzthum, an evolutionary anthropologist and researcher at the Kinsey Institute for Research in Sex, Gender, and Reproduction, has shed some light on the issue of how the experience of contraceptive side effects has contributed to the discontinuation of their use, specifically by women in "less-developed" countries (2005). As evident in Demographic and Health Survey (DHS) data from multiple nations, "side effects, whether experienced or perceived, are central to the acceptability, use, and continuation of hormonal contraceptives" (Vitzthum and Ringheim 2005:14). Even

[10] As a result of these (and other) shortcomings and unethical underpinnings of the Enovid clinical trials, this study has been compared to the medical experimentation done in Nazi Germany and in the syphilis experiments done by the U.S. government in Tuskegee, Alabama and Guatemala (Democracy Now 2010).

though these side effects are often assumed to be minimal and manageable, the "experience of side effects is the leading predictor of discontinuation of hormonal methods" of contraception (Vitzthum and Ringheim 2005:20, 13).

Vitzthum and Karin Ringheim advance the argument that "common side effects associated with hormonal contraceptives arise principally from biological variation among women and populations," meaning that the levels of hormones in pharmaceutical preparations effect different women in different ways due to physiological variation (2005:14). They argue,

> despite more than 20 years of research documenting substantial interindividual and interpopulational differences in the pharmacokinetics of exogenous hormones, and despite calls to investigate these differences and their significance for the etiology of side effects, scant attention has been paid to these hypotheses… Rather, the assumption generally is made that species-wide minimal levels of reproductive steroids are necessary for conception to occur and that all fecund women have levels of endogenous hormones above this minimum. [Vitzthum and Ringheim 2005:23]

Furthermore, even though policymakers and health care providers may believe hormonal contraceptives are the most effective means of controlling women's fertility (Stewart and Gabelnick 2004:610), "a perfectly efficacious contraceptive, if misused or discontinued because of unacceptable side effects, will achieve neither personal nor policy goals" (Vitzthum and Ringheim 2005:27). This illustrates the universalizing impact of the RHI vortex I am proposing and shows how the vortex asserts an objective, scientific perspective and routinely ignores subjective experience.

Unfortunately, the perspectives and experiences of women users of modern methods of birth control have been routinely disregarded by policymakers and health care

providers, and undervalued in the research and development of contraceptive technologies (Hardon 1992, Hardon 1997, Kammen and Oudshoorn 2002, Vitzthum and Ringheim 2005). Jessika van Kammen and Nelly Oudshoorn performed an "international comparative sociology of medicine regulation" by analyzing policy documents and scientific publications on clinical testing of contraceptive technologies (2002). Their research demonstrates how models for assessing the risks of contraceptive use are biased on the basis of gender, whereas

> lay perspectives of men are taken more seriously by experts and policymakers than the lay perspectives of women. In the case of male contraceptives, men's wellbeing when using contraceptives was a central issue from the very beginning. Men's emotional wellbeing and sexuality has been put on the international research agenda by the reproductive scientists themselves, and the need for long-term data about male contraceptives has been emphasised by the pharmaceutical industry. In the case of female contraceptives, the concern for the long-term effects of contraceptives was put forward by the women's health movement, and research into women's mental health and libido when using hormonal contraceptives was initiated only at the instigation of women's health advocates. [Kammen and Oudshoorn 2002:453]

Their research has also shown that risk assessment practices in clinical testing "do not change as fast as the changes in discourse" and are, therefore, inconsistent with available risk models, which could improve our abilities to include the users' experience in assessing the safety and efficacy of contraceptive methods (Kammen and Oudshoorn 2002:452). They conclude that the "safety of contraceptives is thus not an inherent, universal quality of the artifact defined by autonomous scientists, but is the result of historically specific circumstances," in which medical authorities and policymakers have

consistently emphasized and negotiated male perspectives, and left women's interests and needs in the hands of women's health advocates (Kammen and Oudshoorn 2002:452).

Anita Hardon, professor of Health and Social Care at the University of Amsterdam, has studied subjective experiences of reproductive health and the cultural construction of reproductive health care interventions since the early 1990s. Her research has focused on the differences in reproductive health needs and interests between the family planning personnel, policy-makers, and researchers involved in the development and evaluation of reproductive technologies, and the women that use them (Hardon 1992; Hardon 1997). She argues that women's perspectives and needs should be taken into consideration in the design and interpretation of controlled clinical and acceptability trials, and technology assessments of contraceptive technologies in different societal and cultural settings (Hardon 1992). Hardon's review of the literature leads her to state that published anthropological studies

> tend to focus on issues that are of importance to programme administrators and policymakers, rather than to contraceptive users themselves. There is little understanding of the range and variation in views, experiences and use of the methods, and it is impossible to draw conclusions about the relative advantages and disadvantages of the pill, injectables and implants as perceived by women in different socio-cultural contexts. [Hardon 1997:72]

She also argues that although hormonal contraceptives are associated with many positive attributes, "high discontinuation rates with the pill and three-month injectables are indicative of a range of problems associated with these methods, including side effects and other health concerns" (Hardon 1997:73).

One major health concern felt by women from many different cultures relates to the effects of contraceptives on menstrual cycles. Hardon writes,

> Anthropological studies of fertility regulation indicate that women value regular menstruation, and have shown that the consequences of menstrual disturbances are far-reaching. Menstruation is an important event in any woman's life. The meaning attributed to menstruation and its absence can affect, among other things, cooking procedures, sexual interaction and religious practice. [Hardon 1997:72]

On the other hand, recent pharmaceutical marketing techniques claim that extended cycling or menstrual suppression with hormonal contraceptives is a healthy and "natural" return to evolutionary and historical circumstances where women did not experience menstruation (and the accompanying exposure to hormones) as often as modern women because our predecessors spent more of their lifetimes pregnant, breastfeeding, or without enough resources to remain fertile for long periods of time (see Coutinho 1999). However, according to Marianne McPherson, reviser of *Our Bodies Ourselves*, a feminist book on women's health, "drug companies are at the center of the [scientific and public] debate" that "centers around the safety and desirability of having drugs specifically marketed for menstrual suppression" (2005:194).

Paula S. Derry, a health psychologist, questions the long-term safety of suppressing menstruation with hormonal pharmaceuticals (2007). She calls to attention the fact that Seasonale (produced by Barr Pharmaceuticals) was approved by the FDA in 2003, but

> long term research was not required for approval… A seemingly scientific argument about the biological nature of women buttresses the idea that suppression can be considered safe even in the absence of

> experimental evidence. However, science involves logic and evidence, and the case against menstruation involves neither. [Derry 2007:955]

Furthermore, menstrual suppression "may seem to mimic pregnancy and lactation, in the sense that there is no period, but the underlying hormonal milieu is far different" (Derry 2007:955).

Sociologists Laura Mamo and Jennifer Ruth Fosket analyzed "ways in which the advertising campaign for Seasonale troubles biological facts and cultural meanings of femininity, reshaping cultural assumptions about menstruating (and non-menstruating) bodies and, by extension, reshaping women's experiences of lived embodiment" (2009:926). They argue "the emergence of Seasonale, along with other drugs aimed at regulating and minimizing menstruation, is part of ongoing biomedicalization processes that emphasize risk reduction and management and the transformation of health itself" (2009:925). Their research draws connections between the production of knowledge about reproductive health, the development of reproductive health technologies, and the media's role in broadcasting information about research and products.

Issues of hormonal contraception and menstrual suppression draw attention to the fuzzy boundaries between cultural and biological aspects of health and wellness, as well as the involvement of for-profit pharmaceutical companies in scientific research, national policy, and medical praxis. It is clear that studies into the efficacy, use, and experience of modern contraceptive methods are compromised ethically as well as scientifically, which certainly comes to bear on hegemonic discourse of reproductive health as a whole. The knowledge produced by these studies is not only inaccurate, but is morally unjust.

Regrettably, the omission or devaluation of women's perspectives is not a new or localized phenomenon, but is part of the larger RHI vortex impacting women's reproductive health throughout the world.

Colonialism, Patriarchy, and the Loss of Indigenous Knowledge

In various places and times, women's reproductive freedom and knowledge about menstruation, ovulation, conception, and birth have faced a multitude of social and political barriers including colonialism, patriarchy, and dominant knowledge authorities (Schiebinger 2000, 2008 and 2009)[11]. It is well established that these barriers, as well as others, have contributed to the devaluing of women's knowledge and experiences, and sometimes to the purposeful exclusion of this knowledge from the historic record and research all together. These factors, no doubt, have affected the ways in which we give and receive information, and make "informed" decisions about our own reproductive health. They have also significantly influenced many reproductive health policies and practices on the international, national, and regional levels, some of which have resulted in severe human rights abuses.

Londa Schiebinger, a historian of science, has focused her research on gender, the global politics of plants, and agnotology, the study of lost knowledge, knowledge suppression, and culturally induced ignorance (Schiebinger 2000, 2008, and 2009). Recently she has turned her focus to colonial and patriarchal control of knowledge about

[11] See also Schoen 2005, Mies and Shiva 1993, Caron 2008, Roberts 1997, Hartmann 1995, Silliman and King 1999, and Silliman et al. 2004.

abortifacients (2008 and 2009). She argues that although colonial expansion brought with it an unremitting campaign to gather exotic specimens and record foreign knowledge, "there were few systematic attempts to transfer into Europe knowledge concerning medicinal herbs for birth control gathered from cultures around the globe" (Schiebinger 2000). To illustrate her research, she tells the story of the Peacock Flower (*Poinciana pulcherrima*, also known as the Pride of Barbados, the Flamboyant Tree, and the Red Bird of Paradise), which grows in the Caribbean and India (Schiebinger 2000). It is a highly politicized plant that was deployed "in the struggle against slavery throughout the eighteenth century, used by slave women in the Caribbean islands to abort their offspring so that they would not be born into bondage… as a deliberate act of resistance to slavery" (Schiebinger 2000). This abortifacient was also widely used throughout the Caribbean by free native women, women forced to have sex with European men, and women in "Suriname marriages," relationships between European men and native or African women (Schiebinger 2008:718).

Maria Sibilla Merian interviewed the women of Suriname about their uses of the Peacock Flower in 1699 (Schiebinger 2009)[12]. According to Schiebinger, in 1705, Merian wrote,

> The Indians, who are not treated well by their Dutch masters, use the seeds [of the Peacock Flower] to abort their children, so that they will not become slaves like themselves. The black slaves from Guinea and Angola have demanded to be well treated, threatening to refuse to have children. ...They told me this themselves. [Schiebinger 2008:718]

[12] At the age of 52, Merian was the only European woman to travel to the colonies for the purposes of scientific research in both the seventeenth and eighteenth centuries (Schiebinger 2009).

According to Schiebinger, "altogether European bioprospectors identified eight abortifacients used by Amerindians and African slaves living in the Caribbean in this period" (2008:718). Alexander von Humboldt, one of these explorers, was surprised to report that, without a cost to their health, "women could time their pregnancies precisely, some thinking it best to preserve their "freshness and beauty" when young and to delay childbirth until late in life in order to devote themselves to domestic and agricultural labours" (Schiebinger 2008:718).

Although the Peacock flower reached European shores and became a popular ornamental shrub, knowledge about its abortive properties did not. Schiebinger suggests that a multitude of "historical forces" kept this knowledge from spreading, including the shift from midwifery to obstetrics, the pro-natalist policies of the state, and the continued social exclusion of women from trade and business ventures (2008). She eloquently summarizes this example of colonial and patriarchal control over knowledge:

> Winds of prevailing opinion kept this valuable knowledge about women's anti-fertility agents from coming into Europe. This knowledge, which might have been enormously valuable to women, was ignored, it was suppressed, and it was finally forgotten. As such, it is a perfect example of agnotology, about how knowledge becomes entangled, how innocent plants really become entangled, in larger political struggles and how they can eventually disappear or go underground. [Schiebinger 2009]

Another clear example of the effect of colonialism and patriarchy on the loss of reproductive health knowledge is found in R. Cruz Begay's ethnographic research in the Navajo nation (Begay 2004). Begay is a member of the Tohono O'odham Nation in Arizona and Chairperson of the Governing Board of Pathways Into Health, "a grassroots organization dedicated to improving the health, health care, and health care education of

American Indians and Alaskan Natives" (Pathways Into Health n.d.). Her research is centered on contemporary issues in rural health, sociocultural and behavioral aspects of public health, and health disparities (Pathways Into Health n.d.). Begay writes:

> In 1955 the U.S. Public Health Service took responsibility for medical care on the Navajo reservation. At the same time increasing numbers of children were being sent to boarding schools for most of the year. Even though children were still being born at home in the 1960s, their older brothers and sisters were often away at school at the time. These school children knew that they had younger siblings born at home, but few of these children were actually able to observe the birth of siblings. A consequence of this was that knowledge about childbirth practices at home began to disappear. Since much information about life outside the purview of formal education is "caught not taught," there were few opportunities for young people to learn about traditional childbirth practices. [Begay 2004:551]

One of the implications of this switch from homebirths to hospital births was a shift in attitudes about the safety of birth: "Giving birth in the hospital because of safety was not a major consideration until several years after the Public Health Service assumed responsibility for medical care" (Begay 2004:552). First-time mothers were both "afraid and relieved that they were going to the hospital," a "safe place," whereas the older women who had given birth at home "said that they were not afraid of childbirth" and that "they did not think that the hospital was a safer place to have a baby than at home" (Begay 2004:551-2). She continues,

> There were, however, systems to provide women both support and healthy outcomes before the introduction of modern childbirth practices. To assume that nothing existed before the new system was introduced not only makes it difficult to perceive that there was a change in attitudes about childbirth but also allows the knowledge about the previous systems to pass from existence. [Begay 2004:551]

The arrival of modern medical services "made traditional practices obsolete and of little value according to the dominant society's standards" (Begay 2004:564).

Although the treatment of Native Americans by the U.S. government is an immense topic, which stretches well outside the limits of this paper, it is a telling example of the effects of colonialism and patriarchy on reproductive health and rights, especially the role the US government and its agencies and citizens played in the execution of oppressive, abusive, and genocidal policies and practices. A very brief overview is necessary here.

The Indian Health Service (IHS) began providing family planning services in 1965 under the authority of the Department of Health, Education, and Welfare (HEW), which is now known as the Department of Health and Human Services (Lawrence 2000:402)[13]. A 1974 study by Dr. Connie Pinkerton-Uri, a Choctaw Cherokee physician, revealed that "IHS facilities singled out full-blood Indian women for sterilization procedures" and sterilized 25 to 50 percent of Native American women between the ages of 15 and 44 (Lawrence 2000:400, 410). Dr. Pinkerton-Uri's study also uncovered that

> Indian women generally agreed to sterilization when they were threatened with the loss of their children and/or their welfare benefits, that most of them gave their consent when they were heavily sedated during a Caesarian section or when they were in a great deal of pain during labor, and that the women could not understand the consent forms because they were written in English at the twelfth-grade level. [Lawrence 2000:412]

These organized forced sterilization programs destroyed families, marriages, and communities. Jane Lawrence writes, "tribal communities lost much of their ability to

[13] The Public Health Service, a division of the Department of Health, Education, and Welfare (HEW), formed the Division of Indian Health (DIH), which was renamed the Indian Health Service (IHS) in 1958 (Lawrence 2000:401).

reproduce, the respect of other tribal entities, and political power in the tribal council" (Lawrence 2000:407). One husband of a woman who was sterilized left her shortly after he found out about the sterilization because he "wanted a real woman" (Lawrence 2000:414). She said, "He didn't think I was a woman anymore without my uterus. What was I? An it?" (Lawrence 2000:414).

