

Women's Empowerment and Rights-based Family Planning:

The Distance Travelled and the Path Ahead

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ACKNOWLEDGMENTS AND FOREWORD

Twenty-five years after the International Conference on Population and Development (ICPD) in Cairo, its Programme of Action (POA) remains an inspired and relevant roadmap towards the realization of reproductive and sexual health and rights and women's empowerment. This paper provides an analysis of the political and technical processes leading up to Cairo, an examination of progress and challenges in implementing the POA after the conference, and an analysis of current opportunities and tensions to be aware of as we continue to work towards and beyond the ICPD POA.

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We are an inspired team of authors driven by an understanding of the importance of history, grateful for our experiences in women's movements, and worried about the times we find ourselves in. Sia Nowrojee is the Program Director of the 3D Program for Girls and Women at the United Nations Foundation. She attended and was involved in the mobilization of women's groups at the ICPD NGO Forum in Cairo in 1994 and her work on sexuality, gender, health and development over the past 25 years was shaped by that experience and the women she encountered. Geeta Rao Gupta is the Executive Director of the 3D Program for Girls and Women and a Senior Fellow at the United Nations Foundation. She has spent her entire career, spanning more than three decades, advancing justice and equality for girls and women, inspired by what the world could be if we gave girls and women the power and opportunity to shape their own destinies. Priyadarshini Rakh, a 2019 Intern at the United Nations Foundation, graduated from The George Washington University in 2019 with a Masters in Global Gender Policy & International Development and hopes to dedicate her career towards the advancement of women's rights globally.

In conducting this review and analysis, we were reminded of the cycles of history and resistance in the ongoing dance to both restrict and realize rights. With this paper we hope to shed some light on those cycles to better understand how and why we need to support movements and initiatives that are advancing the realization of rights.

Family planning retains its high potential as a critical pathway in the realization of women's rights and empowerment. To fulfill that promise, we must avoid the traps and mistakes that have slowed progress, including outright coercion and the instrumentalizing of women as pawns in addressing demographic, political, environmental and cultural anxieties. We must draw from our rich history and track record to infuse and inspire the path ahead.

TABLE OF CONTENTS

Acknowledgments and Foreword.....	4
Executive Summary.....	6
I. Introduction	7
II. The Lead Up to Cairo: Family Planning and Women’s Empowerment	8
Global Politics, Negotiations and Commitments.....	9
Women’s Activism, Movements and Coalitions Advancing Rights.....	14
Developments in Contraceptive Technology	16
Making the Case: Evidence on Women’s Empowerment and Family Planning.....	20
III. Post-Cairo: Challenges and Progress in Implementation	23
The 2012 London Summit on Family Planning	24
Family Planning 2020	25
UNFPA’s Family Planning Strategy 2012-2020	26
Examples of Relevant Frameworks for Rights-Based Family Planning	27
World Health Organization Global Guidance and Tools on Rights-Based Family Planning..	28
The 2030 Agenda for Sustainable Development	30
Recent Agreements on the Right to Safe Abortion	30
IV. Where We Are Today: Opportunities and Tensions	31
Protecting Gains While Pushing for Progress	34
People as Numbers: Pragmatic and Potentially Dangerous	35
The New Battleground: Universal Health Coverage	35
New Technologies, Old Pitfalls	39
The Critical Role of Women’s Movements.....	41
V. The Way Forward	42
References.....	46
Appendix	56

EXECUTIVE SUMMARY

This paper examines the links between women's empowerment and family planning as the basis for recommendations moving forward to fulfil the promise of the International Conference on Population and Development (ICPD) in Cairo, and advance a broader and more inclusive focus on rights through rights-based family planning (RBFP).

The links between reproductive rights and women's empowerment are indisputable. For women and girls, particularly those who may not control much else, the ability to control their fertility can be essential and empowering. Exercising reproductive rights also has health benefits and opens up new educational and economic opportunities, leading to further empowerment. In this context, the global and national policies and local services that determine whether and how a woman can exercise control over her fertility have the potential to impact her life more broadly. Put simply, family planning has the potential to serve as a critical facilitator of women's empowerment, or as a barrier to the realization of rights.

Through the lens of global dynamics and United Nations conferences from the 1960s to the ICPD, the paper highlights the ways in which global political forces and negotiations, women's activism and movements, and developments in contraceptive technology and research have shaped our understanding of the links between women's empowerment and family planning. It surfaces underlying global, national, political, economic, religious, corporate, scientific, cultural and other interests at play and explores how women's fertility and bodies can become instruments in achieving the goals of these different lobbies.

The paper also examines how after Cairo, the global community began the task of implementing the ICPD Programme of Action (POA). While there was general agreement that the focus on women's rights and health was the right way forward, the POA presented some challenges for implementation. Family planning was no longer central to population and development policies and lost momentum, focus and resources. The paper describes key moments and initiatives to restore focus and resources to family planning, as well as conceptual and technical frameworks and tools available to inform the implementation of RBFP.

The paper then explores five key opportunities and tensions to watch out for 25 years after Cairo. These include protecting gains while pushing for progress; the pragmatism and dangers of viewing people as numbers; Universal Health Coverage as the new battleground for reproductive health and rights; new contraceptive technologies and old pitfalls; and the critical political role of women's movements. Many of these are simply contemporary versions of longstanding inequalities and struggles for power and control over bodies and resources.

Advancing RBFP is therefore political, as much (if not more so) as it is technical. Technical solutions are necessary to advance rights, but they are not sufficient. The full achievement of rights by women – reproductive or otherwise – requires a political commitment to structural and systemic change to dismantle the norms and systems that perpetuate power imbalances and inequality. Efforts that focus on individual empowerment without addressing structural inequalities will fail at creating sustainable social change. Structural change may seem ambitious but it is critical and can only be brought about when demanded by those most affected

by those inequalities. Additionally, any efforts to support structural change must be informed by those voices and those demands. Women's movements have long recognized the power of mobilizing to advance broader structural changes because those movements, both at the grassroots and global levels, understand the connection between the achievement of personal rights and the need for broad structural changes and have advanced an intersectional agenda that recognizes the need to address those systems that perpetuate inequality based on sex, race, class, caste, ability and other social markers.

Building on this analysis, as well as the commitments made at the ICPD25 Nairobi Summit, the paper offers a way forward to continue to make progress towards the promise of the ICPD. Specifically, we recommend fully committing to reproductive and sexual rights to protect and advance progress on RBFP; using our existing arsenal of technical tools to implement RBFP, demonstrate how it can be done effectively, and build broader support for its implementation; and most importantly, supporting and engaging women's organizations and movements. If we get this right, there will be benefits across all sectors of development, including family planning, human rights, health, climate justice, gender equality and women's empowerment, and we will in fact deliver on the promise of Cairo.

INTRODUCTION

The links between reproductive rights and women's empowerment are indisputable. For women and girls, particularly those who may not control much else, the ability to control their fertility can be essential and empowering. Exercising reproductive rights also has health benefits and opens up new educational and economic opportunities, leading to further empowerment. In this context, the global and national policies and local services that determine whether and how a woman can exercise control over her fertility have the potential to impact her life more broadly.

Many of these connections at the individual, relationship, community, national and global levels are now proven through evidence and recognized in global agreements, national policies, and in the advocacy and manifestos of community-led movements around the world. However, this was not always the case. It was not until the 1994 International Conference on Population and Development (ICPD) in Cairo that these connections were acknowledged. Cairo was a pivotal moment for women's empowerment, marking the global consensus that reproductive rights are human rights, that they are a precondition for girls' and women's empowerment and the realization of their sexual and reproductive health, and are therefore central to development and population policies.

This consensus came about in large part due to the efforts of the global women's movement (Antrobus 2004).¹ By strategically mobilizing over decades, the movement pushed the global

¹ Peggy Antrobus of DAWN notes that any reference to one global women's movement is controversial, appearing to minimize the diversity that lies at the heart of the movement. However, it is precisely the respect for and integration of local specificities, combined with a common agenda related to gender equality, that led to and strengthened the global women's movement.

community to move beyond demographic targets and focus on reproductive rights. This advocacy also led to researchers and planners beginning to understand and fill gender data gaps to better understand the ways in which women's empowerment and rights-based approaches to family planning can be implemented, monitored and measured. It also advanced the imperative to engage women as decision-makers – not instruments – in population and development policies and programs. As a result, family planning, which was initially focused primarily on reducing population in the Global South, has become one of many strategies in a broad agenda that focuses on the health, rights and empowerment of women.

The ICPD Programme of Action (POA) gave us a roadmap through which the global community committed to doing better by girls and women in a fundamental way – by placing their rights at the center of development. Twenty-five years later, the 2019 ICPD25 Nairobi Summit highlighted the progress we have made since Cairo, as well as continuing gaps, confirming that we have yet to achieve the promise of the ICPD. An examination of the past sheds important light to help us seize the unique opportunities and navigate the challenges in our current global context. In assessing progress since Cairo and in continuing to fulfill the promise of the ICPD, we do not have to reinvent the wheel, nor should we repeat the mistakes of the past. We can learn from the global conversations and political struggles to date, as well as the frameworks, processes, and outcomes forged by the global women's movement to advance the realization of women's rights and shape development strategies. We must apply what we know about the potential for women's empowerment offered by contraceptive technology, as well as the potential for abuse. We can learn from the considerable tools and resources developed to help define and implement rights-based family planning (RBFP)² as one strategy to achieve the goals of the ICPD POA. All these resources and lessons learned can help us as we continue to mobilize key stakeholders within the current context to influence relevant policies, contraceptive technology development and strengthen service delivery systems to ensure that family planning is contributing to – and not undermining – the realization of women's rights and empowerment.

THE LEAD UP TO CAIRO: FAMILY PLANNING AND WOMEN'S EMPOWERMENT

This section describes four streams of activities over the past few decades that have shaped our understanding of women's empowerment and family planning in the lead-up to the ICPD in Cairo: global politics, negotiations and commitments on population and development; women's activism and movements; developments in contraceptive technology; and research on the links between women's empowerment and family planning (see Appendix 1: Timeline on Rights-Based Family Planning and Women's Empowerment).

² FP2020 defines 'rights-based family planning' as an approach to developing and implementing programs that aims to fulfill the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence (<https://www.familyplanning2020.org/rightsinfp>).

Global Politics, Negotiations and Commitments (Antrobus 2004, Finkle and Crane 1975, Golini 1984, UNFPA 2019)

‘Population and development’ encompass a range of high-stake issues, including the global allocation of resources, political alliances and conflicts, culture and religion, and the circumstances under which individuals negotiate their most intimate relationships. Global agreements are often hard-won consensus documents, and do not necessarily reflect the contentious discussions and lobbying interests leading up to them. This section provides an overview of some of the key events, players, stakes and interests involved in shaping global and national conversations about population and development (see Appendix 1: Key Moments: Rights-based Family Planning and Women’s Empowerment Timeline).

In the 1950s, global conversations about population were driven primarily by Northern governments and donors and rooted in a population movement guided by Malthusian principles,³ concerned with population growth in the South and its purported relationship to what were defined as limited resources and Northern national security. In this context, the reproductive functions of women in the South were seen simply as the problem or the means to a solution through family planning. The 50s also saw the beginning of the ‘population establishment’, with the founding of the Population Council and the International Planned Parenthood Federation (IPPF) in 1952. The first was formed with a mandate focused on both individual decision-making and demographic trends. The second balanced a progressive agenda affirming reproductive choice, gender equality and sexual health with the contradictory legacy of IPPF’s first president Margaret Sanger who was an advocate for women’s reproductive rights but also held racist and ableist eugenic views. The 1952 John D. Rockefeller Conference on Population Problems held in Virginia in the United States (US) focused on food supply, industrial development, depletion of natural resources, and political instability resulting from unchecked population growth. The end of the decade saw the formation of General Draper’s committee on development assistance by President Eisenhower, which was the foundation for development assistance on population when the United States Agency for International Development (USAID) was created a decade later.

The 60s saw gains in public health, especially declines in infant mortality, which after initial acknowledgment of progress in public health, led to increased concerns in the North about population projections in the South. With critical advances in contraceptive technology (see Section II.C), family planning continued to be seen as a means to tackle population growth. The 60s also saw an interjection by the Vatican in global discussions on contraception. In 1963, Pope Paul VI issued *Humanae Vitae*, an encyclical that stated that essentially all forms of artificial contraception were inherently and morally wrong. Ever since, the Vatican has stood strongly against all forms of artificial contraception and abortion and *Humanae Vitae* contains the crux of its arguments (Catholics for Choice 2018, Romero 2018; Box 1).

³ The Malthusian Theory of Population is a theory of exponential population growth and arithmetic food supply growth. Malthus argued that if left unchecked, a population will outgrow its resources, leading to a host of problems. He believed that natural forces would correct the imbalance between food supply and population growth in the form of natural disasters such as floods and earthquakes and human-made actions such as wars and famines. He also suggested preventative measures to control the growth of the population, such as family planning, late marriages and celibacy.

Box 1: THE VATICAN'S INFLUENCE ON REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

The Holy See has been an active participant in UN negotiations on reproductive and sexual health and rights over the past few decades. It has taken a consistently conservative position on reproductive and sexual rights, and opposes abortion, contraception, sex education and the rights of LGBTQIA+ people. The Vatican has been strategic in its advocacy against reproductive and sexual rights, relying on empirical evidence, coopting the language of rights to support its own positions, and successfully forming alliances with sometimes unlikely allies (Coates, et al. 2014).

