

Abstract

A decade after Cairo there remains a serious gap between the fields of reproductive health and reproductive rights. This article draws on findings of a multi-year project that brought together experts from around the world from both fields to analyze case studies in the areas of maternal mortality, access to care, trafficking, gender-based violence, internally displaced persons, and sexual orientation. Based on these analyses as well as outside sources, this article makes explicit some of the key premises and strategies in each field and examines some of the possibilities as well as challenges for bringing the two together. It then takes up issues relating to underlying philosophies, goals and outlooks, strategies and roles, and methods—exploring each for divergences and convergences, as well as for conflicts within each field.

Dix ans après la conférence du Caire, il existe toujours un sérieux décalage entre le domaine des droits de la reproduction et celui des droits à la santé génésique. Cet article part des découvertes d'un projet plurianuel qui a rassemblé des experts des deux domaines, venus du monde entier, pour analyser des études de cas concernant la mortalité maternelle, l'accès aux soins, les commerces illicites, la violence envers les femmes, les personnes déplacées au sein de leur pays et l'orientation sexuelle. En se basant sur ces analyses, aussi bien que sur des sources extérieures, cet article explique clairement certaines des clauses liminaires et des stratégies les plus importantes dans chaque domaine et examine certaines des possibilités aussi bien que les difficultés rencontrées pour les faire coïncider. Cet article expose des problèmes liés aux philosophies sous-jacentes, aux objectifs et perspectives, aux stratégies et rôles et aux méthodes – en s'attardant sur les divergences et les convergences de chaque question, aussi bien que sur les conflits au sein de chaque domaine.

Una década después de Cairo, sigue existiendo una brecha grave entre los campos de salud sobre la reproducción y los derechos sobre la reproducción. Este artículo se basa en conclusiones de un proyecto llevado a cabo a lo largo de varios años que reunió a expertos de ambos campos alrededor del mundo para analizar estudios de casos en las áreas de mortalidad materna, acceso a la atención, tráfico, violencia basada en el género, personas desplazadas internamente y orientación sexual. Con base en esos análisis, así como en fuentes externas, este artículo aclara algunas de las premisas y estrategias clave en cada campo y examina algunas de las posibilidades, así como desafíos, para la unión de ambos campos. Este artículo aborda temas subyacentes relativos a filosofías, objetivos y perspectivas, estrategias y papeles, y métodos, explorando cada uno en busca de divergencias y convergencias, así como conflictos dentro de cada campo.

PROMISING BUT ELUSIVE
ENGAGEMENTS:
Combining Human Rights and Public
Health to Promote Women's Well-Being¹

Alicia Ely Yamin

The 1994 International Conference on Population and Development (Cairo, 1994) was widely hailed as having established a new paradigm.² It was in Cairo that we saw confirmed the potential of a human rights approach to transform our understanding of reproductive and sexual health as products of social—gender, race, class—relations, as much as of biological or behavioral factors.³ Such a momentous shift in conception requires dismantling the institutions, laws, and policies that prevent diverse women (and men) from exercising agency over their bodies and lives and participating fully in their communities and societies. It also requires dismantling deeply entrenched thought structures.⁴

More than 10 years later, we continue to struggle to clarify the meaning of the language that emerged from Cairo and the linkages between the fields of reproductive health and human rights. In addition to now facing the need to (re) defend the validity of the very concept of reproductive and sexual rights, a decade after Cairo there remains a serious gap between the two fields.⁵ To some extent, the two fields have adopted the same language even as terms continue to have very different meanings; to some extent, reproductive rights advocates have struggled with the limitations of the larger field of human rights just as reproductive health ad-

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vocates have struggled within the larger field of public health. Perhaps the most obvious indicator of the elusiveness of the promises held out in Cairo is that, too often, conventional population and health policies and programs continue to reflect and reproduce traditional gender and family relations and constructions of sexuality, rather than transform them.⁶ There are multiple ways to attempt to bridge the gap between the two fields as well as to describe the complex interactions between them, including guides and manuals, literature reviews, collections of best practices, and various forms of dialogues.⁷ This article draws on findings of a multi-year project that brought together 12 experts from around the world from both fields to analyze 6 case studies in the areas of maternal mortality, access to care, trafficking, gender-based violence, internally displaced persons (IDPs), and sexual orientation.⁸ Informed by their broader knowledge of the state of the field, these authors applied human rights and public health approaches to concrete situations.⁹ In turn, based on this collection of analyses as well as outside sources, this article makes explicit some of the key premises and strategies in each field and examines some of the possibilities as well as challenges for bringing the two together. This methodology implies a necessary subjectiveness—both because 12 experts cannot claim to be representative of all aspects of the two fields and also because the conclusions drawn regarding the interactions are entirely personal and do not necessarily reflect the views of the experts involved.

From among the wide array of issues that emerged in this project, this article considers four issues of intersection, overlap, and divergence. First, it looks at the Liberal and utilitarian philosophies that underlie human rights and public health, respectively, as well as the ways in which reproductive health and rights have evolved together. Nevertheless, influences of the larger fields linger in their frames of reference as well as their understandings of key concepts. Second, it examines how advocates in reproductive health and human rights have begun to move beyond the distinct goals of services and accountability, respectively, to a shared understanding of the importance of legal and policy frameworks, and health programming. Third, the

article focuses on the relationship that nongovernmental organizations (NGOs) maintain with the state, examining tensions that can exist with the traditional dissident position of rights-oriented NGOs, but also exploring potential impacts on health services provision when rights advocates align themselves with the state. Fourth, the article reviews the differing methods, including approaches to indicators, which the two fields deploy and argues that these involve not only questions of technical tools and skills but also approaches to truth and knowledge. However, work in maternal mortality illustrates how the two fields might use indicators to monitor for human rights and public health purposes. The conclusion acknowledges that a discussion of concepts and premises in the abstract is only a first step in evaluating the possibilities and challenges involved in engaging the two fields in practice. Yet, as Krieger and Gruskin argue, "Explicit articulation [about assumptions and frameworks] not only is useful in and of itself, but also helps us communicate more clearly across disciplines."¹⁰

Philosophies and Premises

Starting Points: The Collective v. the Individual; Utilitarianism v. Liberalism

The discourses and disciplines of public health and human rights emerged around the same time in the eighteenth century in Western Europe and were both very much products of a new vision of the nation-state.¹¹ However, as Heilborn et al. note:

... to some extent they have traditionally remained separate. Even in the texts of human rights conventions, public health features as one of the factors permitting some rights to be suspended. The traditional practices of public health express a problematical relationship between individual rights and the social rights of collectivities, where the former are very often neglected and even breached for the sake of the latter. This rift appears as an impediment to the emancipatory potential of human rights in that social rights should guarantee conditions for the full exercise of individual citizenship.¹²

Although the circumstances under which rights may be suspended are closely circumscribed, it is true that collabo-

ration between the two has been portrayed as a matter of negotiation between points on opposite axes.¹³

Another way of construing the foundational difference between the two fields is that, despite their shared rationalist underpinnings, human rights emerged out of a classical Liberal philosophical tradition, the cornerstone of which is that all individuals are ends in and of themselves by virtue of their inherent dignity and therefore cannot be reduced to instruments of government policy.¹⁴ Public health, on the other hand, was plainly utilitarian from the outset—whether the issue was adopting safety and sanitary measures or quarantines to combat infectious diseases.¹⁵ For example, influenced greatly by the Industrial Revolution and massive urbanization, British sanitary reformers of the nineteenth century argued that society had a legitimate interest in health because disease and infirmity created drains on the economic well-being of the broader community.¹⁶ As governments assumed responsibility for maintaining the welfare of their citizens, a sick or disabled worker translated into lost productive labor, while the death of one married male worker meant that a widow and often children went on public relief.¹⁷ Following this logic, the government had a justified role in regulating even private behavior in the interest of public health. Gender subordination, coupled with the growing interest in furthering economic and social goals, led to both subtle and blatant social control of women's reproductive capacities across many different cultures.¹⁸

Challenges to the Traditional Premises of Public Health and Human Rights

Research and advocacy work on reproductive and sexual health and rights has challenged not only the utilitarian premises of public health but also the individualistic premises of traditional human rights. As Lynn Freedman has written, in the health field advocates have reacted against, among other things, "population control efforts that treat women as 'targets' of contraceptive programs, blatantly manipulating their capacity in order to achieve demographic goals ... They have reacted against maternal/child health policies that view the health of women

as an instrument to ensure the health of children, and not as an important or valuable matter in their own right."¹⁹ Advocates also have sought to expand the boundaries of reproductive health, to include women's entire lives, and encompass concern for other health needs such as mental health, aging, violence, occupational health, and sexual pleasure.²⁰

In the rights realm, advocates have reacted against Liberal individualism that views people in atomistic fashion, pursuing their own interests in isolation from or even in opposition to the collective.²¹ This Liberal philosophy reflecting classic formulations of rights, stemming from the writings of John Locke and others, leads to a strict dichotomy between the public and private spheres; rights are protections from the state, shields against intrusion into the private sphere.²² Hilary Charlesworth and Christine Chinkin have noted the gendered implications of this division, which traces its origins back to Greek thought: "The two spheres were in symbiotic position: men were able to participate as equals in the public realm only because they were supported by the work of wives and slaves in the private realm."²³

As Romany writes, a feminist reconceptualization of human rights grapples with "... core narratives underlying the individual and the state, [including that] conception of the self deemed autonomous and free which immunizes the state from implication in the genesis of a system of gender subordination."²⁴ One of the key aims of reproductive rights advocates has been to demonstrate that discrimination in access to services and goods in the public sphere—education, employment, and health care—cannot be decoupled from discrimination within the household that leaves women with reduced choices, power, and status.²⁵ Work on violence against women (VAW) has analogized domestic violence to torture to demonstrate that it should be a central concern of human rights.²⁶ The 1993 World Conference on Human Rights and other international and regional documents have affirmed the view that violations suffered by women in the private realm are indeed human rights violations, even if the insight is not always—or often—reflected

in the practice of UN committees and mainstream human rights NGOs.²⁷

The reproductive health and rights movements thus envisioned a different relationship between public health and human rights. The relevant question was not simply what impact human rights violations, such as torture, had on health, or what impact health policies had on civil liberties (such as through quarantines and other coercive measures generally seen in the context of infectious diseases). This vision grew from the conviction that rights and well-being were inextricably linked and could only be realized through the capability to exert agency over the course of one's own life.²⁸

Consequently, it was natural that the reproductive health and rights movement would dismantle old paradigms in human rights as well as in public health. For example, from this perspective it is clear that a meaningful concept of reproductive freedom includes not merely choice in the abstract but also the adoption of laws, policies, and programs that enable women to exercise that choice, revealing the interdependence of civil, economic, and social rights. Manisha Gupte writes of the obstacles to exercising such choice in three countries:

[Under the growing influence of the Catholic Church,] Poland's abortion law is now one of the most restrictive in Europe, limiting access to abortion in a very limited number of situations. Those who can afford to go to another country to get an abortion do so to escape the restrictive law in Poland, giving rise to what is popularly known as "abortion tourism"...By way of comparison, in Romania, abortion was legalized within three days of the revolution. Yet Romania continues to have a high death rate for women, arising out of complications related to abortion. Ironically, people are expected to buy their own contraceptives, whereas abortion is paid for by the state and so, not surprisingly, abortion is widely used as the only means of birth control by most women!...In the very different context of India, where Medical Terminations of Pregnancies have been legal since 1972 the issue is complicated due to its relation to sex-selective abortions, the population control policy and lack of women's access to health care services.²⁹

Thus, as Gupte writes, "Whether abortion is illegal as in Poland, or legal as in Romania or India, it does not nec-

essarily increase a woman's choices and freedom to chart her own life. Abortion and birth control are not rights in a vacuum but are embedded in a specific context and mean different things for different women."³⁰ The broad language of Cairo, linking reproductive health to the wider conditions of a woman's life, was a natural outgrowth of this understanding of rights—and health—experienced within social contexts.³¹ Indeed, this notion of rights as participation in a social context—"as referring to the capacity of individuals to negotiate between and among themselves about the exercise of entitlements and the effects of their actions on others' rights," as Juan Guillermo Figueroa says—connects choices about reproductive and sexual rights to choices about our societies and about how we want to live.

Lingering Differences in Frames of Reference: The Individual v. the Collective

Despite convergence between reproductive rights and health advocates, however, the underlying utilitarian and liberal philosophies that permeate the broader fields of public health and human rights have implications for both conceptual understanding and practical engagement. Sometimes, the differences lie in our respective frames of reference.