Allegations brought against the IHS include failure to provide women with necessary information regarding sterilization, use of coercion to get signatures on the consent forms, improper consent forms, and the lack of an appropriate waiting period (at least 72 hours) between the signing of a consent form and the operation (Lawrence 2000:400)[14]. In 1973, the HEW published guidelines for providing family planning services[15] and soon afterward, the courts defined informed consent as "the voluntary, knowing assent" (Lawrence 2000:406). Congress passed the Indian Health Care Improvement Act in 1976, which "gave tribes the right to manage or control Indian Health Service programs," and since then, the Department of Health and Human Services

[14] To grasp the scale of these sterilizations, the IHS performed 3,406 from 1973 to 1976 in just the cities of Aberdeen, Oklahoma City, and Phoenix; of those, 39 were performed on women under the 21-years-of-age minimum, there were 13 infractions on the 72-hour waiting period, and the repeated use of inadequate consent forms were also reported (Lawrence 2000:407).

[15] These guidelines included, "directives protecting an individual's rights to receive informed consent for family planning or sterilization procedures," "regulations establishing a moratorium on the sterilization of anyone under the age of twenty-one and on anyone doctors had declared mentally incompetent," and regulations stating that "there must be a consent form in the possession of the agency providing the sterilization showing that the patient knew the benefits and costs of sterilizations, and that a seventy-two hour waiting period must occur between the time of consent and the surgical procedure" (Lawrence 2000:405-6).

"only audits the computer records on reported sterilizations that do not meet the guideline's requirements" (Lawrence 2000:414)[16].

Issues of consent, choice, and coercion are commonly raised, highly contextual concepts that deserve some elaboration. Johanna Schoen writes, "analyzing the role that birth control, sterilization, and abortion have played in public health and welfare programs of the twentieth century brings issues of control and agency into sharp focus" (Schoen 2005:7). She uses the state of North Carolina as a case study to explore what Rosalind Petechesky has called "the tension between the principles of individual control and collective responsibility over reproduction" (Schoen 2005:3).

For most of the twentieth century, "birth control, sterilization, and abortion found legislative support partly because supporters used eugenic rhetoric and arguments for population control to support them," making it so "poor women were rarely able to gain access to these technologies on their own terms" (Schoen 2005:3). However, women would also find ways to manipulate the system to achieve their personal goals. Schoen writes,

> Women at times used the programs for their own purposes and in ways that contradicted the intentions of policy makers and health professionals. Lacking access to elective sterilization, for example, some women applied for eugenic sterilization through the North Carolina Eugenics Board, even though this necessitated that they be diagnosed as feebleminded. [2005:5]

[16] More recently, the US Congress passed the Native American Apology Resolution as part of a defense appropriations bill, which was signed in December 2009 by President Obama without a formal ceremony or much coverage in the media, apologizing "on behalf of the people of the United States to all Native peoples for the many instances of violence, maltreatment, and neglect inflicted on Native peoples by citizens of the United States." (Toensing 2010, Capriccioso 2010). The Prime Ministers of Canada and Australia have also issued formal apologies for oppressive laws and policies targeted at indigenous people in their countries (Capriccioso 2010). Former California Governor Gray Davis issued an apology in March of 2003 to 20,000 people who were sterilized against their will in California between the early 1900s and late 1960s, but the California Senate has not yet passed a resolution on the subject (The Statesman 2003).

Schoen also notes that medical technology does "not hold only one meaning for all women," but has multiple meanings (Schoen 2005:7). Location also matters:

> Social policies played out differently in different places. Race and class relations varied, as did the meaning of sex, reproductive control, and motherhood. Moreover, reproductive policies were defined at the center for the periphery, embedded in a framework of us versus them. And while those on the periphery influenced policy and implementation, they remained locked there, always on the receiving end of social policy. [Schoen 2005:8]

Schoen's study "draws attention to both the parallels and the differences between reproductive policies at home and abroad" (Schoen 2005:8). The RHI lens presented here seeks to do the same.

Reproductive Health in the International Spotlight

International reproductive health discourse, treaties, and policies play significant roles in determining the content and trajectory of the RHI vortex. Agreements have been made and policies have been passed on the regional, national, and international levels that establish reproductive rights and regulate various reproductive health services. Global discourse on reproductive health is deeply entwined with national and international politics and the agendas of research institutions, donor organizations, and NGOs that are involved in turning reproductive health ideology into action.

Although the entirety of the topic of international reproductive rights and politics is too vast to describe in this study, I provide examples below to illustrate the globalization of reproductive health discourse, the evolution of the RHI vortex, and the

influence it has had on knowledge, policy, and practice surrounding reproductive health. These examples also begin to illuminate the ways in which gender, race, socioeconomic status, and nationality affect the quality of reproductive health care one receives, especially while receiving state- or international donor-sponsored services or aid. A brief review of the most influential agreements forged by the United Nations (UN) reveals how international reproductive health ideology has evolved and how it has impacted reproductive health policy and practice.

The passage of the Universal Declaration of Human Rights by the UN General Assembly declared in 1948 "that human rights should be protected by the rule of law… without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (UN 1948). However, as the UN Department of Public Information plainly proclaimed in 2009, "the fact of women's humanity proved insufficient to guarantee them the enjoyment of their internationally agreed rights" (UN 2009). Even though numerous international polices and agreements have been enacted to address women's rights and social subjugation since the Universal Declaration of Human Rights was passed, women's autonomy continues to face challenges.

For example, women's reproductive abilities have specifically been the target of numerous international policies and programs since poverty was linked to population size and medical technology made it possible to control women's fertility. This ideological framework has contributed to the agendas of reproductive health agreements, policies, and practices. One could trace the roots of the reproductive health and population

connection in international politics to a 1962 UN resolution titled "Population Growth and Economic Development," which formally "recognized that the poorest people in the least developed nations had the highest fertility" (Lane 1994:1307). The basic premise was that high rates of fertility were the cause of high rates of poverty, so if population size, and therefore women's fertility, could be controlled, poverty could be overcome. As a result of this resolution almost 50 years ago, the explicit aim of many international development programs is to decrease women's fertility in order to increase overall well-being, meanwhile avoiding or ignoring issues of social inequality, gender discrimination, racism, classism, and neo-liberal globalization.

Also, this international focus on controlling or restricting the fertility of impoverished people has left out many other elements of reproductive health, most obviously infertility. Although infertility is common in sub-Saharan Africa and is a traumatic experience in the lives of nearly all women who are confronted with it, this health problem is often neglected in reproductive health programs. J. Ties Boerma, now the director of WHO's Department of Health Statistics and Informatics, and Zaida Mgalla, education advisor for the Netherlands Development Organisation, maintain that this neglect is due to the lack of "feasible, affordable and effective treatment interventions" and because "population and health programmes in Africa have primarily been oriented towards [curbing] high fertility and high rates of population growth" (2001:13).

They argue that addressing infertility is a "logical part of a reproductive health programme" since "infertility is a major public health problem as well as a human rights

issue with far-reaching consequences for the individual, the couple and, to a lesser extent, the health system. Furthermore, infertility is intertwined with many other elements of reproductive health" (Boerma and Mgalla 2001:13). They insist that a "broad intervention package to improve reproductive health as a whole may thus have a much greater effect than the sum of the effects of the individual packages" that focus on family planning to prevent unwanted pregnancy or promoting condom use to prevent the spread of sexually transmitted infections (Boerma and Mgalla 2001:13). They, like many others, also put forward that "programmes that are successful in addressing underlying gender issues are likely to benefit many areas of reproductive health" (Boerma and Mgalla 2001:13).

International discourse on women's health and reproductive rights regularly gives rhetorical attention to underlying gender issues, but as the overall status of women continues to face challenges, women's reproductive health, rights, and justice remain compromised. Since the 1970s, many international agreements have expanded the definition of what constitutes reproductive health. They have also repeatedly established the state's responsibility to ensure the protection of reproductive rights and provide access to reproductive health care and quality information for making informed decisions about one's reproductive health.

After more than thirty years of work by the UN Commission on the Status of Women (a body established in 1946 to monitor the situation of women and to promote women's rights), the Convention on the Elimination of All Forms of Discrimination Against Women was adopted by the UN General Assembly in 1979 to further solidify

equal rights for men and women under international law and was enforced as an international treaty on September 3, 1981 (UN 1979). This Convention explicitly addressed issues of reproductive rights. In the thirteenth clause of the preamble, it declares,

> Bearing in mind the great contribution of women to the welfare of the family and to the development of society, so far not fully recognized, the social significance of maternity and the role of both parents in the family and in the upbringing of children, and aware that *the role of women in procreation should not be a basis for discrimination* but that the upbringing of children requires a sharing of responsibility between men and women and society as a whole. [UN 1979, emphasis added]

Article 10h of the Convention affirms, "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning" (UN 1979). Article twelve also asserts that states are responsible for ensuring women's equal and appropriate access to healthcare including family planning, prenatal, and postnatal care, as well as access to sufficient nutrition during pregnancy and lactation (UN 1979).

International discourse on issues of violence against women often includes declaring and defending women's reproductive rights. In an effort to protect women from physical, sexual, and psychological violence, the international community first needed to identify and define it. In 1993, the UN Declaration on the Elimination of Violence Against Women provided a basis for formally and comprehensively defining *gender-based violence*:

> Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female

> children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. [UN 1993]

The Declaration also recognized the social and historical context of gender-based violence as a

> manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men. [UN 1993]

These declarations and agreements acknowledge that the oppression of women on the international level is at the root of gender-based violence. They also set out specific measures in order to provide women protection against physical, sexual, and psychological violence and ensure gender-based equality, specifically in access to health care, but it was not until 1998 that the UN established an International Criminal Court, which included gender-related crimes and crimes of sexual violence as crimes against humanity (UN 1998).[17]

[17] Echoing a similar sentiment, the UN Commission on Human Rights adopted a 2003 resolution, entitled the Elimination of Violence Against Women, which emphasized that

> violence against women has an impact on their physical and mental health, including their reproductive and sexual health and, in this regard, encourages States to ensure that women have access to comprehensive and accessible health services and programmes and to health-care providers who are knowledgeable and trained to meet the needs of patients who have been subjected to violence, in order to minimize the adverse physical and psychological consequences of violence. [UN 2003]

The 1994 International Conference on Population and Development (ICPD) in Cairo (also referred to as the "Cairo Conference") is hailed as a milestone in the international reproductive health field and is repeatedly referenced in policies and program objectives and reports. At the ICPD, 11,000 participants representing governments, UN specialized agencies and organizations, intergovernmental organizations, non-governmental organizations, and the media from 179 countries negotiated a 20-year Programme of Action. It is known for furthering the "new comprehensive concept of reproductive health" and as well as the notion of sustainable development, "reflecting the growing awareness that population, poverty, patterns of production and consumption and the environment are so closely interconnected that none of them can be considered in isolation" (UN 1994). The ICPD report recommends that

> governments, non-governmental organizations and the private sector should invest in, promote, monitor and evaluate the education and skill development of women and girls and the legal and economic rights of women, and in all aspects of reproductive health, including family planning and sexual health, in order to enable them to effectively contribute to and benefit from economic growth and sustainable development. [UN 1994]

The more inclusive definitions of reproductive health and rights agreed upon at this conference signaled a noteworthy rhetorical shift away from population control and a turn toward an agenda focused on contextualizing reproductive health within broader social systems.

However, members of the reproductive justice movement were already apprehensive about population and development programs and voiced many concerns about the premises and outcomes of this conference. One of the most outspoken groups

was the Committee on Women, Population, and the Environment (CWPE). The CWPE is a multi-cultural feminist alliance of community organizers, scholarly activists, and health practitioners that works to "ensure true reproductive justice, self determination and human rights for all women" (CWPE 2007a). They support "women's right to safe, voluntary birth control and abortion, while strongly opposing demographically driven population policies" and are "committed to promoting the social and economic empowerment of women in a context of global peace and justice; and to eliminating poverty" (CWPE 2007b). They envision the

> social and economic empowerment of women in a context of global peace and justice and look to a world where human rights are valued above profit-driven consumerism. [A world] free of poverty, white supremacy, militarism, religious chauvinism, patriarchy and other oppressive systems that threaten our health, environment and global well-being [CWPE 2007b]

The CWPE was formed in the wake of the 1992 United Nations Conference on Environment and Development in Rio de Janeiro where population control advocates and environmental organizations used the degradation narrative to garner support for population control programs (Silliman 1999:*x*). At that time, CWPE was "a loose but politically astute network of feminist scholars and activists" that was concerned about the "expansion and greening of this population agenda" (Silliman 1999:*x*). CWPE pulled together a network of allied, mainstream environmental, environmental justice, and feminist organizations and developed a "New Approach," a statement and call to action that "challenged the argument that population growth is the major cause of environmental deterioration" and "defined the root causes to be social and economic structures, rather

than the population demographics and women's fertility" (Silliman 1999:*xi*). They argue that population control programs "treat women as objects of control" and violate their "reproductive choice and bodily integrity" (Silliman 1999:*xi*). They also "made the connections between the processes of economic, social, and political marginalization affecting poor women in both the North and the South" (Silliman 1999:*xi*).

Betsy Hartmann, one of the organizers of the CWPE and professor of Development Studies at Hampshire College, describes how, in an effort to manufacture consent for the 1994 Cairo Conference, population organizations and agencies strategically allied with feminists, and not with anti-abortionists (Hartmann 2006a). She writes that the Programme of Action forged at this conference superficially valued "women's reproductive rights over both coercive population control programmes and conservative religious fundamentalists that are opposed to contraception and abortion" (Hartmann 2006:196). Although this new concept of reproductive health may seem like a step forward for women's health and overall social status, much of the underlying paradigm was still supported by Malthusian-influenced ideology and, therefore, remained virtually the same. Furthermore, as CWPE argues, "since such conferences are set within a framework of liberalization, privatization, and market supremacy, … injecting a feminist and environmental impulse is a contradictory move, because this paradigm runs counter to feminist and environmental values and principles" (Silliman 1999:*xii*).

In response to growing discourse focusing on women's empowerment and greater equality and opportunity for women, the UN Commission on the Status of Women held its Fourth Conference on Women: Action for Equality, Development and Peace in

Beijing in 1995. The conference's "Platform for Action" also forwarded a broad definition of reproductive health and stated that men and women have the right to

> be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. [UN 1995:35]

This agreement also explicitly stated that the responsibility of promoting these rights for all people should be the "fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning" and that "all governments, irrespective of their political, economic, and cultural systems, are responsible for the promotion and protection of women's human rights" (UN 1995:36). One of the actions to be taken includes that "governments, the United Nations system, health professions, research institutions, non-governmental organizations, donors, pharmaceutical industries and the mass media" are to "promote gender-sensitive and women-centred health research, treatment and technology and link traditional and indigenous knowledge with modern medicine, making information available to women to enable them to make informed and responsible decisions" (UN 1995:46).