In 1968, Pope Paul VI ignored the report of a 1963 commission to update the teachings of the Catholic Church on marriage (Catholics for Choice 2018) and issued *Humanae Vitae*, an encyclical that stated that all forms of artificial contraception were inherently and morally wrong. The *Humanae Vitae* was unpopular among Catholics worldwide. In fact, over 50 percent of American Catholics believed that birth control should be permitted by the Church. However, the encyclical has influenced countless policies worldwide that impact women's ability to exercise their reproductive rights (Romero 2018). In 1978, soon after the *Roe vs. Wade* judgement, the Vatican, under the papacy of John Paul II, launched a global campaign against abortion, artificial birth control, reproductive rights, sex education, and broader definitions of gender roles and the family.

The Vatican has permanent observer status at the UN and is influential in deliberations on reproductive rights. The Vatican refused to endorse the 1974 and 1984 UN population conference documents. At the 1992 Conference on Environment and Development, the Vatican resisted language on health services to “include women-centered, women-managed, safe and effective reproductive health care and affordable, accessible services, as appropriate, for the responsible planning of family size” (Catholics for Choice 2012). In Cairo, the Vatican endorsed half of the ICPD POA but used its influence to change or eliminate language around sexuality, gender roles and the family that contradicted its views (Kissling 1999, Ruether 2006).

Since the ICPD, the Vatican has continued to influence governments and multilateral organizations to shape policies around reproductive rights and preserve the definition of the ‘family’. However, the Holy See did not attend the ICPD25 Summit in Nairobi, blaming the excessive focus of the conference on “a few controversial and divisive issues that do not enjoy international consensus and that do not reflect accurately the broader population and development agenda outlined by the ICPD” (The Permanent Observer Mission of the Holy See to the United Nations 2019).

The first global consensus on human rights related to family planning came in 1968. On the 20-year anniversary of the adoption of the Universal Declaration of Human Rights, a UN Conference on Human Rights was convened in Tehran, Iran. Representatives of the then 84 Member States, along with delegates or observers from UN bodies and specialized agencies, regional intergovernmental organizations and non-governmental organizations, adopted the Proclamation of Tehran which affirmed the basic right of parents “to determine freely and responsibly the number and the spacing of their children”. This was later to become a cornerstone of the ICPD POA. Ironically, the same year, Paul Ehrlich published his alarmist book, *The Population Bomb*, which became, in the North, a populist rallying cry for population control.

In 1971, the United Nations Population Fund (UNFPA) was founded to serve as the designated UN body on population and development. This was followed by the Bucharest World Population Conference in 1974. The Bucharest World Plan of Action affirmed that “All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the needs of their living and future children, and their responsibilities toward the community”. The Plan of Action further stated that “Equal status of men and women in the family and in society improves the overall quality of life. This principle of equality should be fully realized in family planning where each spouse should consider the welfare of the other members of the family” and that “Improvement of the status of women in the family and in society can contribute, where desired, to smaller family size, and the opportunity for women to plan births also improves their individual status”.

Differing views on population, development and women’s empowerment were expressed during the conference, confirming the deeply political nature of these issues. While the planning of the conference was dominated by traditional population interests of the US, conference deliberations were strongly influenced by the economic and political interests of relatively new independent nations of the Global South and their allies, as they positioned themselves in the global arena. Pushing back against population control as the response to concerns about the environment, limited resources, and migration patterns, the Indian delegation claimed that “Development is the best contraceptive”. The Argentine and Algerian delegations led the call for a new more globally equitable economic order rather than a focus on population and fertility. The Chinese delegation asserted that unemployment and poverty were not due to overpopulation, but rather to imperialist exploitation. The instrumentalist linking of women’s empowerment and population goals was reaffirmed by J.D. Rockefeller, who said, “...If we are to have progress in achieving population goals, women increasingly must have greater freedom of choice in determining their roles in society”.

The 1970s saw a surge of women’s activism for gender equality and empowerment both within the North and globally. The UN Decade for Women was launched in 1975, which had enormous implications for the ways in which women’s empowerment and family planning were positioned in global agreements (see Section II. B.).

At the national level, following the Bucharest Plan of Action Principle that “The formulation and implementation of population policies are the sovereign right of each nation,” the 70s also saw the implementation of national policies and programs in countries like China and India that focused on fertility targets and systematically undermined the reproductive rights of citizens. The 1979 one-child policy in China limited the number of children in most family units to one each, in order to reduce the country’s population growth rate.⁴ The policy relied on both rewards, such as financial incentives and employment opportunities, and punitive actions, such as forced abortion and sterilization (Pletcher 2019). In India in the late 1970s, encouraged by

⁴ China’s one-child policy has since been rescinded, in January 2016.

significant loans from the World Bank, the Swedish International Development Authority and UNFPA, the government embarked on an ambitious population control program. This was exacerbated during the 1975 Emergency, when civil liberties were suspended and Sanjay Gandhi, son of the former Prime Minister Indira Gandhi, began a campaign to forcibly sterilize men. More than six million men were sterilized in just one year (Biswas 2014).

On the other end of the spectrum, in the US, years of activism and lobbying culminated in the landmark 1973 judgement 'Roe v. Wade' that declared abortion a legal and constitutional right under US law based on the principle of an individual's right to privacy (Planned Parenthood 2019). Activists for safe and legal abortion (also known as the pro-choice movement) hoped to turn to issues of access to and quality of abortion and other reproductive services but were soon met with a strong opposition movement and attention and resources were diverted to counter it. The first major legislative gain of the opposition movement was the Hyde Amendment that banned federal Medicaid funding for abortions, which disproportionately affected women of color, immigrants, people with low incomes and young people reliant on Medicaid for affordable healthcare coverage (Fried 2013).

The next International Population Conference in Mexico City in 1984 reviewed and endorsed most aspects of the agreements of the 1974 Bucharest Conference. There was now general agreement that the 'population problem' required both containing fertility and increasing investments in development. Conference discussions also reaffirmed the commitment to human rights while stressing a continued concern about "the inextricable links between population, resources, environment and development". The resultant Plan of Action was described as "an instrument of the international community for the promotion of economic development, quality of life, human rights and fundamental freedoms." Migration was raised as an issue of concern and agreement was reached on protecting the human rights of internal and external migrants. Compared to Bucharest, discussions on the status of women were more definitive, with the conference document reaffirming the need to improve the status of women as a goal in and of itself and as a way to 'influence family life and size in a positive way'.

However, advocacy for women's reproductive rights suffered at the conference when the US Administration under President Reagan, reflecting his anti-choice political base, announced the Mexico City Policy, which required foreign NGOs to certify that they would not "perform or actively promote abortion as a method of family planning" with non-US funds as a condition of receiving US family planning assistance (The White House Office of Policy Development 1984), along with the Kemp-Kasten amendment, which stated that no US funds may be made available to "any organization or program which, as determined by the president of the United States, supports or participates in the management of a program of coercive abortion or involuntary sterilization." Kemp-Kasten has been used to withhold funding from UNFPA and both policies have had a devastating impact on pro-choice movements and reproductive health services in the South. Since 1984, USAID has enforced the policies, which have been upheld by all subsequent Republican Administrations and rescinded by all Democratic Administrations, reflecting typical US political alignments on reproductive rights (KFF 2019).

The 1990s were marked by a series of UN conferences which together advanced women's rights within development agendas focused on the environment, human rights, population and development, social development and women (Box 2).

Box 2: KEY MOMENTS FOR WOMEN'S RIGHTS AND EMPOWERMENT: UN CONFERENCES IN THE 1990s

The **1992 Conference on Environment and Development** in Rio was influenced by the World Women's Congress for a Healthy Planet, which formed the Women's Agenda 21, a parallel agenda to the conference's Agenda 21, as well as the Women's Tent organized by the Women, Environment and Development Organization (WEDO), highlighting the links between environmental issues and socioeconomic realities, including international trade agreements, sustainable development and poverty eradication. The resultant Agenda 21 recommended that "policies should be designed to address the consequences of population growth built into population momentum, while at the same time incorporating measures to bring about demographic transition. They should combine environmental concerns and population issues within a holistic view of development whose primary goals include the alleviation of poverty; secure livelihoods; good health; quality of life; improvement of the status and income of women and their access to schooling and professional training, as well as fulfilment of their personal aspirations; and empowerment of individuals and communities. It further recommends "women-centered, women-managed, safe and effective reproductive health care and affordable, accessible, responsible planning of family size and services, as appropriate, in keeping with freedom, dignity and personally held values" (UNSD 1992).

The **1993 Conference on Human Rights** in Vienna was underpinned by the women's movement's campaign led by the Center for Women's Global Leadership at Rutgers University, which emphasized that women's rights are human rights and demanded attention to violence against women (VAW). The Global Tribunal on Violations of Women's Human Rights, created by a broad coalition of women's groups, provided a platform for women all over the world to testify on abuse and advocacy, creating an unprecedented standard for linking local realities with global advocacy. By highlighting the range of violence women experience, the global women's movement broke down the distinction between the private sphere of the home and the public sphere of the state. This led to the UN General Assembly adopting the Declaration on the Elimination of VAW, the appointment by the UN Commission on Human Rights of a Special Rapporteur to investigate VAW, and informed international agreements and platforms to address rape as a war crime and VAW in humanitarian and crisis settings (OHCHR 1993).

The **1994 International Conference on Population and Development** in Cairo. The conference shifted the narrative from demographic targets to reproductive health and rights, defining reproductive health for the first time in an international policy document, as: "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system." It asserted that reproductive health care should enhance individual rights, including the "right to decide freely and responsibly" the number and spacing of one's children, and the right to a "satisfying and safe sex life." A key recommendation was to provide comprehensive reproductive health care, including family planning; safe pregnancy and delivery services; abortion where legal; prevention and treatment of sexually transmitted infections (including HIV/AIDS); information and counseling on sexuality; and elimination of harmful practices against women (such as genital cutting and forced marriage) (UNFPA 1994).

The **1995 World Summit for Social Development** in Copenhagen provided another forum for the global women's movement to highlight the contradictions within global economic policies such as structural adjustment and trade liberalization, and their impact on women. Delegates advocated for alternative policies focused on poverty reduction, employment creation and social security and acknowledged that social and economic development cannot be secured in a sustainable way without the full participation of women and that equality and equity between women and men must be at the center of economic and social development. Delegates committed to promoting and protecting the full and equal enjoyment by women of all human rights and fundamental freedoms. As a result, the International Gender and Trade Network, a women's watchdog of the World Trade Organization was formed in 1998 (United Nations 1995).

The **1995 Fourth World Conference on Women** in Beijing produced an agenda for women's empowerment with delegates unequivocally affirming that women's rights are human rights and committing to ensuring equal access to and equal treatment of women and men in education and health care and enhancing women's sexual and reproductive health as well as education; promoting and protecting all human rights of women and girls; and preventing and eliminating all forms of VAW and girls (UN Women 1995).

This included the 1994 ICPD, the third UN conference on population and development. That conference was seminal due to key shifts in the discourse on population and development that took place in Cairo. Notably, delegates moved away from the earlier focus on demographics and numbers, and instead focused on reproductive health and rights, leading to a comprehensive reproductive and sexual health agenda. Additionally, the conference POA located the most intimate and personal of rights, reproductive and sexual rights, within the broader context of women's empowerment and rights. It affirmed that "...reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so; and the right to attain the highest standards of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." (UNFPA 1994)

These shifts were the outcomes of concerted activism and mobilization by women's movements (see Section B.). It is important to note that while the ICPD POA reflects a groundbreaking global consensus, it was achieved despite opposition from religious and conservative forces by making critical compromises. Key compromises that continue to impact us today included a compromise on the language on abortion and the exclusion of sexual rights from the POA.

Women's Activism, Movements and Coalitions Advancing Rights⁵

Over the past few decades, through growing local and regional action and participation in the UN conferences, the global women's movement⁶ has increasingly contributed to our understanding of the global challenges that confront us, primarily through its political and mobilizing capacity and with an aim to shape coherent response and action. This includes the global challenge of women realizing their comprehensive reproductive and sexual health and rights. The advocacy leading up to Cairo and the resultant groundbreaking POA was in fact the culmination of two decades of women organizing and a global women's movement that through the previous three decades had grown in strength and sophistication.

The Women's Decade (1975-85) created unprecedented spaces for women from all over the world to come together. The first UN women's conference in 1975 in Mexico City, convened 8,000 participants at the official conference and an NGO forum, 'La Tribune', 70 percent of whom were women from 125 of the then 133 UN Member States. The agenda focused on women's economic and political participation. Health, nutrition and population were discussed, as were the family, household and marriage, and discussions highlighted women's reproductive and productive roles. However, these discussions defined reproduction narrowly and biologically, and did not address socioeconomic issues related to reproduction, including sexuality and violence against women. The lack of data on the role and status of women was revealed, laying

⁵ For more details on the evolution of the global women's movement and its global advocacy, see Antrobus 2004, which was a key reference informing this section.

⁶ Any reference to one global women's movement is controversial, appearing to minimize the diversity actually lies at the heart of the movement. Antrobus 2004 outlines the ways in which the respect for and integration of local specificities combined with a common agenda related to gender equality has led to and strengthened the global women's movement.

the foundation for important future links between advocacy and research and the continued quest to fill gender data gaps.

The conference was a new experience for many delegates, as was the opportunity to meet women from around the world. Fierce debates raged, reflecting different experiences of advocacy, including the focus on individual rights by the US women's movement compared to more collective approaches of women's movements in the South. At the same time, powerful new connections were forged against a backdrop that highlighted the commonalities between women from the North and the South and the possibility of a global women's framework that would benefit from diversity. Many feminists believe that the conference brought women around the world to 'a range of common understandings despite different starting points,' (DAWN 1985), and the conference's World Plan of Action for Women rightly predicted that 'In our times, women's role will emerge as a powerful, revolutionary social force'.