For example, in writing about a case study relating to an internally displaced person (IDP) in Colombia who contracted a sexually transmitted infection through a sexually abusive relationship forced on her by her employer, Charles Ngwena and Therese McGinn define the issues of concern very differently. Ngwena, writing from a human rights perspective, states: "From a holistic perspective, it is the right to human dignity that has been violated in Marta's case. Human dignity is arguably the source of all human rights. For the purposes of seeking practical remedies, however, the facts implicate violations of discrete human rights by the government of Colombia as well as by private actors."³² Ngwena then goes on to enumerate the many violations of rights suffered by the individual, Marta.

In contrast, McGinn, writing from a public health perspective, states:

The fundamental public health issue presented in the case of the internally displaced person in Colombia is that armed conflict causes death, physical and psychosocial morbidity. Moreover, the massive disruptions caused by five decades of conflict in Colombia have destroyed or dispersed the structural and social networks—such as health facilities, school systems, work patterns, family ties, social trust—on which public health improvements are built. Thus, both directly and indirectly, armed conflict impoverishes the public's health. Another set of public health issues revolves around the needs of people once they become displaced.³³

McGinn then goes on to enumerate both a traditional package of services that might be provided to IDPs as well as broader components of public health strategies. But McGinn's focus from the beginning is on the collective—"public health" and the needs of "people" once they become displaced—while Ngwena considers Marta's personal case and posits her as an individual seeking remedies against the state and, potentially, against her employer.

Both McGinn and Ngwena bring to bear sophisticated analyses and are sanguine about the limitations of their own fields. Ngwena writes, for example, "Marta and others in her position should not depend solely on the existence of favourable legal provisions and the diligence of lawyers in negotiating difficult legal terrain and advancing persuasive arguments to the courts."³⁴ McGinn, for her part writes, "public health, even at its best, does not address all social concerns. A public health program can treat Marta's STI, but it is not likely to effectively address the fundamental inequities that put her in the position to contract the STI in the first place."³⁵ Thus, these differences in defining the issues involved in a given situation need not be obstacles to collaboration, but they do reflect different starting points.

Influence of Underlying Premises on Key Concepts: The Example of Participation

At other times, key concepts may be understood quite differently by the two fields. For example, "participation" is clearly a critical component in moving forward with a rights-based approach to reproductive and sexual health—in advo-

cacy vis-à-vis governments and within our own movements. Participation is a defining characteristic of a human rights approach to health, according to the UN Committee on Economic, Social and Cultural Rights.³⁶ Participation, especially community participation, also has a long history in public health and was a fundamental part of the seminal 1978 Alma-Ata Declaration on Primary Health Care.³⁷ Yet it is unclear that this concept—which is touted everywhere from the Cairo Declaration to neo-liberal discourse on development to health sector reform—means the same thing in public health as it does in the human rights field.³⁸

Why participation is deemed important largely determines how it is implemented. Even though Cairo refers to participation in broader terms in public health participation is generally instrumental to promoting public health goals. In keeping with the utilitarian premises of public health, participation by communities, especially among women and girls, makes reproductive and sexual health interventions more effective.³⁹ Thus, although numerous approaches exist, the focus is usually on participation in projects and programs.

In contrast, in a rights framework, “the participatory process is driven by the idea that considering options, making decisions and taking collective action to fight injustice are empowering.”⁴⁰ Participation is construed as part of basic citizenship. Unrelated to how it promotes effectiveness or efficiency, the devolution of decision-making power to the individual or group from the state harkens back to the classical deontological underpinnings of rights.⁴¹ Thus, rights-based understanding of participation goes beyond specific projects or programs and concerns itself with the mechanisms whereby, as Alice Miller writes, “affected persons can meaningfully participate in the determination of the frameworks and policies that govern their lives at all levels.”⁴² Needless to say, neither field’s approach to participation is monolithic. Further, there are discrepancies between theory and practice in both rights and public health.

In short, the reproductive health and rights movement has diverged in significant ways from the visions offered in the broader fields of public health and human rights. Rights

approaches are increasingly paying greater attention to the conditions that enable rights to be enjoyed rather than construing them as individualistic protections in a vacuum. Nevertheless, reproductive rights and health advocates continue to be influenced by the underlying collective versus individual outlooks, as well as the philosophies of the two fields. Differing conceptions of “participation” are but one illustration of how advocates in both reproductive rights and reproductive health need to make transparent the underlying assumptions of their working models, both within each field and together.

Goals and Objectives

Laws and Accountability v. Service Delivery

The differences in philosophy translate into differences in goals and approaches. In the most simplistic terms, human rights approaches seek justice, and public health approaches seek well-being. In conventional practice, these amorphous aims become transmuted into the concrete objectives, respectively, of ensuring an appropriate legal and policy framework, including accountability for violations, and ensuring adequate health facilities, goods, and services.

A human rights approach places great emphasis on examining whether laws and policies support women’s reproductive and sexual freedoms and well-being or whether there are *de jure* restrictions of women’s rights. Human rights analyses almost invariably discuss both the relevant international human rights norms, as well as the status of related domestic legislation.⁴³

Notwithstanding all of their limitations, laws create a framework for governmental and individual behavior; they also can be used to establish expectations of rights among citizens and accountability from the government.⁴⁴ When legislation is retrogressive or restrictive, or discriminatory against women, it has very real consequences in terms of women’s health and lives. When there are vast gaps between law and practice, rights advocates document abuse and draw attention to the discrepancy between stated standards and reality.⁴⁵

A human rights approach asserts that the state has legal—and not just moral—responsibility for issues re-

garding sexual and reproductive health. Legal accountability means that, as Honkala writes, “the satisfaction of human needs would not lie at the mercy of the economy or of charity or social services.”⁴⁶ On the contrary, it means that the rights at issue should be guaranteed in law and practice, and that there should be mechanisms and procedures in place for women to vindicate their rights in the event of violations, whether they are judicial or extra-judicial.⁴⁷

Accountability is a crucial objective of human rights approaches.⁴⁸ Tamayo, for example, writes how important it has been that “...individual cases brought to supra-national bodies of human rights protection have allowed for independent experts to determine whether a given State has complied with its obligations as well as offering the arguments that underlie the decision and the terms that would satisfy or remedy the violation found.”⁴⁹

In seeking to vindicate rights, human rights advocates are most used to denouncing state violations—whether failures to respect, protect, or fulfill rights—and declaiming what the government “must” do to meet its obligations. Often human rights analyses pay little attention to how such actions will be funded and what trade-offs such decisions may imply. At the most extreme, Ken Roth, Executive Director of Human Rights Watch, has argued precisely that, because “respect for ESC [economic, social, and cultural] rights often requires the re-allocation of resources” international human rights organizations have little standing to engage in advocacy that would go to the substance of spending decisions and should instead focus on exposing blatant abuses.⁵⁰