The UN conferences and agreements presented here, as well as many others, have greatly influenced the way reproductive health is understood, especially in a global context. The agreements and policies that are forged at these gatherings have a direct impact on reproductive health ideology, discourse, and research, as well as the implementation of reproductive health programs and services, thus having a huge bearing

on the RHI vortex and its actors and agendas. While a great number of international reproductive health policies and services are focused on promoting family planning in the context of sustainable population and development strategies, a comprehensive reproductive health, rights, and justice approach would involve addressing much broader issues as suggested by multiple academics, activists, and those working in the international development field. Because reproductive health projects often fall under the umbrella of international development, a brief deconstruction of the ideology behind so-called "development" is necessary. Then, in the chapters to follow, I will describe how the ideologies and policies described above have played out on the ground.

International Development and Reproductive Health: Shifting Frameworks and Changing Focus

To end global poverty by 2015, eight "universal objectives" called Millennium Development Goals (MDGs) were agreed upon by the UN General Assembly in 2000. According to UN Secretary General Ban Ki Moon,

> the Goals represent human needs and basic rights that every individual around the world should be able to enjoy—freedom from extreme poverty and hunger; quality education, productive and decent employment, good health and shelter; the right of women to give birth without risking their lives; and a world where environmental sustainability is a priority, and women and men live in equality. [UN 2010b:4]

After ten years of striving to achieve these goals, he comments, "gender equality and the empowerment of women are at the heart of the MDGs and are preconditions for

overcoming poverty, hunger and disease. But progress has been sluggish on all fronts—from education to access to political decision-making" (UN 2010b:4).

The MDGs and their related policies have resulted in numerous development projects designed to enforce the rights and freedoms of women, including access to reproductive health, education, and political representation. By improving women's access to reproductive health care within the framework of international development and under the guise of dominant population-environment discourse, development agencies and organizations can effectively claim success in achieving any or all of these goals.

According to the language used to describe MDG five, "achieving good maternal health requires quality reproductive health services and a series of well-timed interventions to ensure a woman's safe passage to motherhood" (UN 2010b:30). This is one example of how interventions are routinely positioned as the way to improve women's reproductive health within international development discourse. However, using the development and intervention models automatically situates these reproductive health projects within a hierarchical system of unequal power relations, which is not only in direct conflict with achieving MDG three regarding the promotion of equal gender relations and the empowerment of women, but is problematic on many other theoretical and practical levels.

In the 1990s, participatory and bottom-up development frameworks began to emerge from resistance to and criticism of the Western-dominated, -identified, and -centered dynamics in previously established development discourse. This shift ushered in new ways of planning and doing development that paid particular attention to the so-

called “empowerment” and “participation” of its subjects. In this case, empowerment was mostly restricted to having a place, a voice, and representation within a management system – development was to deliver “power *to*, rather than power *over*” (Mosse 2005:102). Development’s purpose and priorities also had to be modified to adjust to the new political climate. These new frameworks of development required new ideologies of the ‘other,’ interpretations of their needs and desires, and parameters from which to judge the relative success or failure of a given project.

In *Cultivating Development: An Ethnography of Aid Policy and Practice*, David Mosse gives an anthropological account of his experience as a former development consultant to a Participatory Rural Appraisal development project in India in the 1990s (2005). Mosse describes in detail the very real ideological and institutional effects and consequences of development and its discourse from the point of view of an “expert” cultural consultant. He presents an ethnographic retrospective on the complex and sometimes constrained relationship between development policy and practice, especially those that claim to be participatory and poverty-focused. He contextualizes the complex relationships forged between development actors, participants, institutions, and donor organizations, and explains how these relationships are highly influential and intimately intertwined with social systems of power and inequalities, ideas surrounding development and identity, and perceptions of needs, values, successes, and failures.

Mosse defines the first fifty years of post-colonial development as a “framework within which the relationship between the affluent West and its ‘others’ has been

understood" (Mosse, 2005:1). He cites Ferguson and draws critical connections between colonialism and development:

> A now extensive literature argues that, like those of colonial rule, development's rational models achieve cognitive control and social regulation; they enhance state capacity and expand bureaucratic power (particularly over marginal areas and people); they reproduce hierarchies of knowledge (scientific over indigenous) and society (developer over the 'to be developed'), and they fragment, subjugate, silence or erase the local, all the while 'whisk[ing] these political effects out of sight' through technical discourses that naturalise poverty, objectify the poor and depoliticise development. [Mosse 2005:4]

He quotes Cooper and Packard when he argues, development can also be simply understood as "a regime of unequal international relations" (Mosse 2005:40).

Mosse describes development projects as operating within particular constellations of participants and workers acting within the broader context of hierarchical and unequal power systems. Therefore, to better understand the multifaceted context of development, an analysis must be attentive to systems of power, privilege, and oppression both between social institutions and organizations and within them. He argues that the production and interpretation of ideas, needs, and desires of development should be understood as situated within the context of the relationships composing these constellations.

Although touted as operating under the guise of a participatory framework, the perspective, approach and terms of reference for development projects are pre-defined by institutional and donor policy. Pre-determined strategies, methods, ways of interpreting also came from the top-down, "satisfying an ever more demanding audit culture of the donor" (Mosse 2005:164). Automatically there is a dispossession of the local partner

when external policy imposes the framework for interpreting effects and ignores the actual on-the-ground implementations within a so-called participatory approach to development (Mosse 2005:233).

The degree to which a project is committed to participation, empowerment, and a bottom-up philosophy should be routinely interrogated, especially when outside "expert" consultants and donor policy provide an authorized model of building community capacity and self-reliance. According to Mosse, "expertise is relational" and, citing Grammig, "expertise necessarily implies cultural distance and ignorance of the local in order to establish a privileged 'universal' point of view" (Mosse 2005:107, 133). This highlights the irony inherent in participatory, bottom-up development interventions, which essentially come from this globalized, universal perspective.

Andrea Cornwall and Karen Brock take a critical look at the use of the terms *participation, empowerment,* and *poverty reduction* as "buzzwords" in mainstream development policy (2005). They argue that in addition to signaling a different approach to development and providing a new sense of direction, these buzzwords place development within a consensus narrative and "lend the legitimacy that development actors need to justify their interventions" (Cornwall and Brock 2005:1044). Deconstructing development policy and the language that is used to frame its intent and justification, can help to problematize the dominant development paradigm and incite alternative discourses (Cornwall and Brock 2005:1044).

The problems described above illustrate the evolution of international reproductive health as a field of study, a political issue, and an approach to achieve

international development goals. It is a complex web encompassing many different actors and subjects, all with their own perceptions and agendas. It is difficult to tease apart the various aspects of international reproductive health because they are all so intertwined, interdependent, and influential. This difficulty highlights the strength and power of the RHI vortex, and its role in shaping an unquestioned reality. The impact of the vortex encourages an uncritical perspective that parades as objective, but, in fact, universalizes and shapes a powerful trajectory that disempowers and silences those that use it to configure their reproductive health choices.

However, the ways that individuals confront the RHI vortex is individual, situational, and complex. Mosse observed that "subordinate actors in development… create everyday spheres of action autonomous from the organizing policy models,… but at the same time work actively to sustain those same models – the dominant interpretations – because it is in their interest to do so" (Mosse 2005:10). Both local development workers and clients of participatory-style development projects, including reproductive health interventions, negotiate their positions within this arena and participate under varying and simultaneous degrees of both autonomy and subjugation. My point is that no one operates with total reproductive autonomy within the framework of international development, and, as stated above, the basic conception of what reproductive health encompasses is highly contextual and in a state of constant change. Therefore, it is crucial to examine the multiplicity of perspectives involved in the ideas about, and implementation of, reproductive health care in different times and areas of the world.

Now I will provide two case studies to focus in on the contextual complexities of RHI and, by utilizing in-depth examples, I will analyze how the RHI vortex impacts individuals, communities, states, and the field of reproductive health as a whole. The first is an analysis of a reproductive health and natural resource management intervention in the Philippines, and the second takes a broad look at various reproductive health research and interventions in Bolivia. This contrast shows how RHI hits the ground in these two different places.

A CASE STUDY OF RHI IN THE PHILIPPINES

This case study presents a critical analysis of a development program that integrated a reproductive health component into a coastal resource management intervention designed to alleviate poverty, hunger, and environmental degradation in the Philippines. This analysis intersects multiple disciplines including ecology, anthropology, history, political science, women's studies, and medicine. I will demonstrate how RHI influences, and is influenced by, reproductive health policy and practice as it is applied on the ground. This study of an international development program exemplifies how links are drawn between population, resource depletion, and international reproductive health. I also indicate how this program both addressed and ignored different issues of structural and social inequalities, and reproductive rights and justice. I begin this analysis by looking at how problems were identified and defined, and what solutions were proposed and applied.

The IPOPCORM Interventions: Defining Program Goals and Objective

An experimental development program called Integrated Population and Coastal Resource Management (IPOPCORM) was implemented by a collaborative of NGOs and local governments in the Palawan Province of the Philippines (see Figures 2 and 3). It was in operation from 2001 to 2008 and was administered by the PATH Foundation Philippines, Incorporated (PFPI), an American non-profit NGO focused on "alleviating

poverty, improving health, [and] promoting environmentally sustainable development" (PFPI 2006a).

The purpose of the IPOPCORM interventions was to "improve the quality of life of human communities that depend upon coastal resources while maintaining biological diversity and productivity of coastal ecosystems" (PFPI, 2000d). Their approach to solve these problems was three-fold: to decrease population size, increase food supply, and improve coastal and marine biodiversity (see Figure 4). The reproductive health component of this interdisciplinary approach was heavily influenced by dominant discourse surrounding reproductive health, international development, and population-environment issues.

The marine environment of the Philippines is considered a "biodiversity hotspot" – an area of extreme species richness – and has a reputation of being characterized as "threatened by exceptionally high rates of human population growth" (Castro et al. 2004:1). The nation is an archipelago of over 7,000 islands and is home to roughly 90 million people with an annual population growth rate of 2.1 per cent (World Bank 2010:170). It is considered a lower-middle income country with a per capita gross national income of $1,890 in 2008 (World Bank 2010:170). 65 per cent of Filipinos reside in urban areas and 39 per cent of the country's land area is utilized for agriculture (World Bank 2010:170). Socio-economic development in the Philippines has been slower than in neighboring nations despite a 95 per cent literacy rate for men and women, a strong tradition of universal education, and a democratic political system (Lakshminarayanan 2003:97).

Figure 2: Orthographic projection of the Republic of the Philippines in green, with the Association of Southeast Asian Nations (ASEAN) states highlighted in dark gray (Connormah 2010).

Figure 3: Map of the Philippines highlighting the location of Palawan in red (Gildemax 2005)

Figure 4: “Too many mouths to feed” (PFPI 2000d)

The previously untried aim of IPOPCORM was to promote family planning within the context of sustainable coastal resource management in order to achieve several of the UN's MDGs and increase food security for people living on Palawan. The objectives were to improve reproductive health outcomes in coastal communities, develop coastal resource management capacity at the community level, and increase the public and policymaker's awareness and support for Population, Health, and Environment (PHE) integration (D'Agnes 2009:3). As indicated by PFPI,

> the goal of IPOPCORM is consistent with the National Biodiversity Strategy and Action Plan of the Philippines' Department of Environment and Natural Resources and the goal of the United Nations Joint Group of Experts.
>
> The purpose of IPOPCORM is to encourage and support integration of population management and reproductive health strategies into coastal resource management (CRM) plans and projects in selected biogeographic zones characterized by high marine biodiversity, high population growth and young population age structure. [PFPI, 2000d]

The vision of the program is "Eco-Human Health", which "implies an inter-relationship between the health status of ecosystems and the health status of human population in biodiversity-rich areas" (D'Agnes 2009:2). This may seem like an improvement to the piecemeal approach to solving social and ecological problems, but the underlying assumptions and ideologies need to be interrogated. According to the "Conceptual Model for the IPOPCORM Approach" (see Figure 5), the "Target Conditions" needed to achieve "Eco-Human Health" are food security, fish availability, and stable marine ecosystems (D'Agnes 2009:2). The "Direct Threats" (white boxes) to the "Target Conditions," and therefore "Eco-Human Health," are "Large Family Size,"

"Destructive Fishing," "Overfishing," and "Illegal Commercial Fishing" (D'Agnes 2009:2). "Indirect Threats" (blue boxes) and "Opportunities" (yellow boxes), which include "Lack of Access to Family Planning," "Traditions and Preferences," "High Fertility," "High Population Growth," "Need to Generate Income," and "Reliance on Resource Extraction" with a "Lack of Alternative Livelihood", are considered the "root causes" of the "Direct Threats" (D'Agnes 2009:2-3).

The problems are outlined here in a very intertwined and convoluted manner. Mosse argues that the "more interests that are tied up with [donors'] particular interpretations the more stable and dominant development's policy models become" (2005:8). Through the perspective of PFPI, high rates of population growth and fertility are considered to be grave threats to Filipino food security, while issues of gender and neo-liberal globalization are never raised to the foreground. One can see how hegemonic, neo-Malthusian ideology has influenced the framework of the IPOPCORM approach.

Implementing IPOPCORM: Methodology & Methods

PFPI proposes that the integrated model developed through the IPOPCORM initiative will increase both the health of the people and the ecosystems of Palawan Island. This approach has a theoretical foundation in Marten's "linked eco-social systems" concept, which theorizes "small improvements in ecological and social systems can reinforce one another to turn around both systems from deterioration to health" (Castro et al. 2006:3).

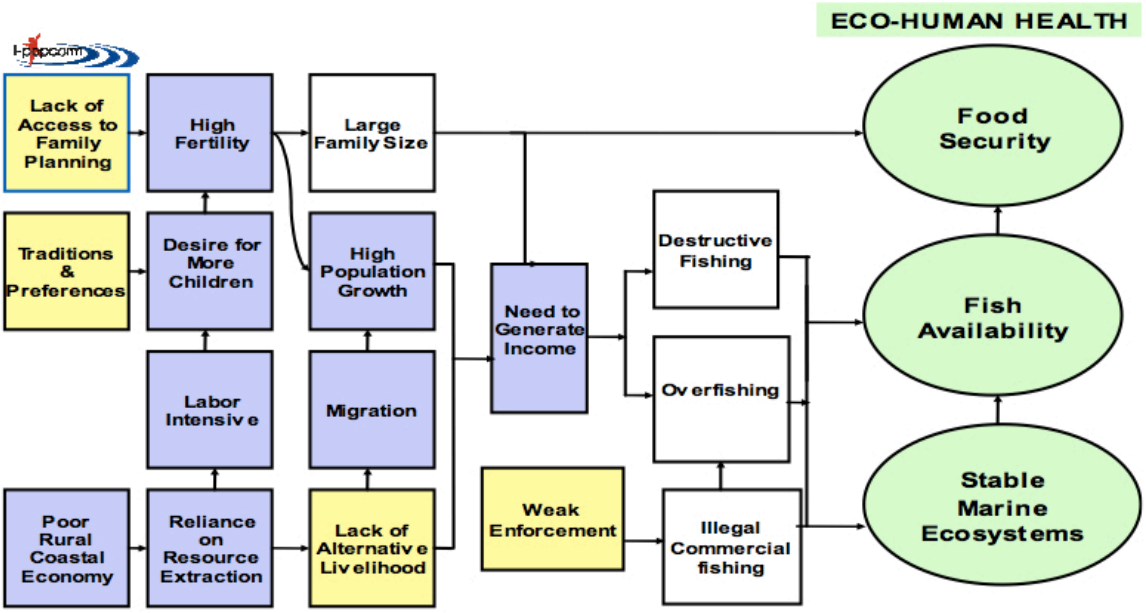

Figure 5: Conceptual Model for the IPOPCORM Approach (D'Agnes 2009)

The program implemented three intervention models in three different areas of Palawan Province (Castro et al. 2009). Independent research groups conducted community surveys and ecological assessments in the three study sites both before and six years after the interventions (in 2001 and 2007) (Castro et al. 2009). Behavioral monitoring surveys were implemented by partner NGOs during the interventions to "track changes in family planning and fishing practices among the target groups which primarily consisted of fishers, women and youth (Castro et al. 2009). Qualitative data from these surveys and assessments were gathered and cataloged according to 18 ecosystem health indicators grouped under three categories (coral reef, reef fish, and mangroves) and nine human health and wellbeing indicators grouped under two categories (reproductive health and food fish security) (Castro et al. 2009).