The Decade for Women that followed the Mexico conference was spent building the infrastructure, fostering cadres of 'activists, advocates and practitioners, (Tinker 1990) and building the evidence base and sophistication of what became the global women's movement. An International Women's Tribute Center was established which linked a mailing list of thousands that had its beginnings in Mexico. Special mechanisms were established in governmental and non-governmental bodies around the world, women's organizations were created or re-energized, and researchers began to focus on women, creating unique partnerships with feminists and beginning to address gender data gaps (Watkins 1993). 'Women in Development' programs emerged at universities and institutes around the world. Third World women's networks and organizations emerged and began to challenge western assumptions, including the Western feminist focus on individual liberation or the assumption that the capitalist model of development was benign. Grassroots movements learned the ins-and-outs of government negotiations and UN processes.

At the half-way point of the Decade, the 1980 conference in Copenhagen, women began to more clearly articulate the links between their own realities and broader political, economic, social and cultural structures. By the end of the decade, the women's movement, now comprised of seasoned and strategic networks, dominated the 1985 women's conference in Nairobi in both governmental negotiations and the NGO Forum. The Decade had fostered a movement that was not afraid to address the range of women's realities, from the personal and domestic to the political and the public, firmly placing women's issues and perspectives at the center of development and demanding that discussions of rights and development coalesce.

Despite this, at the end of the Decade, women were actually doing worse on indicators ranging from income and employment to health and education to violence than they were in 1975 (Antrobus 2004). Looking deeper, women's movements began to analyze the impact of the broader global context, such as the impact of structural adjustment policies⁷ and the collapse of the Soviet Union on their communities. Rather than focusing on 'women's issues', they be-

⁷ Structural adjustment encompasses economic policies that countries are expected to implement in order to qualify for loans from the International Monetary Fund or the World Bank. (Studies 1998). Theoretically intended to enable governments to save money and encourage increased production by the private sector to pay down their international debt, the policies also cut allocations to public social sectors and impact the capacity of states to address the social welfare needs of their citizens (Antrobus 2004).

gan to provide 'women's perspectives' on global issues, highlighting the experiences of women and the particular consequences of these issues for women. This opened up new forms of organizing and coalition building and sophisticated analysis which highlighted the connections between issues and began to shape the global debates and platforms at UN conferences of the 1990s, including those on the environment in 1992, human rights in 1993, population in 1994, and once again, women in 1995. This work was done with the strategic support of progressive governments and private foundations, who coordinated their support to ensure that diverse groups of women could participate in strategic preparations for Cairo, and in Cairo itself.

This advocacy led to global agreements that included a focus on women's empowerment and participation and advanced broad strategies requiring multi-sectoral engagement. In this context, then, with its radically changed agenda from a focus on demographic targets to one on reproductive and sexual health and rights, the Cairo POA could be seen as a 'coming of age' moment, clear evidence of the women's movement's ability to strategically build coalitions and mobilize around common issues, to draw clear connections between the personal and the political, and to demand rights-based, inclusive solutions to complex issues that multiple stakeholders are accountable for (Box 3).

The 1995 Fourth World Conference on Women was an affirmation of the power of this kind of coalition building and global women's advocacy. The resultant Beijing Declaration and Platform for Action was adopted unanimously by 189 countries and unequivocally reaffirmed the ICPD POA. Beijing represents the strongest consensus on girls' and women's equality and justice ever produced by the world's governments. Anchored in human rights, the Beijing Platform established clear expectations about State accountability for the achievement of gender equality and defined strategic objectives aligned with twelve key areas of concern, including sexual and reproductive health and reproductive rights, poverty, violence, media, the environment, and girls.

Developments in Contraceptive Technology

In the 1960s and 1970s, developments in contraceptive technology revolutionized women's ability to control their fertility and family planning services and paved the way for broad social and economic change, as well as changes in supply chains and service delivery.

While technologies can be imperfect, they are not necessarily in and of themselves problematic. They become problematic when the focus is on their efficacy rather than their safety.⁸ The development and delivery of contraceptives globally have been shaped by the need for accessible and affordable birth control but has also been informed by the pursuit of population control and profit. While they can be positively life-changing for women, contraceptive technologies can also be the means through which women's rights are curtailed. A look at the history of the contraceptive pill in the US highlights these dichotomies.

⁸ Efficacy can be defined as the performance of an intervention under ideal and controlled circumstances, whereas effectiveness refers to its performance under 'real-world' conditions (National Institutes of Health).

Box 3: WOMEN'S COALITIONS MOBILIZE FOR REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

Women's coalitions have successfully mobilized across diverse regions, sectors and issues to address complex issues related to reproductive and sexual health and rights. Below are some examples related to women's coalitions mobilizing for the ICPD.

The **Reproductive Health and Justice: International Women's Health Conference for Cairo '94** took place in January 1994 in Rio de Janeiro. The Secretariat for the conference included the US-based International Women's Health Coalition and the Brazil-based Citizenship, Studies, Information, Action (CEPIA). Over 200 women from 79 countries gathered to generate the 21-point Rio Statement, and strategies to ensure that women's perspectives would be considered at the ICPD. Following national and regional planning meetings, the Rio Conference aimed to "identify common ground and universalities in women's perspectives on reproductive health and justice," while respecting the diversity that exists in the women's movement. Deliberations in Rio informed the content and strategy of the women's movement's advocacy in Cairo.

Development Alternatives for Women for a New Era or DAWN, a network of women activists and researchers from Latin America and the Caribbean, Asia and the Pacific, the Middle East and Africa was formed in the 1980s. Building on the strength of collective action and finding common ground, DAWN systematically evaluated the impact of development models on gender systems in the Global South. Their advocacy on sexual and reproductive health and rights at the ICPD and in Beijing was situated in the inter-linkages and multiple challenges that women from the Global South encounter, including women's human rights, bodily autonomy and integrity, as well as social and economic justice and sustainable development. DAWN produced effective leadership and analyses that influenced the processes and outcomes of the UN conferences of the 1990s, including the ICPD (Sen and Grown 1987, Correa and Reichmann 1994, Dandan and Yiping 2018).

The **US Reproductive Justice Movement** was launched in 1994, before the ICPD, by a group of Black women in Chicago. Rooted in the internationally accepted human rights framework created by the UN, reproductive justice combines reproductive rights and social justice within a framework of intersectionality (Ross, et al. 2017).

These perspectives, well-aligned with the agendas of many Southern women's organizations, defined the demands presented by the US Women of Color Delegations to the ICPD (The U.S. Women of Color Delegation 1994) and the Beijing women's conference (The U.S. Women of Color Delegation 1995). SisterSong Women of Color Reproductive Justice Collective was formed in 1997. The most significant and enduring achievement of the reproductive justice movement is that it challenged the framework of abortion rights advocacy in the US from one about individual choice to one about human rights. The reproductive justice movement has become an umbrella movement for women's sexual and reproductive rights, women's agency and empowerment more broadly, racial justice, environmental racism, LGBTQIA rights and social inclusion.

Catholics for a Free Choice: (now Catholics for Choice) is an UN-accredited NGO that highlighted the diverse voices of Catholic women in the lead up to and follow up after Cairo. Building on pro-choice movements within the US and in predominantly Catholic countries, particularly in Latin America, Catholics for a Free Choice successfully brought together progressive religious voices from around the world to advocate for safe and legal abortion. The organization continues to work with partners globally to highlight rights issues within a progressive analysis and understanding of religious and political doctrine.

Alliances Between Women's Advocates and Donors: influenced women's advocacy before and at the ICPD. Through coordinated and strategic funding, government and foundation donors supported advocacy leading up to the conference and participation of women at the conference. This resulted in more strategic preparations to define key messages for Cairo that enabled the women's movement to effectively challenge considerable socioeconomic, political and cultural interests and resistance. It also enabled more equal participation by women from Southern countries, indigenous women around the world, women of color from the North, and other marginalized groups. This meant that diverse groups of women were able to speak for themselves and effectively dispelled the opposition's myth that reproductive and sexual rights were primarily white, Northern women's priorities.

Prior to the 1950s, the culture of silence associated with sexuality meant that contraception received very little attention from governments, doctors and researchers. In the 1950s, Margaret Sanger pushed for the development of new contraceptive technology, advocating that female control over contraception was a precondition for women's emancipation and organizing funding to drive research for the first contraceptive pill (PBS 2019). The pill was officially approved by the United States Food and Drug Administration (FDA) in 1960. It gave women a new level of control over their bodies and reproductive functions. They did not have to depend on men for birth control and if correctly used, the pill was considerably more effective than natural and barrier methods. The pill opened up possibilities for women beyond traditional roles and relationships that were already being questioned by leaders of the women's movement (Friedan 1963). Some claim the pill marked the beginning of the sexual revolution and sexual freedoms that ushered in wider freedoms for women (Carter 2016).

However, there was a less liberating side to the pill for some women. Clinical trials for the pill were conducted over three years by Dr. John Rock of Harvard Medical School in Puerto Rico. The trials were heavily criticized for racism, skirting informed consent of the participants and ignoring the concerns of trial subjects. The first formulation of the pill Enovid had a high concentration of hormones that caused side effects ranging from nausea and headaches to embolisms and blood clots. It took years for researchers and manufacturers to review this formulation and revise it to reduce the side effects of the contraceptive pill, fostering ongoing distrust of hormonal contraceptives and more broadly of pharmaceutical and medical trials. This distrust was further fueled by problems related to other long-acting contraceptive methods in the 1970s, 1980s and 1990s, such as the injectable Depo Provera, the implant Norplant and the IUD the Dalkon Shield, as well as a history of systemic abuses to limit the reproduction of specific groups of people, based on race, ethnicity or class, in the name of the common good (Dehlendorf and Holt 2019).

The interests of the contraceptive industry and of those working towards population control converged, creating alliances between population control groups, pharmaceutical companies and development agencies. This convergence drove further research in the field and large-scale distribution of contraceptives in developing countries, with several biases (Hartmann 2016).

The first bias was that research heavily focused on contraception for the female reproductive system. While contraception had the potential to liberate women, it also became a means through which the traditional gender norm that reproduction is the sole responsibility of women was reinforced. This bias was reinforced by a lack of research on male contraception. Initially in the 1950s, research in hormonal contraception focused on both men and women. Gregory Pincus, the scientist credited for formulating the female contraceptive pill along with gynecologist John Rock, first tested a hormonal approach in men in 1957. Due to Margaret Sanger and Katharine McCormick's investment in his research, Pincus narrowed his focus to women (Extance 2016). Since then barriers slowed research and development in male contraception, including the fact that reversibility was tough to achieve (Extance 2016, Sifferlin 2018), and misconceptions about the need and willingness of men to use contraception. These barriers, combined with an unknown regulatory market and the fact that female contraception remained highly lucrative, kept big pharmaceutical companies away from pursuing male contraception (Sitruk-Ware 2018).

The second bias was toward hormonal, surgical and immunological methods of contraception as opposed to barrier methods. There was a strong preference in the industry for long-acting methods that required minimal action and control by the user, minimal interaction between the user and the provider, and were highly effective at preventing conception. This meant that female hormonal methods received the most attention and funding by the population establishment. While these offered long-acting, discreet contraception that many women opted for, they sometimes did so without adequate information on or access to the full range of contraceptive choices, or within service delivery systems in which long-acting or surgical methods were linked to incentives. Within these contexts, the potential for abuse was high, particularly when the services were linked to population or other targets.

These biases and potential for abuse are clearly evident in the case of sterilization. In the 1960s, US manufacturers began to locate plants in Puerto Rico due to tax-free investment incentives and the availability of cheap labor, particularly women facing economic hardship. Private agencies, including IPPF, along with the Puerto Rican and US governments encouraged women to accept free or low-cost sterilization to free them up for employment. By 1968, one in three women of childbearing age in Puerto Rico had been sterilized. By 1992, two years before the ICPD, female sterilization was the most widespread form of birth control, with an estimated 140 million women of reproductive age and 42 million men sterilized. Female to male sterilization ratios were higher in developing countries, despite the fact that female sterilization is more complicated and riskier than vasectomy, and has a longer recovery time.⁹ In 1989-1990, female sterilization accounted for over 90 percent of sterilizations in India (Hartmann, 2016, Ravindran, 1993), with risks of both abuse and complications exacerbated by poor conditions in health care facilities and mass sterilization camps.

The third bias was the greater emphasis on efficacy rather than effectiveness and safety (Hartmann 2016). The most efficacious methods were usually long-acting and either the method itself or the service delivery system made it difficult for women to change their method if they had unpleasant or unsafe side effects, or even if their contraceptive needs changed over time. Safety issues were compounded in the face of increasing awareness of the multiple reproductive and sexual health risks women face, such as sexually transmitted infections and the emerging HIV/AIDS epidemic that hormonal or surgical methods do not protect against. In 1992, the Population Council brought together women's health advocates, scientists, and program planners to explore the development of microbicides that could be women-controlled and prevent the sexual transmission of infections (Elias and Heise 1993). With the International Women's Health Coalition, the Population Council then formed the Women's Health Advocates on Microbicides (WHAM), which investigated what type of formulation women would find acceptable, how to conduct an ethical clinical trial, and how best to obtain informed consent, informing both the Council's and other product developers' work on microbicides moving forward.

⁹ The exception to this focus on female sterilization is the 1975 Emergency in India, during which civil liberties were suspended and over six million men were forcibly sterilized in one year.

In the years since the development of the first contraceptive pill, women's advocacy in both the North and the South has highlighted the problems driving contraceptive technology development and delivery, which range from poor quality services and benign neglect to significant failures and human rights abuses. At the same time, despite imperfect technologies and service delivery systems, the need for a range of technologies and methods is critical to women's ability to make choices to control their fertility and advance their broader empowerment. Women often assess risks and make decisions based on those risks. They should be able to do that with clear and transparent information and supportive service providers. Women's movements and lessons learned from family planning programs have also clarified that women's contraceptive needs are shaped by their intersectional identities and changing realities over their life cycles and that to be truly responsive, services have to both uncover and accommodate those needs. The ICPD POA recognized the need for safe contraception as well as the need for access to the full range of contraceptive methods for women to realize their reproductive rights.