Human rights advocates’ focusing on principles in the abstract and on seeking remedies in individual cases, which is often a protracted struggle, may frustrate public health advocates who see the provision of services as itself being a remedy to the injustice faced by the poor and marginalized, especially in light of what Paul Farmer has called the “clearly non-binding nature” of international human rights treaties.⁵¹

For instance, returning to the example of Marta, the IDP in Colombia, Ngwena writes that, “... in the short term,

the appropriate course of action would be to exhaust domestic remedies."⁵² McGinn, on the other hand, asserts that "a response to the situation faced by Marta and her friends should be designed to offer prevention and care for the group's immediate health needs, as defined both by them and by skilled public health professionals. Primary health care, basic treatment, reproductive health services and clean water and sanitation must be made available for the displaced women, children, adolescents and men."⁵³

The utilitarian underpinnings of public health lead reproductive health advocates to pragmatically acknowledge the limitations of the health *system* and the need to set priorities. In this vein, McGinn writes:

If we accept that a public health system cannot address all needs [e.g., social and economic status, education, gender roles, justice] then we need a basis on which to determine what will receive its attention. Priority should be determined by a reasoned examination of several factors including the severity, scope and social implications of the problems; the evidence regarding efficacy of the potential interventions; the capacity of the health system (as distinct from society's other systems, such as the legal, social service or educational infrastructures) to deliver the interventions; the acceptability of the interventions from cultural and legal standpoints; and cost.⁵⁴

The focus in public health is thus often on programmatic interventions, which can be accomplished within the health sector, rather than on the laws and policies that may not translate into effective delivery of quality care. Moreover, priority-setting amidst cost considerations is an integral part of public health policy-making, and concepts such as sustainability of programs almost always figure into reproductive health program planning.⁵⁵

Yet, as McGinn herself acknowledges, focusing on what the health sector can do almost invariably shifts the focus from promoting well-being to managing ill-health. In spite of Cairo, public health systems often take an overly narrow approach—focusing on providing packages of services and on changing individual behaviors (e.g., sexual conduct and utilization of health services for childbirth), rather than on

connecting service delivery to strategies for structural change.⁵⁶ Concrete program changes save lives and can also be the basis for longer-term advocacy. Yet, too often, budgetary constraints (and priorities), discontinuities in governmental policies and administrations, and a health sector that works in isolation from other sectors mean that interventions always remain limited, even when stated policies would support a broader view.⁵⁷

Convergences Within the Reproductive Rights and Health Movement

Increasingly, reproductive and sexual health advocates are transcending traditional public health approaches to services and are attuned also to how laws and policies have direct impacts on women's health outcomes. Figueroa, for example, insists on the need to "promote broader approaches to social development" as a practical priority and to ensure that programs construe health "as more than just a biological matter."⁵⁸ Even when underlying health needs have biological bases or behavioral dimensions, laws and policies are relevant. For example, Heilborn et al. suggest:

the assumption of heterosexuality in women's health care both deters women who have sex with women from accessing the health services and prevents health workers and policymakers from considering these women's specific needs ... it is indispensable ... to evaluate the status of homosexuality from the legal standpoint ... including whether ... female homosexuality is criminalized.⁵⁹

Laws and policies therefore are not just background considerations but essential components of a public health analysis.⁶⁰

If public health advocates are seeking transformation of laws and policies as part of their goals, there is also a growing recognition that taking a human rights approach cannot mean only identifying a violation and proceeding mechanically to remedy it in isolation from other rights and the context in which the woman finds herself. Reproductive rights advocates are coming to acknowledge that they have to concern themselves with programs; laws and policies in

and of themselves are insufficient. Ngwena argues, for example, that health services must be a priority in the remedy for Marta, the IDP in Colombia: "Immediate access to treatment must be sought as a short-term goal not only as part of the right to dignified work under just conditions, but also as part of the right to public health care under the Constitution of Colombia."⁶¹ As Miller asserts:

... taking a "rights approach"... demands that we [engage with the] context-specific questions of how rights are made real, services are revised, policy-makers and local authorities are convinced that their practice must change, and affected persons act as if these rights can in fact underpin their actions and demands.⁶²

Moreover, just as addressing the legal and policy frameworks that influence reproductive health and ill-health goes beyond the health sector, a rights approach, which includes looking at the gritty details of how programs are designed, implemented, and evaluated, requires inter-disciplinary collaboration and cannot be left to the traditional human rights community.⁶³

Strategies and Roles

As discussed above, the differences in philosophies and goals between the two fields imply differing strategies. Different strategic choices are also reflected in the roles of NGOs and their relation to the state. Part of the nature of human rights work—which flows from the emphasis on laws and accountability—is a willingness to openly confront the state and to expose the hypocrisy, corruption, and cynicism that too often plague government bureaucracies, including those in the health sector. As a result, human rights NGOs have historically been skeptical of the state and remained fiercely independent in order to criticize the state when it abused the rights of its citizens and sought accountability for such violations. The relationship between human rights groups and the state in almost every country in the world can be described as ambivalent, at best.

Health programs, on the other hand, often require collaboration with the state at many levels. Health programs are generally implemented through the Ministry of Health,

and, in the best of cases, through other sectors that have roles to play, such as finance, education, agriculture, labor, and justice. With good reason, public health discussions invariably revolve around whether and how the government should implement certain policies or programs. Moreover, as Angela Kamara writes, "... it is not enough to improve quality of, and access to care if the system cannot be sustained."⁶⁴ If programs are to be sustainable in the long run, they almost always have to be institutionalized through the state.

Even theoretically independent health NGOs are often dependent on governments, to varying degrees, for funding, medical supplies, licensing and other permissions, certifications of doctors and staff, approval of funding from bilateral and multilateral sources, favorable tax treatment or exemptions on importation tariffs, and the like. In some cases, well-established women's groups that have attempted to provide services as well as engage in rights advocacy have inadvertently, through funding arrangements, compromised their independence and credibility. The inconvenient truth is that all of this work depends on money, and where the money comes from, and with what conditions and expectations attached, determines much of what actors in the reproductive health and human rights movement do and how they go about it.⁶⁵

As Ngwena argues, the complex and entrenched problems in reproductive health and rights would be best suited by a:

multidimensional approach that engages all potential committed stakeholders [including health and human rights NGOs and other organizations]. Some stakeholders, however, may not be comfortable with action that appears hostile to the State for fear that it might nullify any potential for constructive engagement and co-operation with the State.⁶⁶

The potential complementarity of human rights and public health advocates as partners in coalitions in engendering social transformation can all too easily dissolve in light of such very practical issues.