The IPOPCORM program was divided into two interventions: Population and Reproductive Health (Pop/RH), and Coastal Resource Management (CRM) (Castro et al. 2009). In a paper prepared for the 2009 International Conference on Family Planning: Research and Best Practices, these interventions were described as follows:

> The Pop/RH intervention aimed to build the capacity of local institutions to deliver family planning (FP) information and counseling for informed choice, community based distribution (CBD) and social marketing of non-clinical methods of contraception (condoms, oral pills), and peer-mediated behavior change communication (BCC) for pregnancy prevention.
>
> The CRM intervention sought to build local capacity to deliver coastal conservation education, establish and manage marine protected areas (MPA), formulate community-based management plans and committees, safeguard the protected areas, implement mangrove reforestation, and encourage compliance with laws prohibiting use of dynamite and cyanide in fishing. [Castro and D'Agnes 2009]

The IPOPCORM intervention model shapes and is shaped by all aspects of the RHI vortex. It involved regional governments, the media, and education systems, as well as local and international NGOs and funding organizations. The medical-industrial complex was influential because pharmaceutical contraceptives were promoted, marketed and sold. Dominant discourse and previous research contributed to the methodological approach, and in turn, the IPOPCORM program also contributed to and strengthened the vortex because it was touted as such a successful intervention in published and presented research.

IPOPCORM's "Success"

In the end, IPOPCORM used a "quasi-experimental evaluation design" to examine "the hypothesis that integrated approaches to population and coastal resource management generate higher impacts on human and ecosystem health and outcomes compared to sectoral management approaches" (Castro and D'Agnes, 2009). In some areas only RH was addressed and in other areas only CRM was addressed (D'Agnes 2009:12). The outcomes of these areas were compared to an area where both RH and CRM were integrated and addressed together, which was found to have "generated higher impacts on both CRM and RH indicators, and at lower cost" (D'Agnes 2009:12).

PFPI reports that after two years, the IPOPCORM project developed the capacity of 467 peer educators and community based distribution agents to deliver family planning and CRM information and services to their communities (PFPI 2006b). Peer educators

were instrumental in encouraging youth and adults to "become stewards of their sexuality and the environment" (Castro 2009). Local governments were also "capacitated and mentored" by IPOPCORM representatives to formulate development plans and budgets that support reproductive health and family planning activities linked to CRM, and "with the completion of the project, the LGUs [local government units] have assumed responsibility for sustaining the CBD [community-based distribution] and PE [peer education] operations in the target areas" (PFPI 2006b).

They also reported a significant increase in use of contraceptives, "in particular pills, condoms and emergency contraception" (also known as "morning after pills") among adults and youth, a significant decline in use of dynamite and cyanide in fishing, fewer young adults reporting income levels below the poverty line, conditions of coral and mangroves improved, fish catch rates doubled, and fisherfolk incomes increased by 21% (Castro et al. 2009). Interestingly, by promoting family planning as a component of CRM for food security, the program deflected opposition from conservative groups and religious leaders who usually oppose the use of contraceptives (Castro et al. 2004:12).

Joan Castro, PFPI Project Director, and Leona D'Agnes, PFPI Technical Director, conclude that the integrated effort had a higher impact on both the Pop/RH and CRM indicators than the sectoral management approaches and contributed more directly to achieving MDGs (Castro et al. 2009). They report that the IPOPCORM intervention met many of the MDGs by reducing poverty among fisherfolk and youth (MDG 1), enabling women to participate in CRM and livelihood activities (MDG 3), increasing the use of family planning and safer sex practices (MDGs 4, 5, and 6), and enhancing the

community's role in CRM as the "RH component lends sustainability to CRM gains" (MDG 7) (Castro et al. 2009). According to Castro and other PFPI staff, integrated coastal management "provides a comprehensible context for coastal residents to recognize the necessity of limiting family size to achieve food security and improve their family's welfare" (Castro et al. 2004).

According to those who organized and supported it, the IPOPCORM intervention was deemed a great success. However, as Mosse points out, "'development success' is not objectively verifiable but socially produced. It is an institutional process not an objective fact" (2005:171-2). Investigating IPOPCORM's and PFPI's supporting organizations and funding institutions further illuminates this program's underlying ideologies, perceptions of the problems, the approaches chosen to address them, and how the implementing actors manufactured the "success" of the project.

IPOPCORM Actors, Agendas, and Accountability

According to PFPI, "the David and Lucile Packard Foundation, the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) provided complementary funding ($6 million over 5 years) for this Initiative - the Philippines' largest population-environment project" (PATH 2006c). Below are overviews of these four key organizations involved with the IPOPCORM initiative. I will be paying specific attention to their ideological underpinnings and agendas regarding

reproductive health and, more specifically, how reproductive health is integrated into approaches to environmental conservation and international development.

PFPI is a private non-profit NGO based in the Philippines and Hawaii. They accomplish their mission to "improve health, conserve biodiversity and promote sustainable development in the Asia-Pacific region" by "designing and implementing demonstration and research projects and cross-disciplinary initiatives in population, health, and natural resource management in collaboration with local government and private sector partners" (PATH 2006c). PFPI endeavors to "empower communities with self-help approaches that are manageable and sustainable at local levels" and specializes in "peer mediated behavior change" and peer education (PATH 2006c). IPOPCORM was one of several interventions in which PFPI has participated in the Philippines.

The David and Lucile Packard Foundation, which supports multiple projects implemented by PFPI, was created in 1964 by Lucile Salter Packard and David Packard, the co-founder of the Hewlett-Packard Company (David and Lucile Packard Foundation 2009a). Their Population and Reproductive Health program seeks to "slow population growth in high fertility areas of the world and to enhance and protect women's reproductive health and reproductive rights, especially for marginalized and disadvantaged girls, women, and communities" (David and Lucile Packard Foundation 2009b). As indicated on their website,

> Enabling women to manage their fertility improves the health of women and families and contributes to slowing population growth. Nearly one-third of maternal deaths, for example, are from pregnancies that were unintended.

> The relationship between population growth and economic development and poverty is complex; however a significant and growing body of evidence identifies investments in family planning and reproductive health as key to addressing poverty and achieving economic development at the individual, household and national level. [David and Lucile Packard Foundation 2009b]

This program has four major objectives: (1) to promote family planning and reproductive health in development agendas, (2) to develop and share models to increase access to family planning and reproductive health information and services, (3) "address root causes of reproductive health outcomes and population growth, especially through targeted investments in the education and empowerment of girls ages 12 to 18", and (4) to enhance reproductive rights, including access to safe abortion care (David and Lucile Packard Foundation 2009b). Their current strategy operates under a regional framework. It emphasizes "investing in women's organizations and engaging women leaders as champions for family planning and reproductive health and rights," and "catalyze[s] innovation and learning within the field" (David and Lucile Packard Foundation 2009b).

The David and Lucile Packard Foundation and the U.S. Agency for International Development (USAID) have co-sponsored many international development and population projects. Since the Foreign Assistance Act was signed into law and USAID was created by executive order in 1961, "USAID has been the principal U.S. agency to extend assistance to countries recovering from disaster, trying to escape poverty, and engaging in democratic reforms" (USAID 2009a). USAID states that it "promotes peace and stability by fostering economic growth, protecting human health, providing

emergency humanitarian assistance, and enhancing democracy in developing countries" (USAID 2009b).

However, while aiming to improve the lives of the citizens of the developing world, USAID lends its "helping hand" to struggling people overseas, which "has always had the twofold purpose of furthering America's foreign policy interests in expanding democracy and free markets" (USAID 2009a). Therefore, "USAID plays a vital role in promoting U.S. national security, foreign policy, and the War on Terrorism," and, one could also argue, perpetuates Western hegemony (USAID 2009a). It is this so-called "caring" that "stands as a hallmark of the United States around the world -- and shows the world our true character as a nation" (USAID 2009a). USAID argues that it addresses "poverty fueled by lack of economic opportunity, one of the root causes of violence today" (USAID 2009b).

The UN Population Fund (UNFPA, formerly known as the UN Fund for Population Activities) is an international development agency that "promotes the right of every woman, man and child to enjoy a life of health and equal opportunity" (UNFPA 2008a). To accomplish this lofty goal, the UNFPA "supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect" (UNFPA 2008a).

The work of UNFPA has three main areas of focus (reproductive health, women's empowerment, and population and development strategies), which are "inextricably linked" as they believe "the ability to make free and informed childbearing decisions lies

at their intersection" (UNFPA 2008c). The IPOPCORM program goals are consistent with the UNFPA's "6th Country Programme goal which aims to improve the reproductive health of the people of the Philippines through better population management and sustainable human development" (PFPI 2006b). They consider their work on population to be "central to the goals of the international community to eradicate poverty and achieve sustainable development" (UNFPA 2008b).

The UNFPA was created in 1969 mostly as a result of U.S. financial and political support, as the "U.S. government assumed leadership of an international movement to encourage developing countries to adopt policies to reduce population growth" (Crane and Finkle 1989:23). The neo-Malthusian degradation narrative continually runs through the UNFPA's rhetoric. Hartmann writes, "the UNFPA has expended large amounts of resources promoting the view that population growth is one of the major causes of the environmental crisis" (1995:26).

In addition to the Packard Foundation, USAID, and the UNFPA, PFPI also receives general support from the Asian Development Bank (an Asia-Pacific international development finance institution) and other U.S.-based organizations such as the International Institute for Education (a non-profit education and training organization), Tetra Tech International (an international multi-disciplinary planning, engineering, and environmental firm), CDM International (a consulting, engineering, construction, and operations firm), the Population Reference Bureau (a non-profit population data and research organization), and the Coastal Resources Center (a research arm of the University of Rhode Island graduate program) (2006c). It is contextually important to

understand the impact of these organizations on PFPI's ideological perspectives, interpretations of problems, and the strategies used to overcome them. It is also important to recognize that these organizations and the IPOPCORM program shape, and are shaped by, the RHI vortex. The ideologies, policies, and practices employed in developing and implementing this program reflect, create, and reproduce the realities of international reproductive health.

Critical Analyses of the IPOPCORM Interventions

Although population growth is routinely blamed for environmental degradation in the Philippines (and elsewhere), critical analyses are quick to point to overarching systematic social factors, such as gender inequality and the effect of (neo)colonialism, as highly influential culprits (Eder 1990, Eder 2005, Hartmann 1995). For example, the impact of industrial-scale deforestation of commercial logging enterprises in the Philippines has a significant effect on watershed erosion, the siltation of coastal waters, and the socio-economic marginalization and migration of indigenous and impoverished people (Eder 1990, Eder 2005, Hartmann 1995:28).

Other analyses point to the history of socio-political changes in the Philippines as having a great impact on ecological stewardship, such as the major shift from traditional land tenure practices to those of a Western model (Urich et al. 2001, Eder 2005). For instance, James Eder, an American anthropologist who studies demographic and subsistence change in Palawan, writes that wide local discourse "attributes much of the

degradation of Palawan's fisheries to the various and increasingly efficient fish capture techniques introduced there by migrant Visayan fisherfolk; e.g., hulbot-hulbot or Danish seine, a destructive fishing method that employs large weights and scare-lines" (2005:160).

The primary assumption of the IPOPCORM framework is that Filipinos alone are responsible for their lack of access to resources, means to maintain livelihoods and sustain themselves. They are also positioned as lacking knowledge to care for their reproductive health and preserve biodiversity. This is a blatant example of a "blame the victim" approach. The IPOPCORM program and literature do not directly address issues of social inequality or the impact of neoliberal globalization on access to resources and the current state of the environment (mainly forests and fisheries) as initial problems. The long history of European colonialism in the Philippines, and the imposition of neo-liberal capitalism from former colonial powers that followed, were completely ignored by the IPOPCORM program. This is a critical omission given that there has been a historical pattern of environmental degradation and deforestation in the Philippines since colonial rule.

The basic premise underlying the IPOPCORM approach is that by increasing coastal conservation efforts and by slowing population growth, the people living in Palawan would be better equipped to feed themselves and lift themselves out of poverty. However, what is overlooked by the IPOPCORM reports is a critical analysis of the overarching social systems of power and inequality, and the neo-Malthusian line of

reasoning underlying the framing of the problems they wish to alleviate. A cultural-historical analysis is needed.

The colonial history of the area is wrought with the horrors of imperial domination, especially the colonial relationship between the Philippines and the U.S. Filipinos had already been resisting European colonial rule for nearly four centuries when the U.S. Senate voted to annex the Philippines in 1899, putting the nation under U.S. colonial rule and military occupation (Schirmer and Shalom 1987:xvi). In 1947, colonial rule officially ended with the signing of a treaty between the two sovereign nations, but this agreement would not be complete without the 99-year lease of military bases to the U.S. signed three days later (Schirmer and Shalom 1987:xvii). The militaries and economic systems of the two nations still remain closely intertwined. One cannot ignore the impact of the U.S. military and economic polices on the political economy of the Philippines.

In addition to the socio-economic effects of colonialism, the influence of colonial rule on ecosystems and natural resource management has been overlooked by the IPOPCORM program literature. I argue that an analysis of the socio-economic or ecological situation in the Philippines is incomplete without including immensely influential factors such as colonialism, neo-liberal globalization, and social systems of power and domination, which greatly impact ideas about the relationships within and between different groups of people, the relationship between people and their environment, and approaches to natural resource management.

James F. Eder conducted an analysis of another coastal resource management project on Palawan where, citing Pomeroy, "municipal government (rather than local community) authority over local fishing grounds dates back to the colonial period" (Eder 2005:153). According to Eder, "the Philippines has a long history of government regulation of the nation's fisheries, and whatever folk notions of resource management or property rights that might have existed in the nation's coastal areas have long since weakened or disappeared in the face of technological change and outside political and economic forces" (Eder 2005:152).

The Philippine government established a Community-Based Forest Management policy in 1995, signaling a shift in natural resource management from a government-led, top-down approach to one that was more participatory and community-based (PFPI 2007:4, Oliva 1998). Eder comments on the institutionalization of the Coastal Resource Management Project in Palawan, which was jointly sponsored by USAID and the Philippine government from 1996 to 2002:

> [It] is one of many such projects that came about in the Philippines and elsewhere in Southeast Asia following growing realization that fisheries resource over-exploitation and coastal environmental degradation have complex social, economic, and political origins, and that coastal resource management issues will only be effectively addressed when fishers and other resource stakeholders are more involved in the management process. [Eder 2005:148]

This new national strategy was designed to ensure sustainable development of the country's forestlands, including local tenure and access rights to mangrove and all forests, and, as PFPI argues, to ultimately achieve social justice (PFPI 2007:4, Oliva 1998).