Making the Case: Evidence on Women's Empowerment and Family Planning

The ICPD POA identified "empowering women" as a critical element in achieving desirable reproductive and sexual health outcomes. Several definitions of empowerment include the ability to exercise choice, make decisions and act on those decisions. For example, Naila Kabeer defines empowerment as "the expansion of people's ability to make strategic life choices in a context where this ability was previously denied to them". Two key components of empowerment are resources and agency. Resources include capabilities (such as health, nutrition and education), access to opportunities (including economic assets, resources and political opportunity) and security (safety from violence and conflict). Agency requires a process that enables participation and inclusion and recognizes women as agents of change in their own lives. When these are both in place, girls and women are able to assess and make choices and decisions and act on them in all areas of their lives, including their sexual and reproductive lives (Kabeer 1999).

Conversely, there is evidence that access to modern contraception empowers women and girls by reducing uncertainty about the timing of pregnancy and giving them more control over their own bodies (Rao Gupta and Malhotra 2005). This agency can be empowering, enabling them to plan ahead and make informed, strategic decisions about their lives. Accessible contraception allows girls to stay longer in schools and enables them to seek out and pursue opportunities for further professional and personal growth. Having access to education and employment has further positive ripple effects on the lives of girls and women but also their children and families at large (Silverman, Birdsall and Glassman 2016). Recent research suggests that true (not instrumental) economic empowerment of women, specifically the choice of where and when to work and under what terms and conditions, is linked to reproductive empowerment, or the choice of the timing, spacing and number of births, and that without reproductive empowerment, efforts to educate girls or engage women in the labor force are likely to fail to have long-term, sustainable outcomes (Gammage, Joshi and Rodgers 2020).

The relationship between reproductive rights and women's empowerment first became apparent with the approval of the first contraceptive pill in 1960 in the US, which gave many girls and women legal and socially acceptable access to an effective form of contraception. This

access meant fewer unsafe abortions, and also enabled girls and women to plan better for their futures and make strategic decisions about their lives, such as whether to stay in school, delay pregnancy, pursue higher education, pursue employment they may not have been able to previously, and plan for a future that they had control over. The decades following 1960 saw a spike in women's enrollment in law schools and medical schools and women's participation in the labor force. Overall, women's investment in education and employment in high-paying fields also caused the gender pay gap in the U.S. to shrink substantially (Silverman, Birdsall and Glassman 2016).

Silverman et al (2016) suggest that this link between reproductive rights and women's empowerment is based not just on the use of contraception but on knowledge about and access to contraception. For example, parents may be more likely to invest in their daughters' education if they know that their daughters will have access to contraception later in life (Babiarz, et al. 2017). So, the most critical factor in enhancing women's status is women's knowledge that if and when they choose to do so, they can control, delay or strategically time childbearing and that they have access to the required resources and support systems to act on their choice.

The evidence base for the relationship between family planning and women's empowerment in low and middle-income countries is limited to a few methodologically rigorous studies conducted in specific geographical locations, thus also limiting the possibility of making generalizations from the findings. However, several experimental and observational studies provide evidence that supports the link between reproductive rights, or family planning in general, and women's empowerment and its various components, such as fertility, education, aspirations, health, economic empowerment and intergenerational outcomes.

While researchers have debated the primary drivers of fertility decline, including reductions in the demand for children and the contributions of family planning programs, there are studies that establish that the presence of family planning services in a community leads to a reduction in both short- and long-term fertility rates. These reductions in fertility benefit individual women by improving their health and enabling them to access education and employment opportunities (Miller and Babiarz 2016). For example, in the Matlab Randomized Control Trial in Bangladesh, female reproductive health workers visited the homes of married women of childbearing age in the treatment group every two weeks to educate women about reproductive health, counsel them about nutrition, and provide certain modern contraceptives free-of-cost. Maternal and child health services were later integrated into the study (Miller and Babiarz 2016). After the study concluded, a 25 percent reduction was found in the General Fertility Rate (GFR) in the treatment group in the first two years of the study and these effects persisted for at least 20 years after, thus reducing the number of children ever born by 1-1.5 and extending intervals between births by 8-13 months (Joshi and Schultz 2013). In Ghana, the Navrongo Experiment combined family planning service training and community outreach in treatment communities, which experienced a 15 percent reduction in the total fertility rate among married women (Debpuur, et al. 2002). The experiment also had persistent effects on fertility up to 15 years after the experiment concluded (Phillips, Jackson, et al. 2012). Another study found that the presence of family planning services explained approximately 6-7 percent of Colombia's fertility decline between 1985 and 1993 (Miller 2010).

There are various ways in which family planning programs are statistically associated with health outcomes among women. By reducing fertility or even reducing the incidence of risky pregnancies by delaying pregnancy at a young age and by increasing the time between births, they can reduce the number of times women are at risk of maternity-related deaths and can drive down the maternal mortality ratio (Merson, Black and Mills 2012, Cleland, et al. 2012, Miller and Babiarz, Family Planning Program Effects: A Review of Evidence from Microdata 2016).¹⁰ One study of the Matlab Experiment in Bangladesh found that while there was no change in the maternal mortality ratio, the maternal mortality rate halved for treatment areas compared to control areas (Koenig, et al. 1988). Another found that women in the treatment zones were on average less likely to be underweight and were over four pounds heavier than those in the control zones (Joshi and Schultz 2013).

Family planning services have varied socioeconomic benefits for girls and women. For example, studies have found that family planning services enable women to control the timing, number and spacing of births and have the potential to, and in some cases have been shown to, influence women's educational attainment and labor force participation (Greene and Merrick 2005). The study in Colombia found that the existence of a family planning program in a community was associated with a one percent increase in a woman's educational attainment (0.05 years of schooling) and a four to seven percent increase in formal sector employment (Miller 2010). A study in Indonesia found lifetime exposure to family planning programs is associated with gains of between 25 and 27 percent in educational attainment for women, or 1.3 years of schooling (Angeles, Guilkey and Mroz 2005).

There are various mechanisms through which the existence of family planning programs in communities have intergenerational benefits, with some significant benefits for girls. These mechanisms include spacing births to controlling family size or are due to gains in mother's educational attainment, bargaining power and labor force participation (Miller and Babiarz 2016). Two studies on child survival in the Matlab and Navrongo experiments found that family planning programs, bundled with other health services, especially those targeting infant and child health, are associated with significant reductions in child mortality under the age of five (Joshi and Schultz 2007, 2013, Phillips, Bawah and Binka 2006). One study of the Matlab Experiment found that the average BMI scores for girls in treatment villages were above the average of their counterparts in control villages in the experiment (Joshi and Schultz 2007). Another study in the Philippines found that lifetime exposure to family planning services was associated with a 7 percent increase in child height and a 12 percent increase in child weight (Rosenzweig and Wolpin 1986). More recently, findings from a study conducted across 61 low- and middle-income countries indicated that potential improvements in child physical growth provide further evidence in support of the expansion of family planning services (Fink, et al. 2014). Family planning also has the potential to benefit children by increasing their parents' investment in

¹⁰ "The maternal mortality ratio is the annual number of maternal deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy, childbirth, or within 42 days of termination of pregnancy, per 100,000 live births per year... The maternal mortality rate is the number of maternal deaths in a population divided by the number of women of reproductive age" (Sustainable Development Solutions Network 2012).

their education (Becker 1993). A study of the Matlab Experiment found that the experiment increased the years of completed schooling for boys by between five and twelve percent and for girls between six and fifteen percent in the treatment village, by reducing family size (Foster and Roy 1996).

POST-CAIRO: CHALLENGES AND PROGRESS IN IMPLEMENTATION

Following the ICPD, the global community began the task of implementing the broad agenda of the POA.¹¹ While there was general agreement that the focus on women's rights and health was the right way forward, the POA presented significant challenges for implementation. The advocacy leading up to Cairo had coalesced movements and issues. In contrast, implementation in the context of the late 1990s and 2000s, including a growing AIDS epidemic, resulted in their splintering. The funding which had supported movements and advocacy leading up to Cairo was now directed largely at programming. In contrast to the comprehensive, multi-sectoral reproductive health and rights agenda of the POA, international development planning, programming and funding remained siloed. Even government funding designated for 'gender' or 'women's empowerment' after Cairo and Beijing was often sidelined within separate 'women and development' departments or 'gender' divisions, which saw their mandates grow, but not their budgets or authority.

The reality was that each component of the POA required particular focus, expertise and resources and different priorities came into play. With the spread of HIV and the threat of a global AIDS epidemic, advocacy on the development impacts of HIV/AIDS grew, as did investments, such as the US President's Emergency Plan for AIDS Relief (PEPFAR) launched in 2003. In a context in which family planning and STI services were already separated, the different priorities of family planning and STD/HIV prevention led to the 'dual-protection dilemma' for service providers who had to balance different messages with limited method choice (Mantell, et al. 2003). Community-led HIV/AIDS movements diversified and grew to address sexual rights, which had been excluded in the Cairo POA. Growing evidence from work on HIV/AIDS highlighted gender-based interpersonal and systemic risks faced by girls and women, resulting in increased investments to address gender-based violence (GBV) as both a public health and human rights issue.

Targets around safe motherhood were less controversial to gain consensus on and gained more attention. Notably, in 2000, the Millennium Development Goals (MDGs) adopted by the global community in 2000 did not include sexual and reproductive health, due to concern that it might jeopardize the adoption of the Millennium Declaration. Out of the various components committed to in the ICPD POA, only 'Improve Maternal Health' was included as one of the eight MDGs, allowing political opponents of the POA to strategically focus attention and resources on

¹¹ The rights-based Cairo POA was affirmed by the global community a year later at the Fourth World Conference on Women.

other issues.¹² Facing ongoing political battles across the globe, including the reinstatement of the US Global Gag Rule by George W. Bush in 1991, abortion rights advocates focused their always-precarious resources on safeguarding access to safe abortion in both policy and services.

Within this context, and despite the focus by funders on programming, family planning lost its centrality in population and development policies and lost momentum, focus and resources. This happened despite the fact that many girls and women still did not have access to high quality rights-based family planning services. Thus, an opportunity was lost to implement effective, accountable, rights-based family planning services that could provide girls and women with much needed contraceptive services while also advancing their individual rights, shifting norms addressing risks and vulnerability to HIV and other STIs, and creating an enabling environment in which girls and women can both assert and achieve their rights and empowerment.

To fill this vacuum, global action was galvanized, existing frameworks on RBPF were revisited and new ones were created. Since 2012, with further impetus spurred by the 20th anniversary of the ICPD in 2014, the launch of the 2030 Sustainable Development Agenda in 2015, and the reaffirmation of the ICPD POA at the ICPD25 Nairobi Summit, these and other global efforts have brought together technical approaches, frameworks, research and the vigilance of women's and human rights advocates to work to advance RBFP. Some of the key global moments, commitments, frameworks and guidelines on RBFP are described in more detail below.

The 2012 London Summit on Family Planning¹³

In July 2012, in response to the diminished focus on family planning, the UK Department for International Development (DFID) and the Bill & Melinda Gates Foundation (BMGF), with support from USAID, UNFPA and other partners, hosted a Summit on Family Planning in London. Held on World Population Day, the Summit convened private donors and leaders from 26 countries to put family planning back on the global health and development agenda. At the Summit, donors pledged USD 2.6 billion, with an explicit goal to expand family planning services to reach 120 million more girls and women in the world's 69 poorest countries by 2020.

While the renewed focus, political will and investments in family planning were welcome, the quantitative targets of the Summit and their focus on the world's poorest countries, were viewed with suspicion by many who saw them as a return to the pre-Cairo focus on population control in the global South, incentives to reach the desired numbers, and related coercion. This concern was reinforced by early plans for the London Summit, which focused on targets rather than ICPD principles of safeguarding women's rights, enhancing informed choice or promoting equity. Additionally, the Summit's focus was limited to contraceptive access (including sterilization) and reducing the number of unsafe abortions but did not include a focus on access to safe abortion services. For many advocates for women's reproductive health and rights, this

¹² It was not until 2007 that advocates convinced the UN to specify that achieving universal access to reproductive health by 2015 was a necessary component of MDG 5. Although this new target represented progress, its narrow focus failed to reflect the broader sexual and reproductive health and rights (SRHR) agenda that came out of Cairo and was reinforced at the Beijing Women's Conference in 1995.

¹³ For more information on the London Summit, see: Women at the Center (FP2020 2019), www.familyplanning2020.org/progress and Hardee and Jordan, Contributions of FP2020 in Advancing Rights-based Family Planning 2019.

was a serious omission. In large part, this decision was driven by the fact that abortion remains a highly charged political issue and some donors do not fund abortion services. More broadly, however, it reflects the ongoing dance within global discussions, in which abortion is sidelined as too controversial in the interest of moving a broader consensus agenda forward. This trend has not been without consequences for reproductive health and rights, women's empowerment, and the safety and dignity of women.

The Summit's numeric goal and the fact that its original business plan did not explicitly reference rights and the Cairo consensus was concerning for sexual and reproductive health and rights advocates, who felt these signaled a return to pre-Cairo approaches. Amnesty International, working with many other international NGOs, submitted a petition, which led to a revised business plan with an explicit commitment to rights and the Cairo consensus.

The Summit commitments were ultimately aligned with the core principle of the ICPD, rejecting population control and demographic targets and affirming that it is a fundamental human right of all individuals to decide for themselves, freely and without coercion of any form, whether and when to have a child, and the responsibility of government, civil society and development partners to protect, promote and enable people to realize that right. The Summit built on, catalyzed or informed parallel activities and outcomes, advancing and informing work on approaches to and implementation of RBFP.