***Rights Paradigm Shifts:
Violence against Women, Trafficking,
and Potential Impacts on Public Health***

Work on VAW, which in many respects brought feminist concerns into the mainstream of human rights and humanitarian law and created a strong link to women's health organizations, ironically also re-configured the relationship between some women's rights organizations and the state. That is, in struggling to have VAW taken seriously and to combat the impunity of perpetrators, women's rights advocates sought enhanced police involvement and greater prosecutions. For example, Nowakowska writes of a case involving the rape of a Polish girl by her doctor:

The case [shows] the failure of existing law in Poland to adequately address the crime of rape. The existing Polish system actually tolerates the impunity of the perpetrator, if the victim does not press charges. Rape, just as other serious crimes, should be publicly prosecuted. Taking this burden from the victim's shoulders would make her less vulnerable to the pressure from the perpetrator and would send a clear message to the society that rape is a serious crime and the state is going to prosecute it regardless of the victim's will ... all other serious crimes are in Poland publicly prosecuted, which means that initiative of the victim is not necessary to start an official investigation.⁶⁷

This "law and order" posture has the potential to conflict with the position that human rights groups generally adopt, which is to protect the rights of the defendant against the state. Even without reverting to the classical liberal notion of rights as shields against governmental intrusion, some reproductive and sexual rights advocates have acknowledged dangers in a model that seeks protection—and rescue—by the state.⁶⁸

Trafficking is perhaps the issue that presents these questions in the starkest light. In the name of protecting women and decreasing their vulnerability to sexual trafficking, some advocates argue that prostitution must be abolished. Mary Lou Alcid, for example, writes that "... trafficking for sexual exploitation and prostitution are forms of commodification of girls and women. They constitute vio-

lence against girls and women."⁶⁹ Others argue that equating all prostitution with traffic in women essentially reverts to a "sexual purity framework" as opposed to a rights framework and "resurrect remedies to keep women safe by avoiding 'inappropriate' forms of sexual behavior."⁷⁰ The latter group points out that alliances with conservative politicians to crack down on "sex trafficking"—through greater prosecutions as well as changes in funding—ignore the broader nature of servitude and the underlying social and economic factors that lead women to migrate; in fact, despite abolitionists' expressed concerns that the women themselves should not be punished, in practice, legislation and policies emerging from such alliances can disempower the very women they are supposed to protect, by making their status illegal and/or conditioning status on cooperation with authorities.⁷¹ In contrast, an approach that is based on harm reduction seeks to improve the status and conditions of sex workers along with that of other migrant workers.⁷²

These opposing discourses of trafficking and prostitution reflect competing understandings of what would constitute justice and accountability—the traditional rights-based goals. In keeping with its traditional goals and underlying premises, the health field generally does not conceive of trafficking and prostitution primarily in terms of justice, but rather in terms of their health impacts on people directly engaged in sex work and on others in the larger community who become susceptible to STIs or are otherwise affected, such as children of sex workers. For example, writing in this pragmatic vein, Maha El Rabbat asserts that "public health approaches should take into account the heterogeneity of the sex sector and should address the needs of children and adults differently."⁷³ Consequently, she notes that health, educational, and social support programs must be designed to reduce the potential harms through such measures as appropriate family planning; education and sex education; accessible reproductive health services, including medical check-ups, screening, and management of STIs; and provision of contraceptive methods, including condoms. Also, "services for the prevention and control of

STIs, including HIV, should be incorporated into reproductive health care programs, supported by energetic information campaigns and gender-sensitive promotion of condom use."⁷⁴

A specific example of the impact on health of this shift in strategy among some women's rights advocates can be found in the US 2003 Global AIDS Act. Under this legislation, service providers that seek US funding will be required to sign a statement indicating their opposition "to the practices of prostitution and sex trafficking because of the psychological and physical risks they pose for women."⁷⁵ Thus, service providers who work with sex workers in a supportive role are construed as part of the problem in a framework that sees the existence of sex work as the injustice to be remedied. Precisely because health programs depend on not only their own governments for funding, but also foreign governments, Penelope Saunders has written, "the implementation of new policies limiting funding to sex work projects jeopardizes the health of millions of people who engage in commercial sex to secure their livelihoods."⁷⁶

In short, in many areas, the traditional strategies and dissident role of human rights organizations do not facilitate collaboration with health NGOs that often depend on governments for funding and sustainability of programs. Yet, in the area of trafficking, strategies that have aligned abolitionists with the state in lobbying for sanctions as well as curtailing funding may mean that already devalued sex workers are further marginalized and even deprived of health services that depend on funding from governments and foreign aid.

Methods

What Counts As Evidence and Argument

Human rights is driven by norms; public health is driven by data. The two discourses can be complementary ways of establishing truths. For instance, in an essay on fundamentalisms and reproductive health, Lynn Freedman points out, "A political vision of health requires not only a strong factual basis, but also a conceptual framework that can convert scientific insights into political claims of enti-

tlement."⁷⁷ Coupling the strengths of human rights and public health would seem to be the perfect pairing to mount effective, evidence-based advocacy to promote women's well-being. Yet truth, like justice, is an elusive concept, and both truth-finding and truth-telling can have very distinct meanings to these different fields.⁷⁸ Much human rights fact-finding relies on victims' testimonies as a primary source of information. Of course, human rights professionals have developed techniques to ensure the accuracy of fact-finding data and methods for processing information collected from multiple sources.⁷⁹ Nevertheless, the truths of human rights reporting consist mainly of narrative truths that, through the lens of normative principles, help to make sense for the victim—as well as for the larger society—of an individual's or a group's suffering.