The Freedom From Debt Coalition (FDC), a grassroots Filipino multi-sector coalition of organizations and individuals, is critical of imposed neo-liberal policies instituted by international donor organizations. As an economic and social justice advocacy organization,

> FDC has consistently recognized debt as the prism that holds the wide spectra of issues ranging from structural adjustment policies (SAPs) that the multinational financial institutions like the IMF, WB, Asian Development Bank (ADB), et al. were imposing on the Philippines to the power sector issues, taxation, fiscal reforms, water privatization, and the deregulation of petroleum products. [FDC 2006]

The FDC Women's Committee and the Women's March Against Poverty and Globalization (*Welga ng Kababaihan Laban sa Kahirapan at Globalisasyon*) *v*oiced their response to the lack of social services available in the Philippines, specifically reproductive health services, in a joint press statement titled "On health care vs. debt payment" (2008). They assert that "social services have consistently been compromised to accommodate debt payments" (FDC Women's Committee and the Women's March Against Poverty and Globalization 2008). Below is an excerpt of a proclamation made in October 2008 following a march to the House of Representatives in Quezon City urging lawmakers to increase support of social services and suspend foreign debt payments:

> We are caught in a global financial crisis of potentially crippling implications for countries like the Philippines. Yet government, through the use of a measure automatically appropriating funds for debt payments, persists in its track of prioritizing debt service over all other public expenditures and violating the most basic rights. These include our rights to urgently needed health services and resources, which have grown increasingly dismal even by government's own standards…
>
> Access to reproductive health care hardly budged from 49 % in 2001 to 50.6 % in 2006, still far from the targeted increase to 60 % access by 2010 and 80 % by

> 2015. The slow decline is attributed to inadequate access to comprehensive reproductive health services by women, and also adolescents and men. [FDC Women's Committee and the Women's March Against Poverty and Globalization 2008]

The FDC Women's Committee and the Women's March Against Poverty and Globalization promote a discourse that runs counter to the mainstream ideology and discourse circulating within the RHI vortex. Like other activist and advocacy groups, they do not see social, economic, and reproductive health as individual issues, but as issues that require comprehensive solutions.

A nation-wide comprehensive reproductive health bill was introduced to the Philippine legislature in 2008, but still has not passed. It is strongly supported by anti-poverty and women's groups, such as the FDC Women's Committee and the Women's March Against Poverty and Globalization. However, the Catholic Church has thwarted its passage for the past eight years (Santos 2010). The bill would require national hospitals and government health units to make contraceptives available and provide reproductive health services, as well as require sex and family planning education in schools (Torrevillas 2009, Antonio 2010).

The Catholic Church exerts a powerful influence over reproductive health policies and practices in the Philippines. According to the 2000 census, 80.9% of Filipinos identify as Roman Catholic (Central Intelligence Agency 2009).[18] Rama Lakshminarayanan, a Senior Health Specialist for the World Bank, argues that the conservative principles of the Catholic Church in the Philippines contribute greatly to

[18] Religious affiliation in the Philippines in 2000: 80.9% Roman Catholic, Muslim 5%, Evangelical 2.8%, Iglesia ni Kristo 2.3%, Aglipayan 2%, other Christian 4.5%, other 1.8%, unspecified 0.6%, none 0.1%) (CIA 2009).

unequal gender relations, including access to reproductive health and family planning services, and vast income disparities between men and women (2003:104). According to Lakshminarayanan, "church officials are strongly opposed to contraception and abortion and only tolerate "natural" family planning methods, which greatly reduces women's decision-making capacity over their fertility" (2003:97) [19].

Although the Church supports natural family planning methods, modern methods of contraception have been deemed "abortifacients," "artificial," and "immoral" by the Catholic Bishops' Conference of the Philippines (CBCP), a prominent and vigorous influence on the electorate and policy-makers (Torrevillas 2009, Antonio 2010, Santos 2010). Before the 2009 elections, the CBCP warned voters to not vote for candidates who support the reproductive health bill: "It would not be morally permissible to vote for candidates who support anti-family policies, including reproductive health" (Santos 20010). Catholic election guidelines stated that contraception is "morally wrong…endangers the spiritual health of the marriage" and "impedes the process or possible fruit of conception," and that voters who elect pro-reproductive health candidates would become willing accomplices to "evil" (Santos 2010). Currently the CBCP is organizing a panel of lay experts in medicine, law, and economics on the issue of population control to try to convince President Aquino, a member of the Liberal Party,

[19] The Institute for Reproductive Health Philippines, an affiliate of the Institute for Reproductive Health at Georgetown University in Washington, D.C. (funded primarily by USAID), "works at making modern and effective natural methods available and accessible to couples nationwide" (Institute for Reproductive Health Philippines 2003, Institute for Reproductive Health 2009). They promote the use of the "Standard Days Method," in which couples use a circular strand of beads to track menstrual and fertility cycles and avoid sex during days eight through 19, and the lactational amenorrhea method, which can only be used by lactating mothers who have not yet resumed their menstrual cycles after giving birth (Institute for Reproductive Health in the Philippines 2003).

that a "high population rate does not often mean high incidence of poverty" and that "corruption is the major cause of poverty and not overpopulation" (Antonio 2010).

The discourse surrounding the reproductive health bill in the Philippines illustrates how political and institutional power can collide in negotiations over reproductive rights and reproductive health policy and practice. This discourse, as well as the discourse surrounding the IPOPCORM interventions, exemplifies how ideological boundaries between reproductive health policies and population control strategies can become blurred and distorted by the RHI vortex.

IPOPCORM in the Philippines: Concluding Remarks

Even though IPOPCORM is touted as a successful community-based natural resource management project model, merely titling the project components "interventions" automatically denotes an imposing and dominating top-down development framework and not one that necessarily has come from the "bottom." The literature that I could find on the IPOPCORM program was strictly from the perspective of the organization that spearheaded the effort and the financial institutions footing the bill. I feel as if I do not have a well-rounded understanding of the impacts of this project because I haven't heard any accounts from the people; the "stories from the bottom" were missing from the discourse. Overall, a reader is left with many things to ponder regarding the realities of this "community-based" project.

Questions remain about the reproductive health and contraceptive history (and pre-history) of the indigenous Palawan cultures and the many other cultures currently living throughout the Philippines. The 2009 National Statistics Office of the Philippines reports that 50.6% of women between the ages of 15 and 49 in 2006 used some form of contraception, 35.9% used a modern method, and 14.8% used a traditional method (National Statistics Office 2009). Since traditional methods were reported, but not explored, they were ignored, discounted, and omitted from the discourse.

A more comprehensive approach would have included addressing the reproductive health concerns of the community and addressing those concerns in holistic and culturally appropriate ways. For example, PFPI could have looked more deeply into what the traditional methods of contraception are and how they are integrated into the socio-cultural fabric. This information is not insignificant and should have been included.

Given that reproductive health consists of much more than contraception, I am critical of labeling IPOPCORM a reproductive health intervention in the first place. Although increasing access to safe and effective forms of contraception can be liberating for some women, the promotion of modern, Western forms of hormonal contraceptives on a global level carries with it the baggage of the medical-industrial complex, and its underlying ideologies, which seek to benefit from widespread sales, distribution, and use.

In the end, the Pop/RH segment of IPOPCORM did not provide comprehensive reproductive health care, but merely focused on preventing pregnancy through the promotion and distribution of condoms, hormonal birth control pills, and emergency

contraception. It is obvious that the focus was on controlling population growth and not on improving the holistic reproductive health of Palawan residents. It seems that population control was the sole aim of the Pop/RH interventions.

Overall, I consider integrated, interdisciplinary approaches to be strong and effective in moving social change forward. However, the health and well-being of people, communities, and ecosystems can only be addressed holistically by acknowledging crucial social factors such as heavily influential, overarching social systems that impact and mediate cultural, socio-ecological, and economic systems. By consciously addressing underlying causes of poverty, such as socially constructed inequalities and histories of imperial power and control, we can begin to deconstruct them and move toward a more just reproductive health paradigm.

From this case study in the Philippines, we can begin to see that implementing an international reproductive health program is very complicated. We have seen how international, national, and local organizations characterize themselves and how they influence and interact with each other. By analyzing the IPOPCORM program, the ideological roots of its approach, the agendas of the actors, and the reasons behind the actions taken, we can begin to tease apart aspects of the RHI vortex. In the following case study in Bolivia, some of the IPOPCORM players will reappear and I will further explain the ways in which RHI collides with reproductive health on international, national, and local levels.

A CASE STUDY OF RHI IN BOLIVIA

This case study presents a critical analysis of reproductive health policies and interventions in Bolivia. Similar to the previous case study of the IPOPCORM intervention in the Philippines, this analysis intersects multiple disciplines. This case study, however, takes a broader perspective on how RHI has been both implemented and challenged in Bolivia. It illustrates how global RH discourse has impacted policy and practice in Bolivia, how regional players interact with the RHI vortex, and how local policies and practices both engage with and resist RHI. I will pay particular attention to the agendas, actors, actions, and accountability of various reproductive health projects and programs that have taken place in Bolivia. I also focus on how these programs both addressed and ignored different issues of structural and social inequalities, as well as reproductive rights and justice.

Cultural and Historical Context of Reproductive Health in Bolivia

Like the Philippines, Bolivia has a history wrought with colonialism and neoliberal development. The country is officially known as the Plurinational State of Bolivia, highlighting its multiethnic population of approximately 9.7 million people (WHO 2009), most of which belong to one of 34 indigenous nations. Bolivia was colonized by the Spanish in the sixteenth century, declared its independence from Spain in 1809, and established itself as a Democratic Republic in 1825. Prior to European

incursion, most of what is now known as Bolivia was part of the Incan Empire (see Figures 6 and 7).

Currently, indigenous people represent roughly two-thirds of the country's inhabitants (WHO 2004). According to the 2001 Bolivian census, "31% of the population identified itself as Quechua, 25% as Aymara, and 6% as Guarani and other Amazonian ethnic minorities, while 38% did not identify with any particular ethnic group" (WHO 2007). In contrast, the US Department of State reports, 55% of Bolivians are ethnically indigenous, 15% have European ancestry, and 30% are Mestizo or have mixed ancestry (2010).

During the period of colonial conquest, Catholic mission culture was imposed on the local tribal nations and had a great impact on gender roles and relations, subsistence practices, technology, spiritual and political roles, trade, and the economy (Radding 2000). This history is also reflected in the religions practiced in Bolivia today. According to the Latin American Public Opinion Project[20], 81.8% of Bolivians identified as Catholic, 14.6% as non-Catholic Christians, 0.4% as non-Christians, 0.1% as following traditional religions, and 3.3% as not following any religion (Díaz−Domínguez 2009:11). Just as in the Philippines, the Catholic Church has had a significant impact on reproductive health policies and practices in Bolivia, especially those funded and overseen by the state.

[20] The Latin American Public Opinion Project is hosted by Vanderbilt University in Nashville, Tennessee and receives funding from USAID, UNDP, and the Inter-American Development Bank (LAPOP 2010).

Figure 6: Orthographic projection of the Plurinational State of Bolivia, highlighted in green (Connormah 2009)

Figure 7: Map of the Plurinational State of Bolivia (CIA 2010)

Bolivia is often cited as the second poorest nation in Latin America behind Haiti (WHO 2004, CIA 2010), but it has the second-largest reserves of natural gas on the continent (Democracy Now 2006). Nearly two-thirds (64%) of Bolivians live in poverty, meaning that they do not bring in enough income to meet their basic needs and 35% of this group lives in "extreme poverty" (WHO 2004, 2007). In the UN Development Programme's (UNDP) 2010 Human Development Report, Bolivia was ranked 95 of 135 countries in the human development index, a measurement of how a nation enables an "environment for people to enjoy long, healthy and creative lives" (UNDP 2010:12). Bolivia's estimated gross national income per capita (adjusted for purchasing power parity) was $4,357 in 2008 (UNDP 2010:144). Also, according to this report, "poverty was 27 percent among Mestizos, but 1.6 times higher among the indigenous Quechua" (UNDP 2010:99).

The state has gone through significant structural changes since Bolivian President Evo Morales took office in 2005. He is a member of the Movement Toward Socialism (*Movimiento al Socialismo*—MAS) political party and is of indigenous Aymara descent. He has received widespread support in Bolivia (re-elected in 2009 with 63% of the popular vote) running on a platform of resisting neoliberal capitalism, nationalizing industries, expanding indigenous and human rights, and cultivating respect for *Pachamama* (mother earth) (Democracy Now 2009b, 2009c). During a press conference at the 2009 UN Climate Change Conference in Copenhagen, he drew ecofeminist parallels between capitalism and the destruction of the environment and argued that we

cannot end global warming without ending capitalism (Democracy Now 2009c). In an interview that followed, he stated,

> Capitalism is the worst enemy of humanity. Capitalism—and I'm speaking about irrational development—policies of unlimited industrialization are what destroys the environment. And that irrational industrialization is capitalism. So as long as we don't review or revise those policies, it's impossible to attend to humanity and life. [Democracy Now 2009c]

Although widely supported by Bolivians, international support for Morales has been contentious and some of his sweeping reforms have come into direct conflict with US policy regarding aid, trade, and sovereign rights (Democracy Now 2008). For example, the US government sought to weaken the influence of President Morales and the MAS party by supporting the rightwing opposition movement with approximately $4.5 million from USAID with the intent to "help departmental governments operate more strategically and work toward decentralization and autonomy from the central government" (Democracy Now 2008). According to declassified US government documents, a "USAID political party reform project aims at implementing an existing Bolivian law that would . . . over the long run, help build moderate, pro-democracy political parties that can serve as a counterweight to the radical MAS or its successors" (Democracy Now 2008).

In 2009, 60% of Bolivians voted in favor of a referendum to amend the constitution giving the indigenous majority more power by reserving seats in Congress and in the Constitutional Court for smaller indigenous groups and, among other things, granting "autonomy to indigenous peoples that will allow them to practice community

justice according to their own customs" (UN 2010a:2). After the passing of the new constitution, President Morales announced,

> The colonial state ends here. Internal colonialism and external colonialism end here. Sisters and brothers, neoliberalism ends here, too. [Democracy Now 2009a]

The amended constitution called for the redistribution of land, wealth, and resources from rich landowners to indigenous peasants, and the advancement of social programs. Under the new land redistribution program, the government granted 10,300 property titles to women between 2006 and 2008 representing a significant leap forward in women's land ownership, even though in many indigenous patriarchal traditions, women are not permitted to own land (Chavez 2009).

In addition, the constitutional changes call for gender equality in government. Currently, half of the new cabinet members are women, the President of the Senate is a woman, and women hold an unprecedented 30% of seats in Bolivia's new legislative branch (Schipani 2010, Menkedick 2010). On the local level, 337 women hold seats on 329 town councils in Bolivia, however, "many of them never made it to secondary school, which puts them at a significant disadvantage when it comes to having an influence in representing their communities" (Claure 2007).