Family Planning 2020¹⁴

Family Planning 2020 (FP2020) was a direct outcome of the London Summit. A global partnership, FP2020 is led by a 23-member Reference Group (including the BMGF, UNFPA, WHO, DFID, Global Affairs Canada and USAID, as well as ministries of health of various countries in the partnership) overseen by a Secretariat and hosted at the United Nations Foundation. The partnership began with 20 governments making commitments to address the barriers preventing women from accessing contraceptive information, services and supplies. Today, 46 countries have FP2020 commitments and donors have increased their commitments.

Since its founding in 2012, FP2020 has made rights and women's empowerment an explicit focus in its efforts to meet the unmet need for family planning. This is evidenced at various levels of the global partnership, including in its vision and within its governance structures, in measurement and reporting, and in its requirements of and technical support to country partners (Box 4).

Looking beyond 2020, FP2020 acknowledges the need for continued learning and efforts on how to advance RBFP and recommends some concrete actions, including promoting political support for RBFP at the global and country levels; promoting rights literacy; paying more attention to accountability, including social accountability; focusing on equity; increasing attention on adolescents; continued work on rights metrics and guidance; research and dissemination of findings on RBFP; and support for practical tools and training materials.

¹⁴ For more information on FP2020's work on RBFP, see: Women at the Center (FP2020 2019), www.familyplanning2020.org/progress and Hardee and Jordan, Contributions of FP2020 in Advancing Rights-based Family Planning 2019.

Box 4: FP2020 INITIATIVES TO ADVANCE RIGHTS AND EMPOWERMENT

FP2020 convened a Rights and Empowerment Working Group (RE WG) in 2013 to ensure that partnership activities were firmly underpinned by a rights and equity framework. The RE WG produced the FP2020 Rights and Empowerment Principles related to ten dimensions of family planning: Agency and autonomy, availability, accessibility, acceptability, quality, empowerment, equity and non-discrimination, informed choice, transparency and accountability and voice and participation. The principles were informed by existing and emerging rights frameworks, including those developed by WHO, UNFPA, the Futures Group and EngenderHealth (see Section III. for details on some of these frameworks). FP2020's Performance Monitoring & Accountability Working Group collaborated with the RE WG to identify both existing and new indicators to measure aspects of RBFP as a key part of the FP2020's measurement agenda. Core indicators are linked to the Rights and Empowerment Principles, creating a practical tool for measuring how effectively the principles are being applied. In 2016, FP2020 dissolved the Rights and Empowerment Group but hired a Senior Rights Advisor to institutionalize technical support on its rights-based approach.

In addition to promoting a rights-based approach, the partnership also recognized the need to create guidelines for when the violation of rights took place and how to mitigate those violations. Additionally, periodic reviews and convenings at the country, regional and global levels ensure an ongoing focus on barriers to and progress on the realization of rights through family planning programs. Over the years,

FP2020 has engaged and leveraged partnerships to focus on addressing different and current aspects of implementing RBFP, including measurement of rights, engaging youth and championing their rights and access to family planning, RBFP in humanitarian settings, socializing RBFP among partners, and identifying and addressing links between RBFP and other issues including quality of services, gender transformative programs, population, health and the environment, and the integration of family planning and HIV.

For example, in June 2016, FP2020 co-convened a consultation along with USAID and the Interagency Gender Working Group (IGWG) on Realizing Sustainable Programming for Rights-Based Family Planning, where donors, implementing agencies, research groups, UN bodies and CSOs came together to discuss the practicalities of implementing the rights-based approach in family planning. Participants shared lessons learned from the field, best practices, challenges and concerns and identified new ways of incorporating the rights-based approach in existing and new interventions. In 2017, a technical consultation hosted by FP2020 and the IGWG, brought together experts to explore the commonalities between RBFP and gender-integrated family planning and identify elements from both frameworks that support a broader family planning agenda and research, programming and learning. In 2018, FP2020 and Promundo co-sponsored a meeting on male engagement in RBFP and in 2019, FP2020 and the Population Council co-hosted a meeting on Quality, RBFP and Universal Health Coverage.

UNFPA's Family Planning Strategy 2012-2020

Following the ICPD, UNFPA diversified its portfolio to address rights-related issues such as GBV, child marriage and other harmful practices. While this was an important shift that reflected the POA, it contributed to the dilution of the family planning agenda in the decade immediately following the ICPD. UNFPA's Family Planning Strategy 2012-2020: Choices not Chance attempted to rectify this by being aligned with the objectives of the London Summit and the timeline of FP2020. The strategy focuses on achieving universal access to rights-based voluntary family planning as part of sexual and reproductive health and reproductive rights, and UNFPA committed to expanding access to family planning infor-

mation, services and supplies for women, men and young people. The strategy also focuses on improving the quality of care, generating demand and meeting unmet need, and supporting the efforts of countries to strengthen health systems for a reliable and secure supply of modern contraceptives for all, including the poor, marginalized and underserved. Under the strategy, UNFPA also committed to bringing family planning to a new scale, reaching millions more people and contributing powerfully to achieving the results promised to the world at the 2012 London Summit on Family Planning (UNFPA 2013). Notably, the strategy places human rights at the core of implementation and continues a focus on rights-related issues such as GBV and harmful practices. More recently, in its 2019 State of the World Population report, UNFPA reaffirmed its commitment to the ICPD POA and to putting people first by upholding their sexual and reproductive health and rights (UNFPA 2019). While this combined focus on rights and expanded family planning is laudable, and reflects the POA, the challenge still remains in how UNFPA will reconcile ambitious family planning goals with a program agenda that continues to focus on issues such as GBV, child marriage and harmful practices.

Examples of Relevant Frameworks for Rights-Based Family Planning

Several frameworks and conceptual models have influenced or guided the implementation of RBFP. Some of these predate the London Summit and others followed it. Some focus specifically on family planning, and others focus on other health issues, quality of service delivery or in development more generally.

Early examples of relevant patients' rights frameworks include the 2001 Institute of Medicine Framework, which has six quality of care principals: Safety, effectiveness, patient-centeredness, timeliness, efficiency and equity (Institute of Medicine 2001). The Institute for Healthcare Improvement's Triple Aim focuses on patient experience, population health and reducing the cost of health care in the US health care system, and in doing so addresses quality, satisfaction, equity and access (Berwick, Nolan and Whittington 2008). Donors such as DFID and agencies such as UNFPA also had comprehensive rights frameworks, based on principals of participation, inclusion and accountability (Galavotti 2012). In 2000, the UN Committee on Economic, Social and Cultural Rights defined the right to the highest attainable state of health as having services that are available, accessible, acceptable and good quality (AAAQ). The framework offers practical steps to build operational links between principles and realities and has since been applied by advocates around the world to family planning (for example, Hardee, Kumar, et al. 2014) and sexual and reproductive health and rights (for example, Germain, Sen, et al. 2015 and Kähler, et al. 2017).

The Bruce/Jain quality of care framework for family planning services was developed in 1990 and was groundbreaking for its time in that it focused on the needs and experiences of clients, including factors related to rights, rather than demographic outcomes. The framework included six elements: 1) choice of methods, 2) information given to clients, 3) technical competence of providers, 4) interpersonal relations, 5) follow-up and continuity mechanisms and 6) appropriate constellation of services. It was developed to define aspects of quality that could be used for both family planning service implementation and evaluation (Bruce 1990). Almost 30 years later, the framework was revisited and revised to better align it with subsequent policy, technological and service developments and definitions of quality in rights-based programs (Jain and Hardee 2018). The revision is a useful example of how to update and keep relevant

significant frameworks over time, rather than reinventing the wheel. In the revision process, the original six elements were seen as relevant but further elaborated to reflect developments since 1990 and clustered by structure and process. Structure includes those elements related to the quality or readiness of services to provide an intended level of care, including choice of methods and technical competence of provider which were updated to reflect new technologies and make explicit safety issues, as well as appropriate constellation of reproductive health services and the addition of availability of space to ensure audio and visual privacy. Process includes information exchange with clients which replaced information given to clients, signifying a two-way process, and interpersonal relations, with dignity, respect, privacy and confidentiality made explicit.

The 2012 Framework for Voluntary Rights-Based Family Planning (VRBFP) Programs by the FUTURES Group and EngenderHealth (funded by the BMGF) combines public health and human rights approaches to demonstrate that both can be mutually reinforcing if programming is based on achieving both public health and human rights outcomes (Hardee, Kumar, et al. 2014). The key goal of the framework was to translate human rights principles into language that could be better understood by family planning policymakers, program managers, service providers and clients and to assist them with program design, implementation, and monitoring and evaluation. The VRBFP Framework is a practical framework, organized as a logic model that links specific program inputs and activities to public health and human rights outcomes and their impact. The framework details activities and inputs for four levels of the health and development system: policy, service delivery, community and the individual, and situates these four levels within the country context to identify challenges to effective programming.

More recently, the Lancet Commissions' sexual and reproductive health and rights (SRHR) framework explicitly asserts that sexual and reproductive rights must be realized for sexual and reproductive health to be achieved. The framework advances a holistic view of SRHR, calling attention to historically neglected issues such as adolescent sexuality, gender-based violence, abortion and diversity in sexual orientations and gender identities. It recommends an essential package of SRHR services and information, including contraceptive services, maternal and newborn care, prevention and treatment of HIV/AIDS, care for sexually transmitted infections other than HIV, comprehensive sexuality education, safe abortion care, prevention, detection and counselling for gender-based violence, prevent, detection and treatment of infertility and cervical cancer, and counselling and care for sexual health and wellbeing. The framework advocates that these services should be universally available, phased in over time to allow for the varying capacities of national health systems (Starrs, et al. 2018).

World Health Organization Global Guidance and Tools on Rights-Based Family Planning

Since the London Summit, in keeping with its mandate to develop global guidance and tools, WHO created several tools and guides to ensure that human rights are realized and protected through health policies and programs, including reproductive and sexual health.

In 2013, in advance of the ICPD Beyond 2014 Conference, a group of experts at WHO met to review evidence on rights and family planning. The outcome was the guidance document 'Ensuring Human Rights in the Provision of Contraceptive Information and Services', which fo-

cused on aspects of human rights that must underpin a rights-based approach to sexual and reproductive health programming, particularly contraceptive services and information. It incorporated data on health programming and internationally held and recognized human rights laws and treaties and complemented existing WHO recommendations on reproductive and sexual health programming. The document provides examples of how rights must be upheld through programming and highlights nine human rights principals which must be respected, protected and fulfilled in reproductive and sexual health programs: Non-discrimination, availability, accessibility, acceptability, quality, informed decision-making, privacy and confidentiality, participation and accountability.

In June 2014, WHO conducted a human-rights analysis of existing quantitative indicators in contraceptive programming (WHO 2014). In March 2015, WHO and UNFPA co-published the implementation guide 'Ensuring Human Rights within Contraceptive Service Delivery' for mid-level policymakers, program managers and implementers involved with sexual and reproductive health in various settings. It serves as a companion document to WHO's guidance on human rights and contraception. Bringing together the different perspectives and frameworks of the two key agencies, the guide integrated the nine human rights principles and standards in WHO guidance with those in UNFPA's Family Planning Strategy 2012-2020: Choices not Chance.

In 2017, the Department of Reproductive Health and Research at WHO co-authored a research study with the Program on Global Health and Human Rights at the Institute for Global Health at the University of Southern California in which they set out to develop and test a methodology to analyze the human rights sensitivity of standard indicators used in contraceptive programming. This project, undertaken exclusively to support organizations in using human rights to strengthen public health programming, reviewed an initial list of 208 quantitative and qualitative indicators. Further reviews, consultations with experts and key stakeholders led to a final list of 42 priority indicators (13 quantitative, 7 qualitative and 22 policy-level) (Gruskin, et al. 2017). These consultations also led to the understanding that a range of indicators is necessary to assess how contraceptive programs respect, protect and uphold human rights while also efficiently performing on indicators of public health.

WHO also created additional resources to support all aspects of RBFP programming. In 2017, WHO created a user-friendly checklist for primary health care providers directly involved in the provision of contraceptive information and services. This checklist was made to support WHO's existing resources, specifically - *Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations*, and the *Implementation Guide* co-published with UNFPA in 2015 (WHO 2017). It also published a tool for monitoring human rights in contraceptive services and programs (WHO 2017). This tool built on WHO's 2014 *Ensuring human rights within contraceptive programmes: A human rights analysis of existing quantitative indicators* and the 2015 *Ensuring human rights within contraceptive service delivery: Implementation guide* co-published with UNFPA (WHO 2014, UNFPA & WHO 2015). Finally, WHO has also been involved in gathering evidence to support its existing tools and guidance, and ongoing efforts to promote a voluntary, rights-based family planning framework. In 2017, WHO published an evidence brief entitled "Accelerating uptake of voluntary, rights-based family planning in developing countries" that synthesizes all these efforts (WHO 2017).

The 2030 Agenda for Sustainable Development

The 2030 Agenda and its 17 Sustainable Development Goals (SDGs) adopted by all Member States of the UN in September 2015, reaffirms the need for a broad, sustainable development agenda rooted in principles of social inclusion and equality and requires accountability for various components of women's empowerment across sectors, stakeholders, countries and the global community. Correcting the omission of the MDGs, the SDGs include sexual and reproductive health and reproductive rights, but notably not sexual rights. SDGs 3 on Good Health and Wellbeing and SDG 5 on Gender Equality both include explicit targets: SDG target 3.7 ensures "universal access to sexual and reproductive health care services, including services for family planning, information and education, and the integration of reproductive health services into national strategies and programs". SDG target 5.6 ensures "universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the POA of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences". Other goals, such as SDG 4 on Quality Education and SDG 10 on Reduced Inequalities, include relevant targets for reproductive and sexual health services. Additionally, all the goals include addressing gender inequality.