Public health, on the other hand, adopts an entirely different approach to the investigation and classification of social ills, which puts a premium on a different notion of objectivity. Public health relies not only on statistical information that is continually or periodically collected but also on studies—descriptive, analytic, and sometimes experimental—which follow specific design criteria meant to root out biases and confounding factors. Many public health professionals no longer pretend that scientific observations and interpretations—much less the questions that scientists choose to ask—are entirely objective and divorced from political context.⁸⁰ And, of course, decisions on what to study may be based on normative or political considerations. Nonetheless, even critiques usually call for more or differently designed studies, and concepts such as validity and representativeness of the data remain essential in establishing public health truths and designing policies and programs. For example, Heilborn et al. note "... the relative scarcity of studies on lesbians and health care reflects the nascent state of concerns in the health field on the subject of sexual diversity among women.... This profile points to the total lack of information on these women's demands for rights and health in countries where individuals classified as homosexuals are most vulnerable."⁸¹

Different Approaches to Indicators

Perhaps the clearest illustration of how the two fields differ in their methods lies in the very distinct approaches that the two adopt with respect to indicators. The selection, development, and application of appropriate indicators have the potential to bridge these different approaches to truth as well as to the two fields in general. For example, the use of certain indicators could make it clear that public health is not only concerned with aggregate outcomes and utility and human rights merely with individuals.⁸² Despite its historic wariness of statistical measures, human rights might fruitfully concern itself with patterns that indicate systemic inequities that result in differential health outcomes for women—and certain groups of women in particular. Similarly, public health can and, in some cases, does embrace and advance the principles of equity and non-discrimination through the selection and use of certain indicators.⁸³

Indeed, a principal goal of reproductive health advocates post-Cairo has been the development of indicators that would go beyond demographic questions, such as total fertility rate, to broader questions of women's empowerment and gender equity. At the UN/World Bank level, agreement has been reached on 17 reproductive health indicators for national and global monitoring, which are related to the Cairo Programme of Action and in many cases can be tied to specific obligations under international human rights law.⁸⁴ On the health side, a large number of varied efforts have been made in this regard.^{85s}

Yet, for the most part, human rights analyses have tended to treat indicators as secondary. When "indicators" are set out, they tend to relate to broad policy concepts, without clear mechanisms to measure them. Other "human rights indicators" focus on the criminal justice system, such as numbers of prosecutions under a given law.⁸⁶ These approaches reflect the field's goals, as much as the tools that it has available. That is, if the goal of human rights is the creation of a legal and policy framework that ensures accountability, structural indicators that focus on laws and institutions rather than quantitative change make sense, as does measuring prosecutions to evaluate accountability. The human rights field is only beginning to become more so-

phisticated about sorting out different sets of indicators—structural ones to measure laws and policies, versus process and outcome indicators to measure performance.⁸⁷

In order to develop, select, or apply human rights indicators, we must have a clear understanding of what and how we want to measure a given factor, and we also have to sort out the “why” questions. That is, what does the human rights lens bring to the table in terms of the use and interpretation of sets of specific indicators? Why is it important, and how are its terms defined, and what are its limitations? If we are to draw together the two fields in practice, priority should be accorded to the development—and dissemination—of appropriate indicators that can be collected and interpreted by civil society organizations as much as by governments or specialized agencies.⁸⁸

A Promising Convergence: Maternal Mortality

As reflected in the analyses by the public health and human rights authors in the study upon which this article is based, there is a promising convergence in the area of maternal mortality over the use of indicators to measure human rights and public health progress.⁸⁹

There is now a growing consensus that limited access to essential obstetric care (EOC), which reflects the social marginalization of women as well as the state of the health system, must be construed as part of a government’s core obligations with respect to safe motherhood as well as the keystone in any public health program to reduce maternal mortality.⁹⁰ As Kamara writes, most major obstetric complications can be successfully treated with a handful of services, which for the most part should be provided at rural health centers.⁹¹ Although focusing on EOC will not reveal all that a government may be doing with respect to safe motherhood, Tamayo notes that it will provide a critical indication of whether the state is taking appropriate measures to meet its obligations with respect to ensuring that certain essential services are available and accessible on a non-discriminatory basis.⁹²

The agreement between the public health and human rights authors around a set of process indicators to measure

the availability and use of essential obstetric services, which were issued by UNICEF, UNFPA, and WHO (UN Guidelines), is only possible because of underlying convergences in philosophies, goals, and strategies.⁹³ That is, in advocating the use of these indicators, Tamayo and other rights advocates are implicitly acknowledging that it is one thing to shift the burden of proof to the state to demonstrate that a given case or number of cases does not constitute a violation of international law; it is quite another to propose how systems can be changed to avoid future violations. Moreover, as a matter of rights as well as public health, we must be concerned with how to reform institutions, programs, and systems to prevent women from dying in the future.⁹⁴

In short, the UN Guidelines set out public health indicators which can also form the basis for the standard-setting work that the human rights movement has done so successfully in other areas.

As this promising work in maternal mortality illustrates, in order to document those aspects and advocate the appropriate systemic changes—that is, to bridge the level of the individual narrative truth and the level of the collective truth—human rights advocates will need to turn to and incorporate certain indicators in their analyses.⁹⁵

Needless to say, reproductive rights advocates need not become experts themselves in health or other areas of policy, nor do they need to collect or analyze data. However, when a human rights framework is coupled with the skills and insights of public health, it can greatly enhance the methods of both fields and, in turn, our ability to jointly conduct effective evidence-based advocacy.

Concluding Reflections

In effect, Cairo laid a bridge across the divide separating human rights institutions and health policy-makers and program designers; these reproductive health policy and programming issues were suddenly linked at the conceptual level with human rights. But bridges remain in the air, above the messy work of integrating two communities with different ways of doing things. For the past 10 years, that

work has largely been done by experts ferrying back and forth to conduct training programs, write manuals and articles, and generally “build capacity” within the other community, especially by spreading the word of Cairo and Beijing and reproductive rights in the health world. In some cases, system-wide changes have been introduced in practice, such as in the implementation of a rights-based approach to quality of care or the establishment of sex education in school curricula. For the most part, however, the tendency to rely on “ferries” has proven inadequate to change structural issues that continue to keep the two communities apart.⁹⁶

For example, we have come to see that it is not enough to set out a substantive health issue, whether maternal mortality or HIV/AIDS, and then enumerate the human rights aspects; the listing of relevant rights provisions does not move us further toward operationalizing these concepts in the daily work of service providers and health policymakers. At the risk of overextending the metaphor, what we now require in order to forge ahead are tunnels—tunnels that go deep into the underlying assumptions beneath both fields, which almost surely will require dismantling accepted structures of thought as well as of power that are blocking the path. And digging tunnels requires being very familiar with one’s ground, one’s context.