For President Morales, achieving gender equality in government follows *chacha warmi*, a concept that in the Aymara culture means that men and women are complementary in an egalitarian way (Schipani 2010). Gabriela Montano, a senator who represents the eastern city of Santa Cruz ("Bolivia's opposition heartland") on behalf of the MAS party states "this is the fruit of the women's fight: the tangible proofs of this

new state, of this new Bolivia are the increasing participation of the indigenous peoples and the increasing participation of women in the decision-making process of this country" (Schipani 2010).

The inclusion of women and indigenous perspectives has also been reflected recently in policy changes regarding health care in general, and reproductive health care specifically. In 2004, women's groups organized and drafted a framework for a new law placing sexual and reproductive rights in a context of freedom, autonomy, and anonymity (Commission on Women and Development 2008), which was passed by the parliament, but then vetoed by the former president. Opportunely, in 2008, President Morales signed a series of Constitutional reforms "guaranteeing women and men the enjoyment of their sexual and reproductive rights allowing them to decide freely on the number of daughters and sons they wanted to have and the frequency of their births" that are now in the Bolivian Constitution (Commission on Women and Development 2008:11).

Although many internationally supported projects have been implemented, they have not had much success in bringing down Bolivia's maternal mortality rates. Currently, the "government is developing a new strategy based on [an] intercultural reproductive health care approach," which has given traditional medicine institutional relevance in the form of a Vice-Ministry of Traditional Medicine and Intercultural Affairs that is "in charge of promoting, protecting and guaranteeing the conservation of traditional medicines according to the indigenous knowledge and cultures" (Castellanos 2009). For example, a hospital built an "intercultural childbirth room" where indigenous birthing culture and traditions can be honored and where women can "choose to squat

[for delivery], with their family around, and drink infusions of medicinal plants" (Castellanos 2009). This approach has been "well accepted by indigenous communities," but in order to build more intercultural childbirth rooms, the hospital had to solicit outside funding and was awarded a $65,000 donation from the Japanese Agency of Cooperation (Castellanos 2009). Although Bolivia has made great strides toward creating a more just reproductive health approach, it is taking the international reproductive health community a bit longer to adjust to these systemic and structural changes because the Bolivian approach runs counter to the core ideological threads entangled in the RHI vortex.

Bolivia's Population: An International Issue

Bolivia's fertility and population growth rates have received a considerable amount of attention in international development discourse. Accordingly, many international aid and development institutions have targeted Bolivia's citizens for interventions with the goal of achieving various MDGs and improving Bolivia's rank on the human development index. While it is essential to include demographic and statistical information in this research, it is imperative that the data is understood in its intertextual context as it is repeatedly referenced in the reports and briefs of multiple national and international institutions[21].

[21] In other words, the intertextuality of the figures and statistics cited here and throughout this paper should be contextualized and interrogated. Fairhead and Leach use the term intertextuality to call attention to the ways in which information is cited within and shared between many publications and organizational reports, leaving a researcher in the position of wading tediously through webs of citations in order to find

The average annual population growth rate in Bolivia is around 2% (WHO 2007, US Department of State 2010) and, while the total population has tripled in the past 50 years, massive urban migrations have drastically decreased the rural portion of the population from 65% in 1950 to 35% in 2000 (WHO 2004, 2007). In 2003, the total fertility rate was 3.8 (meaning that the average woman gave birth to three or four children in her lifetime) (WHO Department of Making Pregnancy Safer 2010:7). According to a DHS, 2.1 of those children were wanted, 1.7 were not (WHO Department of Making Pregnancy Safer 2010:7). The UN estimates that between 2010 and 2015, Bolivia's fertility rate will be 3.1 (UN 2010), which is a significant decline from 5 in 1989 (WHO Department of Making Pregnancy Safer 2010:7)[22]. The UN estimates the contraceptive prevalence rate (of any method) is 60.6% of married women ages 15 to 49 (UN 2010).

With the exception of Haiti, Bolivia has higher rates of maternal, perinatal, and neonatal mortality than any other country in the Western Hemisphere (Gonzales et al 1998:1). In 2004, the national infant mortality rate of children under one year was 54 per 1,000 live births and the maternal mortality rate was 230 per 100,000 live births (WHO 2007a, WHO 2010). Although, in 2001, UNICEF reported that in certain rural and indigenous areas of the highlands the maternal mortality rate reached 887 per 100,000 live births (UNICEF n.d.). It has also been argued that statistical data on maternal

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the original source. For example, the DHSs referenced in multiple sources in this chapter were performed with funding from USAID. The perspectives and composition of the standardized questions were inherently influenced by the perspective and ideology of USAID, which should be considered in this analysis.

[22] For comparison's sake, the population growth rate in the US is around 1% and the fertility rate is 2 (UN 2010). In the US, 82.3% of the total population lives in urban areas, up from 64.2% in 1950 (UNDESA 2007). Also, Bolivia is almost exactly twice the size of France in area, but the population of Bolivia is only 15 percent of France's population (Market Latin America 2005).

mortality may be unreliable and underestimated because "some deaths are not reported or others are not accurately reported as deriving from circumstances surrounding pregnancy or birth" (Rousseau 2005:10).

Several factors are related to maternal and infant mortality such as access to family planning and adequate medical care during pregnancy and births (Rousseau 2005:10). Rural and indigenous populations are marginalized and lack access to health care and basic services (WHO 2007). Results from a DHS conducted in 2003 showed that approximately 38.6% of rural births were assisted by a skilled birth attendant, compared with 77.7% of urban births (WHO Department of Making Pregnancy Safer 2010:2). There are also wide income disparities between urban and rural Bolivians, which contribute to differences in infant and maternal mortality rates. According to the survey, 98.4% of the richest 20% of the population utilized skilled birth attendants, compared to 26.6% of the poorest 20% (WHO Department of Making Pregnancy Safer 2010:3). Also, 41.8% of births occurred at home, while 57.1% were in a health facility (WHO Department of Making Pregnancy Safer 2010:3).

Certainly, there are factors outside of one's social and physical location that affect whether or not individuals have access to reproductive health care and the approach and quality of that care. Stéphanie Rousseau conducted postdoctoral field research on reproductive health and social politics in Peru and Bolivia. She argues,

> the social rights of reproductive health, inevitably tied to the advances in legal reforms on issues such as the individual right to family-planning, are also fundamentally connected to state and international institutions' policy priorities including health-sector reforms… The main trends in reproductive health policy and health-sector reforms have enlarged

> women's access to key services, while existing class—and ethnic—stratification in relation to women's health care is largely maintained. [Rousseau 2005:3]

In addition to one's particular social location (a combination of one's gender, ethnicity, religion, economic status, and place of residence), changing national and international politics have had a huge influence on the priorities of reproductive health policy and practice, and access to reproductive health care in Bolivia.

Reproductive Politics in Bolivia

Considering that the public health sector is a major source of reproductive health care in Bolivia, women's health in Bolivia is by definition a political issue. The politicization of reproductive health raises the stakes "for social actors to find ways of influencing state institutions to shape policy" (Rousseau 2005:23). Rousseau explains that the entry of the state in reproductive health policy in Bolivia "is connected to the international agenda on reproductive health and national policy-making processes centered on executive power" and the "presidential style of policy-making" (Rousseau 2005:4-5). RHI, and the history of its shifting approaches to reproductive health in the last 50 years, has definitely informed and shaped reproductive health policy and practice in Bolivia.

In Bolivia, population programs were first implemented by non-governmental aid agencies like USAID in the 1960s when services were predominantly from the fertility reduction approach to reproductive health (Rousseau 2005:12). These programs were

"often perceived by the population as an imperialistic project imposed by the USA," and, as a consequence, family-planning programs were outlawed or interrupted out of "fear of foreign-imposed fertility control" (Rousseau 2005:12). Rousseau writes, "in Bolivia, rumours in the 1970s of a program implemented by the US Peace Corps to sterilize Bolivian peasant women led to public outrage and a shutting-off of governmental support to family-planning until 1989" (2005:12).

As a result, reproductive health services, as well as the reproductive rights movement in Bolivia, went underground until the 1980s. These covert family planning activities were "generally depicted in public opinion as a quick remedy to widespread poverty advocated by some sectors of the elite to avoid making structural changes" (Rousseau 2005:12). However, Bertha Pooley and Ximena Machicao write that it was the NGOs that

> were responsible for most of the progress made on reproductive rights—by, for example, protesting against the sterilisation of peasants; the closure in 1974 of the family planning centres of the Ministry of Social Security and Public Health; and the 1997 Supreme Resolution prohibiting public institutions from providing family planning services. [Pooley and Machicao 2000:88]

In 1982, the National Board of Population of the Ministry of Planning and Coordination set three fundamental aims for the national population policy: reduce the infant mortality rate; redistribute the population to fully occupy national territory; and distribute wealth in more equitable ways (Pooley and Machicao 2000:88). These plans did not get implemented in the National Strategy for Development for another ten years when reproductive health issues were framed in terms of "national sovereignty," "optimal

population density," and maternal mortality and morbidity, which garnered international support from USAID, UNFPA, UNICEF, and WHO (Pooley and Machicao 2000:88-9).

Even though the women's movement and public health professionals had already identified maternal and infant mortality as problems in Bolivia, their concerns were not addressed in public health policy until after the first DHS (funded by USAID) measured maternal and infant mortality rates in 1989 (Rousseau 2005:12). This survey forced the state to respond to national and international pressure to improve maternal and infant health. Rousseau writes, "the new perspective which started to take root in the 1980s in the proposals for state policy was that of women's and infant's health, thus making room for more popular support although still facing strong resistance on the part of conservative sectors such as the Catholic Church" (Rousseau 2005:13)[23].

After maternal and infant health became international public health issues, the Bolivian government set up a national infant and maternity insurance scheme, known as "Basic Health Insurance," to address them (Pooley and Machicao 2000:90). Strategies to assist women to avoid unwanted pregnancies and to provide sexual education programs and contraceptive services were presented in the 1989 "National Plan for Survival, Maternal Health and Infant Development," which placed an emphasis on mother-child services (Pooley and Machicao 2000:90). The impact of this was to restrict the accessibility of reproductive health care to those who were able to reproduce, pregnant, or mothers of young children.

[23] The Catholic Church in Bolivia has maintained its stance against abortion and contraceptive methods it deems artificial or abortifacient.

In the 1990s, the feminist movement began lobbying for reproductive rights, "bodily autonomy," and comprehensive reproductive health policy (Rousseau 2005:22). At the same time, public health professionals began to "work to reform state laws and policies initially within the framework of population and family-planning programs and later within the broader framework of reproductive health and rights" (Rousseau 2005:22). Even though "reproductive and sexual health programs in Bolivia had transcended the maternal-child health concept" before the Cairo Conference, "it was not until after the Cairo and Beijing Conferences, however, that a more integral approach was introduced, one that considered health within the broad framework of human rights, especially reproductive and sexual rights" (Pooley and Machicao 2000).

In 1990, the "National Reproductive Health Program" set out to address women's health in a more integrated way and established the "National Board for Coordination in Reproductive Health" with four sub-boards focusing on research, education, services, and training—a "multi-institutional effort, which included the participation of NGOs, government institutions, and international development agencies" (Pooley and Machicao 2000:90). Public health programs have faced rapid turnover as a result of government change, but the primary goal of reducing maternal and infant mortality has remained central to the 1993 "Life Plan," also known as the "National Plan for the Accelerated Reduction of Maternal, Perinatal and Infant and Child Mortality" (Rousseau 2005:27, Pooley and Machicao 2000:90). Reproductive freedom, however, was not given priority, a reflection of how it was still not understood as universal social right.

Since the 1990s, most efforts of the feminist movement in Bolivia have been focused on "proposing policies based on the framework of women's human rights to reproductive and sexual freedom, monitoring state policies adopted since the early 1990s, and [pressing] for the integration of the full range of contraceptive methods within the law and public health care services" (Rousseau 2005:22). In the late 1990s, feminist lawyers produced reports and disseminated information to the public concerning sterilizations that were performed without consent or under poor quality conditions leading to injuries or death in what seemed to be a deliberate attempt by the state to sterilize as many women as possible "at the cost of women's rights" (Rousseau 2005:23-24). This scandal (and other similar reports from around the world) prompted the US Congress to pass the Tiahrt Amendment in 1998 requiring USAID-funded family planning programs to follow specific guidelines to steer clear of coercion and ensure consent of "acceptors" of family planning services (Rousseau 2005:24, USAID 2009c).

Interestingly, the Catholic Church also used the evidence collected by the lawyers to denounce state reproductive health policies as genocidal (Rousseau 2005:24). Ultra-conservative, pro-life organizations in Bolivia also gained strength and weakened women's access to family planning, especially during Republican presidencies in the U.S. (Rousseau 2005:23). The Global Gag Rule (also known as the Mexico City Policy), which put restrictions on USAID funding going toward reproductive health and withdrew financial support to the UNFPA, was put into effect by President Ronald Reagan in 1985, was rescinded by President Bill Clinton in 1993, put back into effect by President George W. Bush in 2001, and was rescinded again by President Barack Obama in 2009 (Obama

2009). Contrary to the goal of reducing maternal mortality, restricting women's access to family planning services during the early 2000s "may translate into an increase in the maternal mortality ratio in future statistical accounts" (Rousseau 2005:27).

These changes in discourse and approaches to reproductive health in Bolivia, and in the international development arena, have greatly influenced the policies and practices of public institutions and NGOs, and the accessibility of reproductive health services. Rousseau argues,

> The entry of the state in the field of reproductive health policy and services since the early 1990s in [Bolivia] responded to societal and international pressures in the face of very negative reproductive health indicators revealing systemic discrimination in access to health care on the basis of gender, ethnicity, class and occupational dimensions. [2005:27]

So, even though the discourse recently incorporated a reproductive health and human rights agenda, it is still biased toward women at a certain period of their reproductive cycle and is only "ambiguously promoting women's autonomy in reproductive matters" (Rousseau 2005:28-9). Overall, there seems to be a disconnect between international development and human rights discourse, national reproductive health policy and practice, and local views of reproductive health, which can be exemplified in an analysis of RHI-inspired interventions in Bolivia.

Reproductive Health Interventions in Bolivia:

Actors, Agendas, and Accountability

To point out how RHI has evolved and directly impacted reproductive health policy and practice in Bolivia, I will briefly outline two collaborative reproductive health interventions in Bolivia and analyze the agendas and actions of the major actors involved. Both the CATALYST Consortium and the AQUIRE Project were joint efforts between international, national, and local organizations in Bolivia. Consider how the interactions between these players, and their financial and ideological backing, influences the agendas and actions of "community-based" reproductive health projects.

The CATALYST Consortium

The CATALYST Consortium was a "global reproductive health activity initiated by the Center for Population, Health and Nutrition, Bureau for Global Programs" of USAID, which was active in Bolivia, Peru, Egypt, India, and Pakistan from 2000 to 2005[24] (CATALYST Consortium n.d.a). The Consortium was comprised of four US-based organizations—the Academy for Educational Development, the Centre for Development and Population Activities, Meridian Group International, Inc., and Pathfinder International—and one Columbia-based organization, Profamilia. Below are synopses of each organization in the Consortium, mostly in their own words.