Recent Agreements on the Right to Safe Abortion

In 2018, the UN Human Rights Committee's¹⁵ General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life affirmed that safe legal and effective access to abortion is a human right protected under the International Covenant on Civil and Political Rights, including under the right to life; that preventable maternal morbidity and mortality constitute violations of the right to life; and that the right to life begins at birth (UNHRC 2018). Also in 2018, the Committee on Elimination of Discrimination against Women (CEDAW) and the Commission on the Rights of People with Disabilities (CRPD) released a joint statement, stating that safe, legal abortion is "a prerequisite for safeguarding their human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill treatment." It further calls on member states to decriminalize abortion in all circumstances and legalize it in a way that respects women's autonomy.¹⁶ While these are not binding documents, they are tools for stakeholders to help secure the full realization of girls' and women's rights.

¹⁵ The Human Rights Committee is the body of independent experts charged with monitoring countries' implementation of the International Covenant on Civil and Political Rights, and periodically issues general comments outlining the obligations of governments under specific articles of the Covenant. The comments also provide specific guidance on implementation to the 172 state parties to the treaty.

¹⁶ CEDAW is the body of 23 independent experts that monitors implementation of the Convention on the Elimination of All Forms of Discrimination against Women. The Committee on the Rights of Persons with Disabilities (CRPD) is the body of 18 independent experts that monitors implementation of the Convention on the Rights of Persons with Disabilities.

WHERE WE ARE TODAY: OPPORTUNITIES AND TENSIONS

The global community marked the 25th anniversary of the ICPD with a Summit, co-convened by UNFPA and the governments of Kenya and Denmark, in Nairobi. The ICPD25 Nairobi Summit was designed to reflect on the progress made since Cairo, the challenges that remain and the new issues that confront us.

At the Summit, nearly 10,000 delegates from 170 countries announced more than 1,200 commitments to further global sexual and reproductive health and rights. Delegates assessed progress, took stock of the unfinished business and made significant new political, financial, and programmatic commitments. While progress since Cairo was acknowledged, “unfinished business” to achieve zero unmet need for family planning, zero preventable maternal deaths, and zero GBV and harmful practices was highlighted in those commitments (UNFPA 2019). Governments, including Austria, Denmark, Finland, Germany, Iceland, Italy, the Netherlands, Norway, Sweden, the UK, and the European Commission, committed to about \$1 billion in new support and the private sector, including companies and foundations made commitments that will mobilize some \$8 billion in combined new pledges. The UN promised to incorporate Summit outcomes as a key component of the “Decade of Action” to deliver on the SDG, and hundreds of government and civil society commitments were made to advance sexual and reproductive health and rights (Jalan 2019).

Not surprisingly, there were efforts by some religious lobbies and 11 governments, including the US, to discount this reaffirmation of the Cairo consensus and progress made since then. Strategically, these efforts coopted the ICPD document, which while being a hard-won victory by progressive advocates, failed to include a global consensus on abortion and sexual rights (Smith 2019). However, it is natural, that 25 years since Cairo, there has been an evolution in the global discourse on sexual and reproductive health and rights, and Summit participants, sessions and commitments reflected that evolution. For example, there was more data shared on the need for accessible, safe and legal abortion and the health, social and economic costs of unsafe abortion. The representation of young people, people with disabilities, LGBTQIA+¹⁷ people, and indigenous communities was stronger. Progress in how the global community understands and addresses sexual and reproductive health and rights in a variety of settings, including in humanitarian crises was also reflected. It is this evolution and progress that should define the next 25 years.

The ICPD25 Nairobi Summit confirmed that today, the ICPD POA remains an inspired and relevant roadmap towards the realization of reproductive and sexual health and rights and women’s empowerment and provides a solid foundation for moving forward. The RBFP commitments, frameworks, principles, tools and approaches described in the previous section represent the growing technical expertise and commitment to actually implementing rights-based

¹⁷ The common abbreviation including Lesbian, Gay, Bisexual, Pansexual, Transgender, Genderqueer, Queer, Intersexed, Agender, Asexual, and Ally.

family planning. Additionally, in contrast to the decade required to build the global women's movement thirty years ago, rights movements benefit from a world made faster and smaller by the internet - social media, migration and travel, and immediate access to news and information. They are growing in strength, creativity, sophistication and diversity, drawing on a sense of urgency, commonalities, disillusionment with those in charge, and the strength of collective action. Local activism on global issues is immediately amplified, resulting in solidarity, growing strength and resources, and further action. We see synergies between those working towards racial, reproductive and environmental justice, youth leading environmental movements, young men supporting feminist movements, and sexual rights movements embracing the entire spectrum of gender and sexual identities.¹⁸

At the same time, the past 25 years have also handed advocates and implementers an endless parade of persistent political challenges and an unacceptably large population of girls and women still lack unfettered access to contraceptive technologies, choices and services and information about their bodies and sexuality. We also know that all contraceptive services are not truly voluntary. We have a greater understanding of the extent to which harmful gender norms persist and how much they impact reproductive and sexual health and rights. We also know that global agencies, governments and donors require evidence and targets to be able to develop policies, plan and implement programs and allocate resources.

Abortion remains a contentious component of the family planning agenda, rights-based or otherwise. It also remains a much-needed service in the continuum of reproductive and sexual health care. Medical and surgical abortions are safe and reliable when administered by skilled health care providers. However, laws and conditions which restrict access to abortion, whether imposed by governments or donors, result in girls and women seeking illegal and unsafe abortions, which can lead to complications and even death. Despite this evidence, with strengthened global religious and political resistance to abortion rights, the right to safe abortion remains a marginalized part of RBFP and is currently in jeopardy. The US Administration's enforcement of the Global Gag Rule under President Trump expanded and renamed it "Protecting Life in Global Health Assistance". This expansion reflects a pandering to the Administration's evangelical base and exerts a deeper punitive impact, encompassing not only family planning assistance but all U.S. global health assistance, including U.S. global HIV (under PEPFAR) and maternal and child health (MCH) assistance. The negative impacts of the policy on safe abortion rates, contraceptive use and the overall health of affected girls and women have been significant, as have the political impacts, with (previous) partner organizations unable to mobilize while also coping with shrinking civil society spaces (Rios 2019).

The policy is just one manifestation of the dangerous context in which we currently find ourselves, which is characterized by populism and fundamentalisms and patriarchal leaders and

¹⁸ In fact, "young activists, coping with the unraveling of religious, economic, government and planetary systems, seem inclined to organize around a single struggle for liberation, rejecting all the binaries, including woman/man, gay/straight and North/South, while the movement's legacy leaders, willingly and knowingly or not, and in a relentlessly embattled state, remain stubbornly ensconced in (occasionally) competitive and (always) under-funded silos" (Michelle Milford Morse, *Alignment and Ambition: Preparing for Beijing +25 and 2020*, United Nations Foundation, 2019).

Box 5: THE DANGEROUS IDEOLOGY OF POPULATIONISM

Populationism provides a useful framework to make sense of persistent efforts and contemporary approaches to controlling population that significantly impact rights (Bhatia, et al. 2019). It includes three components:

Demopopulationism: can be defined intervening in human populations to produce ‘optimal’ population size and composition. It has three interrelated components: the creation of population data that is used to maintain social hierarchies; continued attempts to suppress the fertility of some and enhance the fertility of others; and the promotion of self-disciplining subjects who regulate their own fertility to achieve particular economic and environmental goals. This component is closely aligned to traditional, Malthusian approaches in terms of the focus on numbers and fertility being the cause and solution to a range of global problems. In a 21st Century update, it promotes an ideal female subject as one who empowers herself, promotes economic development and reduces environmental degradation – all by controlling her fertility. The self-disciplining piece also resonates with some threads of activism on climate change that focus on the carbon footprint of each additional person born and promote the choice not to have children.

Geopopulationism: refers to direct and indirect strategies of population control through space making. This includes management of people and resources, surveillance and governance and control to include or exclude particular people from particular spaces through containment or forced displacement. Spaces are defined broadly and can include borders, conservation zones, and family planning clinics or even as geographies of destruction and recovery. This component captures some of the global dynamics around migration, natural and political crises, as well as environmental and climate change advocacy.

Biopopulationism: focuses on the ways in which people engage reproduction to live particular kinds of valued lives. Flipping traditional population policies that viewed people as the problem, this view offers people as potential contributors to the health and well-being of nation states through their roles as informed, judicious consumers and reproducers. Biopopulationist strategies emphasize desires, family composition and birthing ‘quality’ children, including selective reproduction to avoid disability and disease and choose valued traits. This new approach leverages the 21st century brand of personal empowerment to advance older insidious 20th century population imperatives.

forces undermining political, social and economic rights across the globe. The progress made on gender equality in official agreements and by grassroots movements has led to considerable backlash from these regressive forces that now hold seats of power in both the Global North and South.¹⁹ Individual rights and global agreements that protect and uphold human rights are in jeopardy. Action and momentum underlying other issues, climate change and universal health coverage, are creating openings that present both opportunities and tensions in the protection and realization of women’s rights. Feminist advocacy and research centered around the analysis of ‘populationism’²⁰ highlights the ways in which the global community is circling back to what are essentially contemporary versions of many of the issues that the global women’s movement was challenging 25 years ago. (Box 5).

¹⁹ Between 1990-2018, the number of populists in power increased by five times, from four to 20, and are now in leadership positions in both emerging and established democracies.

²⁰ Defined as ‘ideologies that attribute social and ecological ills to human numbers’ (Bhatia, et al. 2019).

Against the backdrop of these realities, family planning has the potential to serve as a critical facilitator of women's empowerment, or as a barrier to the realization of rights. There is a need for strategic partnerships and vigilance to ensure the former. We discuss five key opportunities and tensions to watch out for below.

Protecting Gains While Pushing for Progress

The ICPD POA was groundbreaking, putting women's reproductive and sexual health and rights at the center of development. However, it was not complete. In the past 25 years, we have seen both significant progress and compromises when it comes to women's rights and empowerment in family planning, health and development policies and programs. In the current global political context, we need to take stock of the gains we have made and carefully defend them. However, this is not enough.

Continued abuses and neglect, many of which are documented,²¹ demand that we do better to proactively protect the rights of girls and women. These may manifest as policies that explicitly or implicitly restrict reproductive choices, oppressive experiences in family planning and other services, and a lack of real choice, whether amongst a range of contraceptive methods or the ability to freely make informed decisions (Jain and Hardee 2018). Additionally, at the peril of our quantitative targets, we need to be ready to accept and support women who choose not to use contraception or choose to have children.

In addition, while it is strategic and important to meet the unmet need of women who want to use contraception but are unable to do so, to truly advance rights, we also need to ensure that those who are currently excluded from services, such as unmarried women and adolescent girls, as well as those who are socially marginalized and do not have access to the information or services they need to even express unmet need, are also reached.

Finally, abortion and sexual rights remain marginalized on the global reproductive and sexual health and rights agenda, often ending up on the chopping block of negotiations to advance broad consensus. The result is that efforts aimed at both women's empowerment and RBFP both lose critical components, resources, inputs and advocacy, as well as opportunities to ensure safe and high-quality services and converge essential complementary services. Notably, in Nairobi, advocates released a Global Declaration on Abortion, signed by more than 350 organizations, calling for stakeholders to make abortion safe, legal, available, accessible and affordable; to ensure that UHC integrates an essential package of reproductive and sexual health information and services, including abortion; and to promote gender equality and women's and girls' autonomy through interventions that change harmful social and gender norms and stereotypes on sexuality, pregnancy and abortion.²²

Ironically, today, much of the push-back against reproductive and sexual rights and rights-based approaches comes through the strategic misuse of the language of rights. For example, 'popu-

²¹ See Mohanty and Bhalla 2016 and Senderowitz 1995.

²² Global Declaration on Abortion, <https://www.ipas.org/news/2019/November/global-declaration-on-abortion>.

lution activists’ and anti-abortion activists who seek to restrict the reproductive rights of women claim to protect the rights of children, born and ‘unborn’; anti-abortion activists who claim to protect the rights of women and children of color as well as the religious rights of those opposed to sexual rights, non-binary gender identification and abortion; and populist approaches by majority groups in power who use a framework of victimhood to claim to protect the rights of a so-called under-siege majority (Ali 2019). This cooption of the language of rights is a cynical strategy that is undermining real conversations about how to advance the realization of rights through global policy and programs.

Learning from the transformative advocacy leading up to Cairo and the assessment of progress and gaps in Nairobi, movements need to come together to push the boundaries of how rights are made explicit, realized and protected in global policies and programs.²³

People as Numbers: Pragmatic and Potentially Dangerous

Almost a decade ago, the London Summit and FP2020 put a much-needed spotlight back on family planning. In line with the realities of donor-driven and national development, FP2020 developed quantitative targets by which to measure progress, capturing those women whose need for family planning is not being met, or ‘unmet need’. While pragmatic and measurable, quantitative targets – even within an initiative with rights-based principles – could lead to a neglect of safeguards to avoid both explicit and implicit abuses and alternative rights-based targets, particularly when women choose not to use contraception. Notably, ‘unmet need for family planning’ is not self-defined by women as a direct expression of need, but rather is based on the discrepancy between future childbearing wishes and contraceptive use (Family Planning (Core) n.d.) It is defined as the percentage of women who want to stop or delay childbearing but who are not currently using any method of contraception to prevent pregnancy (Cahill, et al. 2018). Furthermore, it is measured as ‘unmet need for modern methods’ (Cahill, et al. 2018), not allowing for the full continuum of sexual and reproductive behaviors, including sexual abstinence, infrequent sex and traditional methods of contraception (Family Planning (Core) n.d.).