There is now a widespread, implicit recognition among thinkers in both fields that the enjoyment of rights only has meaning in the dense and sticky realities of women’s lives.⁹⁷ However, while it is easy to write about the need to incorporate contextual factors into our understanding of how reproductive and sexual rights can be made real, many of the practical problems in implementing a human rights approach to reproductive and sexual health come to the fore in the nitty-gritty, hard decisions that are only made and become visible in the field.

Further, forging advances is not simply a matter of bridging the two fields—or of importing human rights language and tactics into public health work—but of using interdisciplinary efforts to promote self-reflection on the premises, methods, and strategies within each field.

Collaborations between health and rights advocates are necessarily variable, and generalizations about a single field or a comparison between the two frameworks can be misleading. Reproductive health does not always represent or reflect the wider field of public health, and the same applies to reproductive rights and human rights. The field of rights, in particular, means many different things to different people at different times and contains within it formal legal doctrines, institutions, and procedures as well as critical conceptual frameworks from which to evaluate social relations.

Yet human rights and public health do present distinct modes of approaching issues, and underlying differences in premises, goals, and strategies continue to influence how we define such concepts as participation, how we relate to the state, and how we select the methods that we use to advance our arguments and establish truths. The only way to address these choices—and at times conflicts—is to bring them out into the open to be debated in light of concrete experiences.

Finally, the ways in which human rights and public health engage with one another are also affected by the international context. We cannot discuss the role of governments, the structure of the health system, and the constraints on policy and legal reform as we might have a decade ago. Transnational trends in the global economy, together with rising influence of fundamentalisms in countries around the globe—whether evangelical Christian, Catholic, Jewish, or Muslim—are dramatically affecting the possibilities for women’s health and rights.⁹⁸

Even as we deepen our understandings of the practical application of those concepts in practice, we must stand our ground and reaffirm our common commitment to ensuring that more women and girls can live their lives with freedom, choices, and health, and harness the extraordinarily powerful potential of human rights to convert policy issues into pressing questions of social justice in women’s lives.

References

1. This article would not have been possible without the wisdom and insights of the 12 experts who contributed their analyses to the Ford Foundation-sponsored project that culminated in the book: A. E. Yamin

(ed), *Learning to Dance: Advancing Women's Reproductive Health and Well-Being from the Perspectives of Public Health and Human Rights* (Cambridge, MA: Francois-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health. Distributed by Harvard University Press, forthcoming 2005).

2. See, e.g., J. Pitanguy, "From Mexico to Beijing: A New Paradigm," *Health and Human Rights* 1/4 (1995): pp. 454-460.

3. Report of the International Conference on Population and Development, UN Doc. A/CONF.171/13, (Cairo: 1994): paras. 7.2-7.4.

4. See, e.g., A. E. Yamin, "Embodying Shadows: Tracing the Contours of Women's Rights to Health," in N. Gordon (ed), *From the Margin of Globalization: Critical Perspectives on Human Rights* (New York: Lexington Books, 2004): pp. 223-257.

5. See, e.g., S. Gruskin, "Keeping the Connections in 2004," *Health and Human Rights* 7/2 (2004): pp. 1-3; comments by E. Murphy in *Reproductive Health, Gender and Human Rights: A Dialogue* (Washington, DC: PATH, 2001).

6. See World Health Organization, *Transforming Health Systems: Gender and Rights in Reproductive Health* (WHO/RHR/01.29 2001): p. 4.

7. See note 5; A. Cornwall and A. Welbourn, *Realizing Rights: Transforming Approaches to Sexual and Reproductive Well-being* (New York: Zed Books, 2002).

8. The full findings of this study are synthesized in greater detail and completeness in an essay by this author. See A.E. Yamin, "Introduction," *Learning to Dance* (see note 1).

9. The experts who contributed to the book, *Learning to Dance* (see note 1), were M. L. Heilborn, R. Facchini, and R. M. Barbosa (public health experts from Brazil); A. Miller (human rights expert from USA); M. El Rabat (public health expert from Egypt); M. L. Alcid (human rights expert from Philippines); A. Kamara (public health expert from Ghana); G. Tamayo (human rights expert from Peru); M. Gupte (public health expert from India); U. Nowakowska (human rights expert from Poland); J. G. Figueroa (public health expert from Mexico); C. Honkala (human rights expert from USA); T. McGinn (public health expert from USA); C. Ngwena (human rights expert from South Africa).

10. N. Krieger and S. Gruskin, "Frameworks Matter: Ecosocial and Health and Human Rights Perspectives on Disparities Among Women's Health—The Case of Tuberculosis," *Journal of the American Medical Women's Association* 56 (2001): p.142.

11. See generally G. Rosen, *A History of Public Health* (Baltimore, MD: Johns Hopkins University Press, 1993).

12. M. L. Heilborn, R. Facchini, and R.M. Barbosa, "Public Health and Human Rights: Policies on Sexual Diversity," in *Learning to Dance* (see note 1).

13. See, e.g., L. Gostin and J. Mann, "Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies," *Health and Human Rights* 1/1 (1994): p. 58.

14. See, e.g., H. Charlesworth and C. Chinkin, *The Boundaries of International Law: A Feminist Analysis* (Manchester, UK: Juris Publishing, 2000), pp. 201-247; P. G. Lauren, *Visions Seen: The Evolution*

of *International Human Rights* (Philadelphia, PA: University of Pennsylvania Press, 1998): pp. 5-20.

15. See note 11: p. 26.

16. Ibid.

17. Ibid.

18. See, e.g., G. Sen and R. C. Snow, *The Social Control of Reproduction* (Cambridge, MA: Harvard Series on Population and International Health, 1994).

19. L. P. Freedman, "Reflections on Emerging Frameworks of Health and Human Rights," *Health and Human Rights* 1/4 (1995), pp. 314-349. See also N. Krieger and E. Fee, "Man-Made Medicine and Women's Health," reprinted in N. Krieger and E. Fee (eds), *Women's Health, Politics and Power: Essays on Sex/Gender, Medicine, and Public Health* (Amityville: Baywood Publishing, 1994).

20. M. Gupte, "Reproductive Rights in East Central Europe: A Public Health Concern," in *Learning to Dance* (see note 1). See also note 12.

21. See note 19: p. 328.

22. See note 14: p. 30.

23. Ibid.

24. C. Romany, "State Responsibility Goes Private: A Feminist Critique of the Public/Private Distinction in International Human Rights Law," in R. Cook (ed), *Human Rights of Women: National and International Perspectives* (Philadelphia: University of Pennsylvania Press, 1994): p. 111.