[24] Although the CATALYST project ended in 2005, the Extending Services Delivery (ESD) Project, a follow-on project also funded by USAID, was targeted to run from 2006 to 2011, but is not operating in Bolivia (CATALYST Consortium n.d.b).

The Academy for Educational Development (AED), a nonprofit organization "working globally to improve education, health, social and economic development" (AED 2010a), is recognized internationally for its formal and non-formal education, training and human resources development, behavior change communication, social marketing, and community participation focused on the "application of behavioral research and communication methodologies for interventions in health, nutrition, family planning, STI/HIV prevention, environmental education and programs for adolescents" (CATALYST Consortium n.d.d). AED's strategy is to improve community awareness, increase dialogue between partners, and increase knowledge about "healthy FP/RH [family planning/reproductive health] practices" (CATALYST Consortium n.d.d). AED receives funding from too many national and international agencies, organizations, foundations, corporations, educational institutions, and governments to list here[25] (AED 2010b).

The Centre for Development and Population Activities (CEDPA), founded in 1975, is a non-profit organization with headquarters in Washington, D.C. and offices in India, Nepal, Nigeria, and South Africa that declares that it is "building a groundswell of change agents for effective international development" (CEDPA n.d.). CEDPA seeks to improve the lives of women and girls in developing countries by working "hand-in-hand with women leaders, local partners, and national and international organizations to give women the tools they need to improve their lives, families and communities" (CEDPA n.d.) and to "empower women at all levels of society to be full partners in development"

[25] For the list of AED donors, see http://www.aed.org/annualreport/2010/donors.html.

(CATALYST n.d.d). CEDPA's programs "increase educational opportunities for girls and youth; ensure access to lifesaving reproductive health and HIV/AIDS information and services; and strengthen women's ability to become leaders in their communities and nations" (CEDPA n.d.).

Meridian Group International, Inc, a Washington, D.C.-based corporation, that is "dedicated to improving the health, socio-economic and environmental conditions for those living in the developing world" by working with "the private and public sectors to create innovative programs and partnerships that benefit both business and society" (Meridian Group International, Inc 2006a). Meridian's technical experts in the areas of "social marketing, public-private partnerships, strategic planning, communications/advertising and Corporate Social Responsibility" create partnerships between the NGO community and pharmaceutical corporations to develop "sustainable activities" (Meridian Group International, Inc 2006b) and help "businesses incorporate FP/RH into their workplace code of ethics, as well as their community outreach programs," in Bolivia and other countries (CATALYST Consortium n.d.d).

Pathfinder International is a non-profit organization that has a presence in over 25 countries and states that it "strives to strengthen access to family planning, ensure availability of safe abortion services, advocate for sound reproductive health policies, and, through all of our work, improve the rights and lives of the people we serve" (Pathfinder International n.d.a). Pathfinder currently works with an annual budget of over $100 million, $82.4 million of which came from government grants (Charity Navigator 2010, GuideStar 2010).

Pathfinder International was originally incorporated as the Pathfinder Fund in 1957 by Dr. Clarence Gamble, heir to the Proctor and Gamble company fortune and a strong advocate of birth control in the late 1920s (Pathfinder International n.d.b). Gamble had the resources to influence public policy and the nature of reproductive health services, and, for example, "distributed and tested cheap birth control methods in North Carolina's public health clinics and elsewhere and advocated eugenic sterilization" (Schoen 2005:4). Pathfinder International has undergone many changes since Gamble's controversial support of outright eugenics and population control. Its goal in the 1980s was to decrease birth rates by increasing contraceptive use (Hartmann 1995:194) and then in the 1990s, its approach changed to promoting reproductive health as a fundamental human right, which it now views as "critical for expanding opportunities for women, families, communities, and nations, while paving the way for transformations in environmental stewardship, decreases in population pressures, and innovations in poverty reduction" (Pathfinder International n.d.a).

Profamilia (the Association for Colombian Family Welfare) is a private, non-profit, Columbian organization that operates 42 clinics, coordinates 6,000 locations, and provides 70% of the family planning services in Columbia (IPPF 2010). Profamilia participated in a "South-to-South collaboration" with CATALYST "to improve public and private institutional systems for client-driven FP/RH service provision in Colombia," served as a case study for introducing the Emergency Contraceptive Pill in Columbia, and produced training modules on issues such as Rights and Gender, Reproductive Health Services, Health Sector Reform, Cost Accounting and Internal Control for RH

Institutions, Advocacy and Promotion of Sexual and Reproductive Rights, Adolescent Reproductive Health, and Reproductive Health Services for Men (CATALYST Consortium n.d.e). Profamilia collaborated closely with CEDPA to pilot the CATALYST Advocacy and Adolescent Reproductive Health Modules, and with the Meridian Group Inc. to organize the International Seminar on Corporate Social Responsibility in Bogotá, Colombia in 2002 (CATALYST Consortium n.d.e). Profamilia receives international support from the International Committee of the Red Cross, International Planned Parenthood Federation, MacArthur Foundation, UNFPA, USAID, and RAISE Initiative (a joint initiative of the Columbia University Mailman School of Public Health and Marie Stopes International), as well as other national supporters (Profamilia 2009).

As CATALYST Consortium, these five organizations set a goal "to reduce maternal, infant, and child mortality worldwide through family planning and reproductive health projects," "synergistic partnerships," "state-of-the-art technical leadership," and the increased use of "sustainable, quality family planning and reproductive health (FP/RH) services, and healthy practices through clinical and nonclinical programs" (CATALYST Consortium n.d.a, n.d.b). The multilingual, multidisciplinary staff and partners drew on approaches and techniques from a wide variety of expertise and provided technical leadership, assisted the scaling up of local groups, created opportunities for "South-to-South" assistance and collaboration, established collaboration among "USAID Missions, USAID Cooperating Agencies, U.S. foundations and other donors to help ensure the quality and sustainability of FP/RH programs" (CATALYST

Consortium n.d.a). They also claim to have expanded "FP/RH services through partnerships with private sector and nongovernmental organizations, to address unmet needs of men, youth and underserved populations," and created "linkages between health and non-health programs to provide an environment that supports women's decision making on reproductive health, e.g., incorporating RH messages in literacy and economic empowerment projects" (CATALYST Consortium n.d.a).

In 2003, CATALYST awarded Bolivia's Program for Integrated Health (*Programa de Coordinación en Salud Integral*—PROCOSI), a health network of 37 non-profit NGOs in Bolivia, $30,000 in core funds to carry out "Behavior Change Communication" and counseling activities about "Optimal Birth Spacing Intervals" (OBSI) in 137 rural municipalities (USAID and CATALYST n.d.:2-3). OBSI training sessions were attended by over 1,100 health providers and were "incorporated into PROCOSI's 2003 training program in coordination with the National System of Epidemiological Surveillance of Maternal Mortality" and the Ministries of Health (USAID and CATALYST Consortium n.d.:2-6).

USAID and CATALYST report that, both before and after receiving an informational pamphlet about OBSI, the majority of women recognized that "contraceptive use is the principal way to space births" (n.d.:2-15). However, there were many perceived barriers to client acceptance of OBSI including women being seen as promiscuous if they use contraceptives, the tradition and desire to have more children, desire to have male children, fear of abandonment by spouse, fear of using contraceptives, and belief that using contraceptives would cause infections, cancer,

sterility, or side effects (USAID and CATALYST Consortium n.d.:2-8, 2-13). This highlights the disconnect between global and local actors' ideas about reproductive health and contraception.

The report also concludes that in response to women's concerns associated with the use of contraception, "complete information should be provided on available contraception methods so that women can choose a method that is most appropriate for them, and men should be involved in the process" (USAID and CATALYST Consortium n.d.:2-15). Clarification is needed regarding what constitutes "complete information", especially in light of how research is conducted and knowledge is constructed about modern contraceptive methods.

The AQUIRE Project

Similar to the CATALYST Consortium, the Access, Quality, and Use in Reproductive Health (AQUIRE) Project was the result of a global cooperative agreement focused on international reproductive health. It was financed by USAID/Bolivia, managed by EngenderHealth, a New York-based non-profit NGO, and was conducted in partnership with the Adventist Development and Relief Agency International, CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (AQUIRE Project 2007a). Also, like Pathfinder International, EngenderHealth has changed its name, as well as its mission and goals, to fit the evolving culture and discourse on global reproductive health.

EngenderHealth was originally founded in 1937 as the Sterilization League of New Jersey and has a sordid history with roots firmly planted in the eugenics movement (Dowbiggin 2006:3). According to historian Ian R. Dowbiggin (and a collection of records at the University of Michigan's Social Welfare History Archives), the League changed it's name, agenda, and scope of services multiple times, but still "works with local health care groups in dozens of countries around the world providing training, counseling, and surgical contraception services" (2006:3). It adopted the name Birthright, Inc. in 1943, became the "Human Betterment Association of America (HBAA) in 1950, then the Human Betterment Association for Voluntary Sterilization (HBAVS) in 1962, the Association for Voluntary Sterilization (AVS) in 1965, the Association for Voluntary Surgical Contraception (AVSC) in 1984, AVSC International in 1994, and finally EngenderHealth in 2001" (Dowbiggin 2006:3). Although it has expanded its scope to include "broad-based family planning, maternal care, HIV/AIDS services, and post-abortion care," Dowbiggin argues that "its main concern has been the promotion of sterilization as a key weapon in the struggle to improve the reproductive health of women the world over," and that it carries out "reproductive imperialism" with support and collaboration with the UNFPA and other family planning NGOs (Dowbiggin 2006:3-4).

Something can be gleaned about the ideology behind the AQUIRE Project by reading their "Advocacy Tool" entitled "Long-Acting and Permanent Methods of Contraception: Without Them, a Country's Development Will Be Low and Slow" (AQUIRE Project 2006). In this question-and-answer informational handout, they state,

> experience globally as well as in Sub-Saharan Africa confirms that *without widespread availability and use of long-acting and permanent methods of contraception, a country cannot cost-effectively meet its lowered fertility goals.* In turn, inability to reduce high fertility contributes directly and substantially to poor health, poverty, low levels of education, and high under- and unemployment—that is, to *low national productivity, economic growth, and socioeconomic development.* [AQUIRE 2006:1]

According to EngenderHealth, from 2003 to 2008, "AQUIRE advanced and supported the availability, quality, and use of facility-based reproductive health and family planning services at every level of the health care system and strengthened links between facilities and communities" (EngenderHealth 2010a). AQUIRE sought to strengthen reproductive health services in 33 health networks spanning 131 municipalities by expanding "technical assistance to cover the areas of maternal health and postabortion care," as well as the integration of FP services into other RH services" (AQUIRE 2005:3). AQUIRE was to also focus on services for adolescents and men, intercultural issues, rights, quality, infection prevention, long-acting and permanent methods of contraception, men as partners, fistulae, and contraceptive security (AQUIRE 2005:3, EngenderHealth 2010a). The project resulted in research, reports, and results published about reproductive health interventions in many countries including in Azerbaijan, Bangladesh, Bolivia, Ethiopia, Ghana Guinea, Honduras, Kenya, Madagascar, Malawi Mali, Nepal, Tanzania Uganda, and Zambia (AQUIRE 2007).

EngenderHealth has been working in Bolivia since 1995 providing technical assistance to the Ministry of Health and Sports and to local NGOs to "improve the quality and accessibility of voluntary FP and other reproductive health (RH) services" (AQUIRE 2005:3). According to EngenderHealth, the organization is a "global leader in supporting

facility-based services" providing "technical assistance, training, and information to support ministries of health and health care providers in offering high-quality reproductive health and family planning (RH/FP) services, HIV and AIDS services, and maternal health care" (EngenderHealth 2007b).

The AQUIRE Project's involvement in Bolivia was limited to conducting an Evaluation and Research Baseline Survey Study in Bolivia in 2005. The study "examined antenatal client exposure to FP messages" through interviews and observation, and served as a "proxy to integration of FP into maternal health service," but did not actually implement any strategy for the improvement of Bolivian reproductive health services (ACQUIRE 2005:55). Regarding counseling on contraceptive methods, the study found,

> on average, fewer than three contraceptive methods were discussed with clients during their FP consultations, though for new clients this number was higher (3.6). The method most frequently discussed and accepted by clients was Depo-Provera, followed by the IUD and the pill. Vasectomy and tubal ligation were discussed by only 3% and 12% of clients, respectively, despite their desire for limiting births articulated during the exit interviews. Almost one-third of clients left their consultations without having received or been referred any contraceptive method at all. [AQUIRE 2005:57]

This shows that realities on the ground do not reflect the project's intention and agenda to promote contraceptive use and voluntary sterilization.

Also, "almost half of providers reported that they would offer the pill and injectables only to clients who had a particular minimum number of children; this proportion was almost one-third for vasectomy and tubal ligation" (AQUIRE 2005:56). The study also found that even though there is no requirement for partner consent for any

contraceptive method in Bolivia, "more than half of providers reported soliciting partner consent before offering the pill, the IUD, injectables, vasectomy, and tubal ligation," and "[a]lmost half of providers reported that they solicit partner consent before offering condoms" (AQUIRE 2005:56).

In sum, the CATALYST Consortium and the AQUIRE Project serve as examples RHI-influenced reproductive health interventions that were implemented in multiple developing countries. They were both situated under the umbrella of collaborative, community-based development while depending on financial, organizational, and technical assistance from networks of international aid institutions and development NGOs. The agendas of these reproductive health projects were heavily influenced by these organizations, as well as the RHI vortex, and mainly focused on educating local populations, increasing the use and quality of family planning services, and creating and sustaining partnerships between organizations.

The rhetoric in organizational reports about the interventions was of empowerment and the alleviation of poverty through the use of modern contraceptive technologies, but in-depth analyses attending to the effects of overarching systems of social inequality and neo-liberal globalization were lacking, as well as the subjective experiences of the people that might use them. Moreover, the agendas and priorities of the development organizations did not match the realities of Bolivian women and men. Just because an internationally supported project seeks to increase access to reproductive health services and contraceptive methods, it doesn't necessarily result in the use of these

services or methods, especially if the needs and desires of the people do not align with the objectives of the project.

Challenging RHI in Bolivia With Research

Recent research by Vitzthum presents a compelling challenge to RHI and international approaches to reproductive health in general, and in Bolivia in particular. Project REPA (Reproduction and Ecology in Provincía Aroma) was a "multidisciplinary longitudinal study of reproductive functioning and health among rural Aymara families indigenous to the Bolivian altiplano" (Vitzthum et al. 2004:1443). This study found that "progesterone levels in the ovulatory cycles of rural Bolivian women average ~70% of those in women from Chicago and that such relatively lower levels also typically accompany conception and implantation," which demonstrates significant interpopulational variation in progesterone levels (Vitzthum et al. 2004:1446). There were also considerable differences between the hormone levels of "better-off" and "poorer" Bolivian women, where the "better-off" women had higher progesterone levels than the "poorer" women (see Figure 8) (Vitzthum et al. 2002:1910).

Vitzthum's research offers many insights into the field of international reproductive health. Although relatively lower progesterone levels had been observed in previous cross-sectional studies for the past 30 years, this study concluded that for rural Bolivian women, "lower progesterone levels typically characterize the entire reproductive process" and do not seem to affect their fecundity (the ability to reproduce) (Vitzthum et

al. 2004:1448). If these lower levels represent a species-wide norm, then the very high rates of breast cancer among U.S. women may be attributed to their relatively higher hormone levels (Vitzthum et al. 2004:1448).