More broadly, movements that identify as both progressive and conservative have resurrected and rebranded Malthusian arguments focused on numbers about the dangers of population growth as a cause of global problems, such as climate change and migration, which could result in a refocus on population control as a solution (Box 6 and 7).

The New Battleground: Universal Health Coverage

Global commitments under the SDGs on universal health coverage (UHC) are a welcome acknowledgement of the need for affordable access to health care for all and provide a critical platform through which to advance sexual and reproductive health and rights. WHO specifies that essential health services, including for HIV, tuberculosis, malaria, non-communicable dis-

²³ The Lancet Commission – Accelerate progress – sexual and reproductive health and rights for all: Report of the Guttmacher-Lancet Commission offers an integrated definition of sexual and reproductive health and rights, which consolidates existing agreements, WHO documents and human rights treaties and principles and then goes further to include critical issues related to rights, such as violence, stigma and bodily autonomy (Starrs, et al. 2018).

Box 6: (SOME) PEOPLE VS. THE PLANET: APPROACHES TO CLIMATE (IN)JUSTICE

Reflecting early advocacy on population and the environment, growing advocacy around climate change focuses on the links between climate change and environmental issues, population growth, health, depleted natural resources, and who controls and uses resources. While many climate scientists focus on the threats of climate change to human health and wellbeing, there are those who focus on population growth – and particularly Southern women's fertility – as a major threat. However, while lower-income countries have higher population growth than higher-income countries (some of which now have negative growth), they also contribute the least to carbon emissions and are most impacted by climate change. Many self-defined 'population activists' are careful to avoid language on 'population control' and coopt language on child rights and women's empowerment, and they distance themselves from extreme policies such as China's 1979-2016 One-Child Policy. At the same time, they engage in scare tactics and what they call the science of 'population engineering' which focuses on the carbon footprint created by each child that is born, which they claim undermines gains achieved by lifestyle changes, such as vegan diets, recycling, simpler living, and electric cars.²⁴ The danger of Northern activists focusing on Southern birth rates is all too familiar and vigilance is required to navigate the complexities of climate change and action in a way that both protects individual human rights and allows for the structural factors that impact production and reproduction.

The Thriving Together Campaign, led by the Margaret Pyke Trust, represents a more constructive consensus on family planning and environmental conservation. Over 150 diverse organizations, including FP2020, working in family planning, development, conservation and other issues, signed onto a statement recognizing that "People and nature are interdependent, and health underpins both. Human communities and ecosystems best support each other when the needs of each are met in tandem". They highlight that when conservation and reproductive health organizations join forces to combine activities, project data indicates that this has led to both increased family planning use, improved health and gender relations, and increased support for and participation in conservation and that these multisectoral approaches can be cost-effective and generate sustainable results (Thriving Together 2019). Additionally, women's grassroots organizations around the world, including rural women's organizations in the Global South and women of color organizations in the US, often find themselves addressing both women's reproductive and environmental justice, due to the interconnected nature of the issues and the fact that women, particularly poor women and women of color, are disproportionately impacted by both (Sasser 2018, Global Fund for Women and the Global Health and Gender Justice and Governance programme, Columbia University 2019). With a focus on both reproductive and environmental justice, these efforts are putting rights at the center of both agendas.

²⁴ For example, gatherings such as the 2019 Tackling the Population Taboo conference at George Washington University in Washington DC, USA (<https://sustainability.gwu.edu/tackling-population-taboo-creating-sustainable-future-children>).

Box 7: THE RIGHT TO BELONG: MIGRATION AND REPRODUCTIVE AND SEXUAL HEALTH AND RIGHTS

While the ICPD POA identified migration as an issue that would require greater attention, it did not predict the dramatic increase in displaced and refugee populations over the past few decades and the demographic backlash it has garnered. Populist governments and political parties have leveraged domestic racial and religious anxieties to mobilize support against migration and control the movement of particular groups of people. In the North, these anxieties are exacerbated by falling population rates among white, Christian populations. Instead of common-sense immigration policies that take into account the geopolitics of immigration, the relationships between former colonies and colonizers, the role of Northern governments in facilitating many of the conditions through which people have to migrate, international human rights conventions, and the labor, intellectual and cultural contributions of migrants, cultural populism emphasizes an us versus them nativist mentality, focused on the idea that large numbers of migrants are ‘taking over’ and majority communities are losing ground, and the need for restrictive and discriminatory immigration policies. The results of this kind of population control has been devastating for the protection and realization of a range of rights – political and civil and socioeconomic - of both immigrants and those who support fair and inclusive immigration policies, (UNOHCHR 2019)²⁵ with particular consequences for the sexual and reproductive health and rights (SRHR) of girls and women.

Since Cairo, there has been significant progress in global understanding and experience of providing critical reproductive and sexual health services, including family planning, to displaced populations. The Inter-Agency Working Group on Reproductive Health in Crises (IAWG), a coalition of over 20 Steering Committee member agencies, representing UN, government, non-governmental, research, and donor organization, and over 2,100 individual members from 450 agencies was formed in 1995. IAWG represents a global commitment to expanding and strengthening access to quality sexual and reproductive health services for people affected by conflict and natural disasters. (IAWG 2019) This commitment was reaffirmed at the ICPD25 Nairobi Summit. where “Upholding the right to sexual and reproductive health care even in humanitarian and fragile contexts” was one of five Summit themes. Additionally, in response to regressive immigration policies, immigrant advocacy groups in the North, such as Tahirih Justice Center, are highlighting the links between migration crises and violence against girls and women in their countries of origin, during migration, and in their new locations, and offering critical services to protect their rights and wellbeing (Tahirih Justice Center 2019).

However, these necessary responses are not enough. There is a need for sustained pressure to advance progressive immigration policies at the global and national levels that recognize the global inequalities and geopolitical factors driving migration and protracted crises and focus on protecting the rights of migrants.

²⁵ Joint open letter on concerns about the global increase in hate speech, <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25036&LangID=E>.

eases and mental health, sexual and reproductive health and child health should be available to all who need them. It is important to note that the global commitments focus on health coverage to facilitate access to care, not commitments to actually provide care. WHO acknowledges that not all countries can afford to provide all services and the goal should be to progressively increase the number of services available. Without an explicit commitment to reaching the most vulnerable, protecting rights, and ensuring that coverage includes the full range of services related to sexual and reproductive health and rights specified in the ICPD POA (each ambitious in its own right), there is a danger that the global move toward UHC could actually marginalize sexual and reproductive health and rights, particularly in countries where there is already resistance to them. This could be a highly consequential lost opportunity. At worst, as the tensions in the proceedings at the United Nations General Assembly in September 2019 and at the ICPD25 Summit in Nairobi indicate, UHC could be the new battleground in which the gains of the POA are unraveled.

The first Political Declaration of the High-level Meeting on Universal Health Coverage at the UN General Assembly in September 2019 affirmed the need to ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Cairo and Beijing agreements and their review conferences, including family planning, information and education, and the integration of reproductive health in national strategies and programs. Although abortion is not mentioned explicitly, the declaration recognized that the human rights of women include their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence, as a contribution to the achievement of gender equality, the empowerment of women and the realization of their human rights (WHO 2019). This commitment was echoed at the ICPD25 Summit. “Universal access to sexual and reproductive health and rights as a part of UHC” was one of five themes at the Summit, as was “Financing required to complete the ICPD Programme of Action, and to sustain the gains made” (UNFPA 2019, UNFPA 2019).

However, the Political Declaration and subsequent commitments in Nairobi faced serious opposition. While in the past, opposition came from regressive forces that were seen as fringe threats, increasingly opposition is being voiced by influential or formerly moderate governments such as the US, Russia and Brazil. Rather than being explicit about their agenda to restrict women's rights, they claim the basis for their opposition to reproductive and sexual health and rights are threats to culture, tradition, religion and national sovereignty. This has strengthened the bloc of nations opposed to sexual and reproductive health and rights and women's empowerment and could undermine the gains made in and since Cairo (Sardana 2019).

An additional concern related to UHC is that governments in both the North and the South are increasingly turning to the private sector to fill gaps in services, providing subsidies to private service providers but not always putting in place the necessary accountability mechanisms to ensure that rights-based commitments, not market forces, ensure access to and drive the provision of services. This has particular consequences for SRHR since “biomedical markets and other non-state actors have emerged as the providers of contraception and sterilization with the professed mission to help meet the needs and desires of rights-bearing individuals” (Bhatia, et al. 2019). However, despite these risks and keeping in mind that the private sector is driven primarily by profit, the sector can potentially provide important innovations and efficiencies to the UHC process that are not always found in the public sector.

New Technologies, Old Pitfalls

The opportunities and dangers posed by contraceptive technologies in previous decades continue to play out in the current context. There is a need to leverage the possibilities that new contraceptive and reproductive technologies offer for women's empowerment, while remaining vigilant and ensuring that the rights of all women are protected.

Innovations in contraceptive, reproductive and abortion technologies now offer even more choice and privacy to women and in fact are promoted with the language of rights, choice and empowerment. However, the continued focus on numerical targets by donors and international agencies, and the use of incentives by some governments mean that women's choices and rights could be compromised due to neglect, oversight, coercion or abuse. Additionally, with the shift of responsibility and cost to individual women, without the safety net of health services, counseling and support, there are risks that women cannot safely assess their contraceptive needs and, if desired, change methods. Mobile or commercial distribution of self-administered methods, and lack of back-up services to remove or change devices or methods are an increasing risk of the dual trends towards increased privacy for clients and privatization of supply chains and services. Additionally, new fertility technologies have created new unregulated reproductive markets with considerable risks to the rights and agency of economically and socially vulnerable women (Goodwin 2012) and less accountability to manage those risks.

Male contraceptive technology has gained more traction recently, with new products being explored. These include a reversible polymer gel injected into the sperm duct that blocks sperm while allowing the rest of the fluid ejaculate through. It is being tested under the name Vasalgel in the United States and is similar to Reversible Inhibition of Sperm Under Guidance (RISUG), being tested in India (Robinson 2015, Extance 2016, Sifferlin 2018). Another product being developed in the UK prevents the muscles in the sperm duct from contracting, engineering a sort of 'dry orgasm' (Robinson 2015). The Population Council has developed a topical contraceptive gel which is already approved and marketed in gel form in the United States.²⁶ Other drugs are being developed in other countries including an implant, an herb-based drug, a genetic drug and varieties of the hormonal pill. However, the continued focus on women, the lack of funds, lack of interest from pharmaceutical companies, and an uncertain regulatory environment continue to pose challenges to the development of male contraceptive methods (Robinson 2015).

'New' contraceptive technologies for women are essentially next-generation versions of older technologies. These versions are improved in many ways. There are now birth control pills with less estrogen and fewer side effects. Many women prefer the implant Jadelle, the next generation of Norplant, because of easier insertion and removal procedures, the possible shorter use life, and the fact that the implants are less visible (Brache, et al. 2006). However, delivery systems must listen to women and be careful not to repeat the abuses of the past. Activists have highlighted the similarities between issues related to Jadelle and the self-administered

²⁶ For more information see: The Population Council, Nestorone®/Testosterone Transdermal Gel for Male Contraception, <https://www.popcouncil.org/research/nestorone-testosterone-transdermal-gel-for-male-contraception>.

injectable Sayana Press, the next generation of Depo Provera, to earlier versions, and how they “reinforce unequal geographies in which the Global North serves as a space of technological innovation and policy-making, and the poorest countries in the Global South, including many in Africa, serve as the laboratory for clinical trials, interventions in fertility, and capital extraction (Bendix, et al. 2019, The Center for Health, Ethics and Social Policy and The Center for Biotechnology and Global Health Policy, University of California at Irvine, and PSI 2019).”

Without an explicit commitment to reproductive rights, new technologies do not translate into greater reproductive choices for women. For example, according to a study by the Population Foundation of India, 85 percent of India's family planning budget for 2013-14 was spent on promoting and conducting female sterilization. Only 1.5 percent was spent on other forms of contraception! Health care workers at all levels receive cash incentives for promoting and carrying out sterilizations and patients also receive compensation. In addition to this blatant lack of reproductive choice, the risks of both abuse and complications from sterilization continued to be exacerbated by conditions in poor quality health care facilities and mass sterilization camps in India. A 2016 judgement by the Supreme Court of India ordered an end to sterilization camps in the country, citing evidence that over 360 women had died between 2010 and 2013 during or after surgery in camps due to unhygienic conditions, dirty medical instruments and equipment and an overall lack of care for women (Mohanty and Bhalla 2016).

Access to the full range of contraceptive methods is critical as a core component of women's health care. As the evidence indicates, there are socio-economic benefits to family planning and women's economic options increase with access to contraception. There are also environmental and other benefits related to relieving pressures on community resources. However, linking policy solutions for broader issues such as poverty alleviation and environmental degradation to the delivery of contraception continues to result in a focus on long-acting contraceptive methods and systemic abuses of reproductive rights. Within the US, for example, politicians have argued for expanded access to birth control as a tool to prevent the public costs of single-parenthood (Dehlendorf and Holt 2019) and conservative analysts have assessed the cost-benefits of long-acting contraceptive methods (Sheffield 2014) versus barrier methods. These approaches distract from the structural factors such as the availability of social benefits and services, the distribution of resources, and racial and other discrimination that perpetuate socioeconomic inequalities and determine access to opportunity.