This research also reaffirms the conclusion of others,

> hormonal contraceptive dosages designed for U.S. women and other industrialized countries may be excessively high for women in developing countries, resulting in severe side-effects leading to discontinuation and, potentially, unplanned pregnancy. We have often heard Bolivian women and health workers express concern about negative experiences with hormonal contraceptives. Contrary to arguments that noncompliance is more a matter of education than biology, these data succinctly support the reports of these women that negative sequelae of hormonal contraceptives are more than an imagined problem. [Vitzthum et al.:2004:1448]

In the interest of protecting their own health, these rural women stop using hormonal contraceptives, but are regarded as uneducated and irresponsible. This points to the intertextuality of scientific data as it is repeatedly referenced and unquestioningly applied to reproductive health on a global level, while evidence to the contrary is routinely ignored and excluded from the discourse. Therefore, this control over knowledge and policy is an undeniable example of the power and influence of RHI.

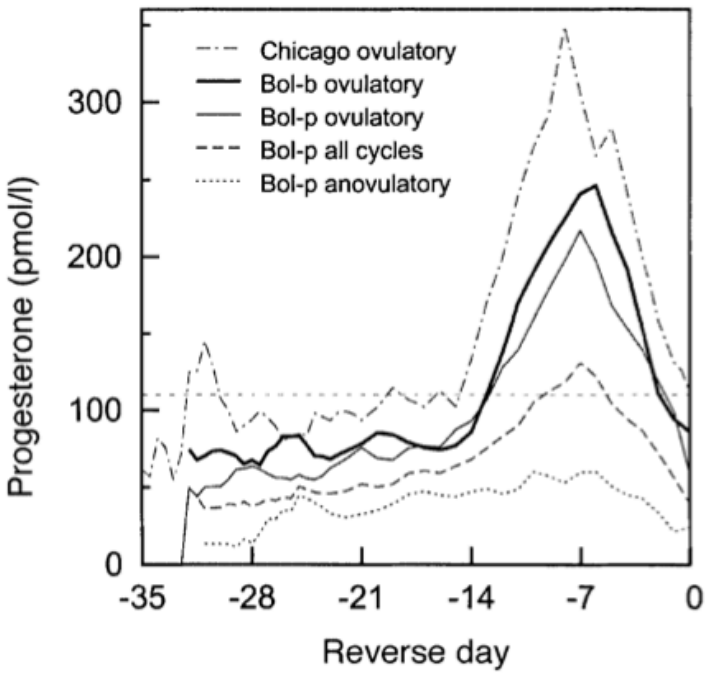

Figure 8: "Comparison of progesterone profiles in Chicago, better-off Bolivian (Bol-b) and poorer Bolivian (Bol-p) samples. Cycles are aligned on the first day of the subsequent cycle, and days are numbered backwards from that point" (Vitzthum et al. 2002:1910).

Reproductive Health in Bolivia: Concluding Remarks

This case study of reproductive health research, policy, and practice in Bolivia shows the vortex-like characteristic of RHI and some measures that can be taken to overcome it. Implementing international reproductive health projects is a very complicated undertaking, especially when there are international, national, and local pressures coming from different directions. An examination of "community-based" collaborative reproductive health interventions reveals the conflicting agendas that come with the acceptance of foreign development funding. The ideologies behind international aid and development, and the medical-industrial complex come into conflict with local and indigenous epistemologies and physiologies. This case study also highlights how regionality influences the local manifestations of the vortex and how Bolivians have instrumented agency and subjectivity in their various responses to RHI. It is clear that understandings, needs, and desires surrounding reproductive health are not universal, but are very contextual, and culturally and biologically specific.

CONCLUSION: IMPLICATIONS OF THE RHI PERSPECTIVE

Researchers may absorb themselves in the technicalities of their study without considering their role in pursuing the wider policy implications. It is important to consider how research will have an impact on policy not as an afterthought or a footnote in a post-results dissemination strategy, but as an integral element of every stage of the research process.
[Philpott et al. 2002:200]

This thesis provides a lens through which to view international reproductive health. The goal was to examine the underlying (and sometimes overpowering) paradigms and ideologies behind international reproductive health research, policies, and practices in order to better understand its evolution, current position, and future direction. This research explored how networks of organizations and institutions, and interlocking systems of power, privilege, and oppression influence dominant discourse surrounding international reproductive health research, policy, and practice. These networks form a powerful and overwhelming vortex-like force, in which actors on international, national, and local levels collide. I call that vortex Reproductive Health International (RHI).

Within the vortex, many international and institutional actors, and their accompanying agendas operate to coordinate RHI and habitually operate blind to their power. However, what I also found was that when this vortex hits the ground, the outcomes are very diverse. Even though RHI has universalizing qualities, the subjective experiences of those who encounter and interact with international reproductive health research, policies, and practices are dynamic and variable. While dominant ideology and

discourse permeate research, policy, and practice at multiple levels, the application of RHI in different places produces different results depending on regionality and factors like individual subjectivity, social structure, cultural norms and values, and biological variation. My hope is that the perspective presented in this paper will help to forward a more just way to understand and approach reproductive health.

Redefining Reproductive Health

The top-down, compartmentalized approach to reproductive health affects women fundamentally. However, we have not been sitting silently as the powers that be define who we are, what issues are important to us, and how to deal with them. For decades, feminist and women's advocacy groups have sustained their support for a redefinition of reproductive health to address much more than family planning and physical health, but also psychological and social health. There is a historical pattern of women's knowledge and perspectives being consistently marginalized, minimized, unwritten, unstudied, erased, omitted, and deemed insignificant, illegitimate, and unworthy of attention. For instance, "most of the reproductive health organizing done by women of color in the United States has been undocumented, unanalyzed, and unacknowledged" (Silliman, et al. 2004: 1). Also, as shown above, the medical community has not given significant attention to women's subjective experiences using modern reproductive technologies. Imagine the information and knowledge that could be gleaned if we listened to these voices.

A feminist approach to reproductive health would give equal value and attention to all genders in research, policy, and practice. It would also value subjective experiences and acknowledge that identity is fluid and dynamic. After all, women as a whole do not constitute a homogenous category of people, but make up a hugely diverse group with different ideas about what constitutes their reproductive health and what can and should be done to make it better.

Rosalind Petchesky argues that even though the Cairo and Beijing conferences resulted a more inclusive understanding of what constitutes reproductive health,

> nonetheless, a stubborn kind of fragmentation seems to persist, not only among international organisations and national policy-makers, but also among women's movement groups. It is a fragmentation born of professionalisation, donor-driven agendas, and a number of other forces. One result is a compartmentalisation of women's movement work into discrete 'issues' – violence, reproductive rights, sexuality, girls and adolescents, women in development (economics, work) – without sufficient attention to the vital points where these intersect. Such compartmentalisation obliterates the most important operational principle of a human rights framework – the principle of *indivisibility*. [2000:12]

Petchesky draws connections between human rights, reproductive health, and economic justice. She gives the example of *dalit* women living in Andhra Pradesh under the Indian caste system where "issues of health and reproductive and sexual rights form a seamless web with land issues, indebtedness and caste discrimination" (Petchesky 2000:13). She writes that this inclusive understanding of human rights, justice, and health from a gendered perspective "signals a moving away from 'issue compartments' towards a more unified vision" (Petchesky 2000:16).

Similar conclusions were drawn from qualitative research done in Mali by Sarah Castle, Sidy Traore, and Lalla Cisse (2002). The purpose of this research was to "inform the development of curricula for an intervention to improve young people's reproductive health" and to explore how "the Cairo definition of reproductive health needs to be made culturally specific in order to facilitate programme design and implementation" (Castle et al. 2002:20). When central Mali teenagers were asked to define reproductive health and to identify reproductive health problems and priorities, they found that "reproductive health is perceived to reflect the social and community dynamics in which reproductive health decision-making is embedded and to comprise the biological aspects of sexual relations and fertility" highlighting the "extent to which social relations influence the way in which these respondents conceptualize reproductive health" (Castle et al. 2002:29). Their research indicates that

> the definition put forward by the Cairo conference may not accurately reflect what emerges from local communities. Rather, it is likely that it comprises the perspective of activists and actors whose 'world-view' may, in some cases, not be those of the populations that they seek to represent. Ironically, and contrary to the spirit of ICPD, local communities can therefore sometimes find themselves in the role of passive recipients of programmes orientated around definitions coined outside their social world and realm of understanding. The findings presented here [indicate] that the Cairo definition needs to be adapted for use in specific cultural contexts. Without such adaptation, community participation in, and ownership of, reproductive health interventions (shown to be the key to their successful implementation) are likely to be limited. [Castle et al. 2002:21]

Similarly, one of the main conclusions of this research is that acknowledging and embracing culturally specific understandings of reproductive health would transform the field and make it more inclusive and accessible. Although there are homogenizing and

globalizing aspects of the RHI vortex, reproductive health research, policy, and practice is only successful when its approach, methodologies, and methods are locally relevant and appropriate.

A comprehensive reproductive health approach needs to address holistic health and well-being, including physical, psychological, and social health. Social issues, such as marriage, family, and community are central to reproductive health and not just contextual; they are considered essential, not merely background factors (Castle et al. 2002:29). As Vitzthum's research revealed, these socio-cultural elements of reproductive health have an influence on biological factors and vice versa, further blurring the boundaries between biology and culture. The complex socio-cultural and biological dimensions of reproductive health must be integrated in order to move toward a more just and truthful reproductive health paradigm that is more inclusive of the diverse perspectives and experiences of people from different places and cultures.

Although great strides have already been made, a major overhaul is needed in the way dominant discourse and international development institutions view reproductive health. When analyzing the research and development of hormonal contraceptive methods, one can see how the relationships between pharmaceutical companies, state agencies, and the media become problematic, especially when research into the safety and efficacy of reproductive technologies is a for-profit venture. In order to move toward a more holistic and just approach, research, policies, and practices must address reproductive health in its particular biological, historical, cultural, social, and political contexts wherever it is applied.

Changing the Reproductive Health Paradigm

Over the past 15 years, governments, international aid and development organizations, and research institutions have shifted RHI discourse from a focus on population control and family planning to a more comprehensive view of reproductive health. Although international reproductive health discourse has superficially undergone this shift, the ideologies behind the policies, practices, and methods of research have not substantially changed.

The IPOPCORM population and reproductive health interventions claimed a community-based, comprehensive approach to addressing poverty through changing natural resource management and reproductive health methodologies, but still applied Malthusian and neo-Malthusian ideology when identifying the program's goals and objectives. The IPOPCORM approach should have included analyses of the underlying historical and contemporary causes of poverty and environmental degradation instead of merely focusing on promoting family planning and improving subsistence fishing methods. Reproductive health projects that function as a part of a population-environment program are inherently problematic as they conjure up oppressive ideologies and ideas about the relationship between humans and our ecosystems. The IPOPCORM reproductive health intervention was not justified because the people of Palawan exhibited poor reproductive health, but because their population was considered to high or out of control. As stated by Hartmann, "good quality reproductive health services depend on viewing women's rights as worthy of pursuit in and of themselves, not as a

neo-Malthusian instrument of national defence" (2006b:218). Reproductive health research, policies, and practices should be focused on providing the best, culturally appropriate, comprehensive reproductive health information and services as possible within the context of achieving reproductive, environmental, and overall social justice.

In the case of reproductive health in Bolivia, we saw how the organizations reform themselves to capture funding and to remain in line with the times. The evolution of international development and aid organizations like Pathfinder International and EngenderHealth are tangible examples of how the rhetoric and agendas of organizations adapt in response to evolving reproductive health and development discourse. Their flexibility is influenced by and contributes to the spin and global coordination of the RHI vortex.

When these organizations were formed, they proudly and publicly supported eugenic ideology, policies, and methods, and top-down approaches to population control by promoting widespread sterilization and contraceptive use in impoverished populations. Then, in the 1990s, Pathfinder adopted the language and rhetoric of the reproductive rights movement while maintaining its stated goals of decreasing poverty and population pressures, promoting environmental stewardship, and boosting opportunities for women. EngenderHealth seemed to change its name along with every rhetorical shift it endured, although the underlying paradigm still endorsed by the organization hasn't substantially changed. For instance, they still ignore broader social and historical context when they blame high fertility rates for poverty, widespread poor health, and slow socio-economic development. This adaptability retains the organizations' relevance and keeps the

funding flowing, but, given their ongoing support of oppressive ideology and practices, makes their reproductive rights approach questionable.

Although there has been a change in rhetoric toward a more participatory and human rights-based approach, the intentions of international reproductive health interventions do not seem to be totally aligned with the concerns, desires, and experiences of the people targeted by them. Vitzthum's research on the diversity of reproductive endocrinology and physiology presents substantial challenges to implementing a globalized reproductive health agenda in Bolivia and, I argue, also calls into question the whole RHI paradigm. Not only does the definition and understanding of reproductive health need to be inclusive of multiple and varied social and cultural aspects, but significant biological variation needs to be taken into account as well. This multi-faceted perspective runs counter to the one-size-fits-all framework under which RHI has operated for so long. In both case studies, I showed how the trajectory of the RHI vortex differed from the perspectives and desires of the local people in the Philippines and Bolivia. Indigenous political activism in both countries was more nuanced and progressive, evident that the local people are deeply aware of historical and global politics.

Although the points of view perpetuated by the vortex pretend to be objective and scientific in international reproductive health research, policy, and practice, dominant discourse has absorbed and reproduced certain knowledge claims, while ignoring others. For example, the intertextual repetition and replication of scientifically and ethically compromised research surrounding the safety and efficacy of hormonal contraceptives

and menstrual suppression runs counter to claims of evidence-based medical practice in mainstream Western medicine. If the data gathered and used to support mainstream reproductive health policies and practices is undermined, authoritarian knowledge claims ultimately rest on an unsound foundation.

Hegemonic reproductive health discourse has also inopportunely neglected the population-specific hormone issue, which could offer many insights into human endocrinology, physiology, and oncology. The fact that Bolivian women have ceased their use of hormonal contraceptives because they experience negative side effects, they have assumed levels of responsibility for controlling their own reproductive health and avoided regimes that made them sick. However, the international development community assumes that their cessation of birth control is an education issue, which serves to reinforce the sexist and racist notions of women in the Global South and justifies interventions from international institutions and development organizations.

If the focus of international reproductive health was truly turned toward improving the health and rights of the people, which most of the discourse now claims, then indigenous and women's perspectives and experiences would be prioritized and incorporated into the aims and agendas of research, policy, and practice. For example, women's experiences would be sought after and required in medical research and clinical trials for contraceptives and other reproductive health and medical technologies. Those planning and implementing reproductive health interventions, as well as those conducting research, would take the diversity observed in human reproductive endocrinology into account. Cultural diversity would be honored and respected, and multiple epistemologies

would be utilized in he research and development of reproductive technologies and practices.

This is an exciting time to be doing important research about the diversity of reproductive health, physiology, and culture as they exist today, as they were in the past, and in terms of directions for the future. Applying a feminist, reproductive justice approach will result in holistic, high-quality, comprehensive, and contextualized knowledge about reproductive health. Equal rights and justice would be the foundation on which we build reproductive health research, policy, and practice. We have a lot to learn.

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