Finally, there are continued tensions related to the need for dual protection to prevent pregnancy and sexually transmitted infections (STIs), including HIV. The most effective contraceptives are hormonal and do not offer protection against STIs.²⁷ Efforts continue to develop microbicides. The International Partnership for Microbicides was formed to develop HIV prevention products and other sexual and reproductive health technologies for women, and to make them

²⁷ The emphasis on hormonal contraceptives parallels the focus on clinical solutions to HIV/AIDS. More investments are being directed towards pre-exposure prophylaxis or PrEP and treatment, rather than a focus on socio-economic risks and prevention. While the clinical solutions are much needed and indeed lifesaving, there is a need to address and change the socio-economic risks that are facilitating the spread of HIV among girls and women.

available and accessible where they are urgently needed.²⁸ The Global Campaign for Microbicides (GCM) was formed by former WHAM members in July 1998 with funding from UNAIDS to advocate for the critical need for new HIV prevention options, especially for women globally (Global Campaign for Microbicides n.d.). WHO reports that “Researchers have developed a mathematical model that shows that if even a small proportion of women in lower income countries used a 60% effective microbicide in half the sexual encounters where condoms are not used, 2.5 million HIV infections could be averted over 3 years” (WHO 2019). However, while there are about 30 microbicide products being developed and tested, a safe and licensed form is still not available (Naswa, Marfatia and Prasad 2012, WHO 2019).

Tensions around dual protection recently came to the fore in the Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial. Led by WHO, the Wits Reproductive Health and HIV Institute in South Africa, the University of Washington and FHI 360, the ECHO trial was prompted by observational data implying a greater HIV acquisition risk among women who use the injectable hormonal contraceptive depot-medroxyprogesterone acetate (DMPA-IM) or Depo Provera, which is the most common birth control method available in sub-Saharan Africa. The 2015–2018 trial enrolled almost 8,000 women in four countries in East and Southern Africa, randomly assigning them to receive either Depo Provera, a copper IUD or a hormonal contraceptive implant. At the end of the study, researchers concluded that the women who received Depo Provera were not significantly more likely to acquire HIV than the women who received the other two methods. However, the trial and the results were not without controversy. Critics argued that ECHO violated medical ethics guidelines set out by the Helsinki declaration of 1964 and that the results should not be used to perpetuate near-exclusive use of Depo Provera in Africa, where the method was used in a forced contraception program in apartheid South Africa (FP2020 2019).

The Critical Political Role of Women’s Movements

A key and enduring takeaway from Cairo was that women organizing across borders, issues and communities, with the coordinated support of progressive donors, can make significant policy change happen. Women’s movements have skillfully uncovered the high political stakes and interests underpinning global negotiations by governments and other lobbies that significantly impact the bodies and lives of girls and women. Combining this political acumen with strategic coalition building and lobbying, and supported by adequate funding, the global women’s movement effectively changed the global narrative on population and development.

However, in the two and a half decades since Cairo, much of the funding that women’s organizations and networks received to strengthen their ability to mobilize and participate in global platforms significantly declined. While some women’s organizations continue to influence the agenda, they do so without adequate resources. When resources were made available, they were directed to program interventions rather than advocacy. In most cases, those resources went to technical organizations who lacked the capacity to design, implement, monitor and

²⁸ For more information, see: International Partnership for Microbicides, <https://www.ipmglobal.org/>.

evaluate programs with a feminist perspective, discounting the deeply political nature of the work they do. Funding that bridges the two and creates equal partnerships between technical and women's organizations, who bring critical political acumen and a clear focus on rights to the table, would foster consistency and could go a long way toward ensuring the ICPD POA is implemented in the rights-based spirit in which it was envisioned.

With the advent of social media, grassroots women's movements are able to fuel and inform national and global action, making social movements increasingly inclusive and continuing to provide roadmaps for how to engage diverse constituencies around complex questions related to rights. This was evident at the ICPD25 Nairobi Summit, where coalitions of diverse organizations, both from the grassroots and from global advocacy platforms, facilitated sessions on challenging issues related to laws and policies, service delivery and rights. For example, a session on Sexual and Reproductive Health and Rights and Women with Disabilities: Bringing Two Movements described efforts to bring together representatives from both movements and explored how advocacy on sexual and reproductive health and rights can be more inclusive of women with disabilities. This included an unblinking assessment of how women with disabilities have been excluded from advocacy on sexual and reproductive health and rights and how histories of reproductive rights abuses inform their perspectives (CREA, Kenyan Women with Disabilities Network and Women with Disabilities India Network 2019). These are the kinds of conversations that need to happen across and within women's movements to ensure that complex issues such as diversity and inclusion, religious views, climate change, migration and other critical issues that impact reproductive and sexual health and rights are addressed through movements and agendas defined by women and not coopted by those who wish to restrict reproductive and sexual rights and roll back progress.

THE WAY FORWARD

Twenty-five years after Cairo, the ICPD POA remains a relevant roadmap towards the realization of reproductive and sexual health, reproductive rights and women's empowerment and provides a solid foundation for moving forward. At the same time, there is a need to acknowledge and work towards a more inclusive and progressive rights-based agenda that builds on the frameworks and work that has been done since Cairo. We are at a critical moment in history to assess progress and to plan for a future in which women's rights, dignity and empowerment remain at the center of development and family planning.

Family planning retains its high potential as a critical pathway in the realization of women's rights and empowerment, especially if the family planning community continues to push for progress, while avoiding the traps and mistakes that have engendered skepticism and slowed progress – from coercion to the instrumentalizing of women as pawns in addressing demographic, political, environmental and cultural anxieties.

Between these poles is a rich history and track record that should infuse and inspire the path ahead. To capitalize on this moment, we must learn from the past and ask ourselves: What worked? What did not? Where did we progress? Where have we continued to let down girls

and women? Where have we actually endangered them? Where were our most effective investments? Our most disappointing? Where are the openings for continued progress? Where are the barriers? And ... what do we need to do next?

We offer the following three recommendations:

1. **Fully commit to reproductive and sexual rights:** We are now at a critical moment of opportunity to protect progress on RBFP. The ICPD provided a roadmap, albeit with key compromises, and put rights at the center of development. The London Summit revived the focus on family planning within a rights framework, and key agencies such as WHO and UNFPA have affirmed rights-based approaches and created practical tools for implementation. The Nairobi Summit reaffirmed this progress and challenged the global community to move beyond the compromises of Cairo to fully commit to reproductive and sexual rights. We need to recognize the costs of the compromises to date. What has been politically expedient has undermined our effort to fully implement programs and services that facilitate the realization of rights. The time has come to recognize the right to safe and legal abortion an integral part of RBFP. Additionally, we need to learn from growing movements led by young people to define and advance a practical agenda on sexual rights. These are not easy challenges and they will require a convergence of evidence, movement and consensus building and political will from across sectors. The good news is that we know it can be done, as it was in Cairo.
2. **Implement and strengthen RBFP:** Resisting regressive push-back requires strong evidence – proof that the challenges can be met and RBFP can be done. Due to the considerable work of movements, partnerships and technical institutions we now have global agreements, a considerable body of technical knowledge, comprehensive frameworks and practical tools to implement RBFP. We do not need to create more tools. We need to use and learn from the tools we have to implement RBFP, demonstrate how it can be done effectively and through that, build broader support for implementation.
3. **Support and engage women’s organizations and movements:** Over the past five decades, women’s movements have demonstrated their ability to serve as experts in advancing rights in various sectors and contexts and as bulwarks, holding the line to keep the political tide moving in the ‘rights’ direction (pun intended). The issues we seek to address are complex and require skillful alliance building across diverse interests, principled parameters and evidence rooted in the realities of girls and women’s lives, and political acumen to hold stakeholders accountable. Women’s organizations have been demonstrating their ability to bring all these to the table, beginning in the Women’s Decade, and at and since Cairo. Work on RBFP must therefore engage women’s organizations and movements at the local, national and global levels in order to remain relevant and credible. Additionally, to continue to effectively do this work and leverage growing diverse social movements, in the face of current political challenges, women’s organizations and movements require both flexible financial support and political support.

Given the history and analysis outlined above, we need to accept that advancing RBFP is political, as much (if not more so) as it is technical. Technical solutions are necessary to advance

rights, but they are not sufficient. Understanding the different interests at play over the decades – global, national, political, religious, cultural and corporate – clarifies how much is at stake and how women's fertility and bodies can become instruments in achieving the goals of these different political lobbies. The waves of political resistance to the realization of rights for all is another reminder of what we are up against.

The full achievement of rights by women – reproductive or otherwise – therefore requires a political commitment to structural and systemic change to dismantle the norms and systems that perpetuate power imbalances and inequality. Efforts that focus on individual empowerment or liberties without addressing structural inequalities will ultimately fail at creating sustainable social change (Girard 2019). Structural change may seem ambitious but it is critical, and effective political challenges to systemic inequalities can only be brought about when demanded by those most affected by them.²⁹ Additionally, any efforts to support structural change must be informed by those voices and those demands. Women's movements, both at the grassroots and at the global levels, have long recognized the power of mobilizing to advance broader structural changes because they understand the connection between the achievement of personal rights and the need for broad structural changes and have advanced an intersectional agenda that recognizes the need to address those systems that perpetuate inequality based on sex, race, class, caste, ability and other social markers.³⁰ Therefore, of all the three recommendations mentioned above, the third one is most important to get this right. We must nurture and support women's organizations and movements to do this work. If we do get this right, there will be benefits across all sectors of development, including family planning, human rights, health, climate justice, gender equality and women's empowerment, and we will in fact deliver on the promise of Cairo.

²⁹ While news cycles have focused on the rise of populism globally, there is also a recognition of unrest around the world (the 2010s were dubbed 'a decade of protest' by The Guardian), as popular movements across the globe spoke up in protest of a range of injustices, including wealth inequality, unemployment, sexism, racism, environmental degradation, corporate greed, violence against girls and women and other issues. These movements successfully shaped global discussions, impacted policy decisions and reshaped political systems and parties. For more details see Safi 2019 and Younge 2019.

³⁰ This has been recently demonstrated in the past two years. For example, women's movements and protests in India have effectively organized around issues such as citizenship, criminal justice, violence against girls and women and workers' rights, while highlighting inequalities based on sex, religion, caste and class. Similarly, the U.S.-initiated Women's March movement successfully mobilizes women around a range of issues, including reproductive justice, climate justice, criminal justice and constitutional issues, while highlighting the impact of racism, homophobia, xenophobia, ableism and other forms of discrimination. For more information see: <https://womensmarch.com/home2020>.

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APPENDIX 1:

Key Moments: Rights-based Family Planning and Women's Empowerment Timeline, 1950s - 2020

1950s: A Northern Focus

1952

John D. Rockefeller **Conference on Population Problems**, in Williamsburg, Va. focused on food supply, industrial development, depletion of natural resources, and political instability resulting from unchecked population growth.

Population Council, founded with a focus on both individual decision-making and demographic trends.

1952

International Planned Parenthood Federation established

"I dream of the day when every newborn child is welcome, when men and women are equal, when sexuality is an expression of intimacy, joy, and tenderness." IPPF Co-Founder Ottesen-Jensen

"Margaret Sanger had some beliefs, practices, and associations that we acknowledge, denounce, and work to rectify today." Planned Parenthood Federation of America on Sanger's racism and ableism

1959

Eisenhower forms **Draper's committee** on development assistance.

"Problems connected with world population growth will be among the most serious to be faced by the younger generation of today."

1960s: Public Health Gains, Demographic Concerns

1960

First oral contraceptive approved by the FDA

1967

Kingsley Davis, **Population Policy: Will Current Programs Succeed?** proposes programs that include incentives (food, cash, household items, housing/lending preferences)

1968

Tehran International Conference on Human Rights affirms basic right of parents to determine freely and responsibly the number and spacing of their children

The Population Bomb

Paul Ehrlich: *"Whatever your cause, it's a lost cause without population control"*

1969

USAID established, with influence from Draper's committee, with provisions of FP information and services

1970s: Global Dialogue, National Policies

1971

UNFPA designated lead UN body on population programs

1972

Limits to Growth report (Club of Rome/MIT) on concerns on population growth, food production, industrialization, pollution, consumption of non-renewable natural resources

1974

Bucharest World Population Conference

"Development is the best contraceptive" – K. Singh, Indian MoHFP

Unemployment and poverty not due to overpopulation, but to imperialist exploitation – H. Shu-tse, Chinese delegate

"...If we are to have progress in achieving population goals, women increasingly must have greater freedom of choice in determining their roles in society" – J.D. Rockefeller

1975

Mexico City Women's Conference

Decade for Women positions women as active participants – not recipients – of development policies and investments

1975

India state of emergency (until 1977) with forced mass-sterilization of men spearheaded by Sanjay Gandhi, the Prime Minister's son

1979

China's One-Child Policy (in place until 2015)

1980s: Spotlight on Agency and Rights

1980

2nd International Women's Conference in Copenhagen: Focus on women's ability to exercise rights

Kenya's fertility rate is the highest in the world at 8%

1984

Mexico International Population Conference (Mexico City policy/Gag Rule) 1984

1985

3rd International Women's Conference in Nairobi: All issues are women's issues

1987

Safe Motherhood Initiative launched

Act Up founded

1990s: Global Advocacy Informed by Women's Movements

1992

Rio Earth Summit

Population growth in the South vs. consumption in the North debate. Climate change on the agenda

1993

Vienna Human Rights Conference

The human rights of women and of the girl-child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community.

1994

International Conference on Population and Development (ICPD)

Broad focus on reproductive and sexual health and rights and social and economic empowerment

1995

Beijing Women's Conference

Women's rights are human rights

1995

First UN Climate Change Conference in Berlin.

Led to annual Conference of Parties (COP)

2000s: Implementation and Progress

2000

The Bill & Melinda Gates Foundation (BMGF) formed
Millennium Development Goals (MDGs) adopted. No target on reproductive and sexual health. A goal on 'Improving maternal health'

2005

UN Secretary General commissions a review of progress towards the MDGs which reveals lack of progress on maternal and reproductive health outcomes

Universal access to sexual and reproductive health added as a target under MDG maternal health goal

2010s: The Stakes are High