25. See, e.g., R. Ralph, "Challenges in Promoting Women's Reproductive and Sexual Rights," in *PATH Dialogue* (see note 5): pp. 23-28.

26. See, e.g., R. Copelon, "Understanding Domestic Violence as Torture," in *Human Rights of Women ...* (see note 24): pp. 116-152.

27. The Vienna Declaration was extremely important in recognizing women's human rights as international human rights and in highlighting gender-violence in the private sphere as a matter of human rights. See Report of the Drafting Committee: Final Outcome of the World Conference on Human Rights, UN Doc. A/CONF.157/DC/1/Add.1 (Vienna: 1993) [Vienna Declaration]; Beijing Declaration and Platform for Action, Fourth World Conference on Women, Chapter IV: Strategic Objectives and Actions ("Women and Health"), UN Doc A/CONF.177/20 (1995); Committee on the Elimination of Discrimination against Women, General Recommendation No. 24, Women and Health, UN Doc. A/54/38 (Part I), p. 5. (Beijing: 1995); Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000): paras. 20-21; Committee on the Elimination of All Forms of Racial Discrimination, General Recommendation XXV, Gender-Related Dimensions of Racial Discrimination, UN Doc. CERD/A/55/18, annex V. (2000).

28. See A. E. Yamin, "Transformative Combinations: Women's Health and Human Rights," *Journal of the American Medical Women's Association* 56 (1997): pp. 169-173; Freedman (see note 19): p. 324.

29. See note 20.

30. Ibid.

31. See note 3.

32. C. Ngwenya, "Internally Displaced Persons—Human Rights," in *Learning to Dance* (see note 1).
33. T. McGinn, "Internally Displaced Persons in Colombia: A Public Health Analysis," in *Learning to Dance* (see note 1).
34. See note 32.
35. See note 33.
36. See note 27: para. 54.
37. World Health Organization, Declaration of Alma-Ata, in *Health for All 1*(1978): p. 2-3.
38. See note 3. See also R. K. Murthy, B. Klugman, S. Weller, and L. Aizenberg, *Draft 2: Sexual and Reproductive Rights in Service: Accountability and Community Participation* (presented at the expert consultation on decentralisation, integration of service programmes, community participation and accountability as these pertain to sexual and reproductive rights and health (Cape Town, South Africa, April 24 and 25, 2003): p. 2.
39. A. Kamara, "Maternal Mortality: A Public Health Perspective," in *Learning to Dance* (see note 1). See also C. Overs, J. Doezema, and M. Shivdas, "Just Lip Service? Sex Worker Participation in Sexual and Reproductive Health Interventions," in A. Cornwall and A. Welbourn (see note 7): pp. 21-35.
40. See note 39: p. 23.
41. See G. Tamayo, "Case Study on Maternal Mortality—A Human Rights Perspective," in *Learning to Dance* (see note 1).
42. A. Miller, "A Human Rights Approach to Issues of Sexual Diversity," in *Learning to Dance* (see note 1).
43. *Ibid.*; See note 32; See note 41; M. Alcid, "Human Rights and Neela the Girl-Child," in *Learning to Dance* (see note 1); U. Nowakowska, "Eleonora's Case: An Analysis of Human Rights Violations," in *Learning to Dance* (see note 1).
44. CEDAW has recognized the importance of legislative and judicial measures in protecting women's rights to health. See CEDAW General Recommendation No. 24 (see note 27): para. 15.
45. See note 42.
46. See note 1.
47. A. E. Yamin, "Challenges and Possibilities for Innovative Praxis in Health and Human Rights: Reflections from Peru," *Health and Human Rights* 6/2 (2002): pp. 35-64.
48. CEDAW General Recommendation No. 24 (see note 27): para. 13.
49. See note 41.
50. K. Roth, "Defending Economic, Social and Cultural Rights," *Human Rights Quarterly* 21(2004): p. 65.
51. P. Farmer, *Health, Human Rights and the New War on the Poor* (Berkeley, CA: University of California, Berkeley, 2003).
52. See note 32.
53. See note 33.
54. *Ibid.*
55. See, e.g., A. Kamara (see note 39).
56. For critiques of conventional approaches and alternative visions of "social epidemiology," see, e.g., L. Berkman and I. Kawachi (eds), *Social*

- Epidemiology (Oxford: Oxford University Press, 2000); N. Krieger, "Theories For Social Epidemiology in the 21st Century: an Ecosocial Perspective," *International Journal of Epidemiology* 30 (2001): 668-677.
57. See M. G. Andrade, "Poros y Grietas de los modelos de gestión en salud," ["Pores and Fissures in Models of Health Mangement"] in *Saude, equidade e Genero: um desafio para as politicas públicas* [Health, Equity and Gender: A Challenge for Public Policies] (Buenos Aires: Abrasco/ALAMES/UnB, 2001): 113-126.
58. J. G. Figueroa, "Access to Health Care: A Public Health Perspective," in *Learning to Dance* (see note 1).
59. Heilborn et al. (see note 12).
60. This understanding of health in a broader light has even been incorporated into the thinking of the Millennium Development Project task force on child and maternal health. See L. P. Freedman, M. Wirth, et al., Millennium Development Project Task Force 4: *Interim Report on Child Health and Maternal Health*, p. 40. Available at: www.unmillenniumproject.org/documents/tf4interim.pdf.
61. C. Ngwena (see note 32).
62. A. Miller (see note 42).
63. Transforming Health Systems (see note 6); see also L. P. Freedman, "Using human rights in maternal mortality programs: from analysis to strategy," *International Journal of Gynaecology and Obstetrics* 75 (2001): 51-60.; id., "Shifting Visions: 'Delegation' policies and the building of a rights-based approach to maternal mortality," *Journal of the American Medical Women's Association* 54 (2002): 154-58.
64. A. Kamara (see note 39).
- 65 See A. E. Yamin, "Protecting and Promoting the Right to Health in Latin America: Selected Experiences from the Field," *Health and Human Rights* 5/1 (2001): 116-148.
66. C. Ngwena (see note 32).
67. U. Nowakowska (see note 43).
68. See A. Miller, "Sexuality, Violence against Women, and Human Rights: Women Make Demands and Ladies Get Protection," *Health and Human Rights* 7/2 (2004): 16-47; P. Saunders, "Prohibiting Sex Work Projects, Restricting Women's Rights: The International Impact of the 2003 U.S. Global AIDS Act," *Health and Human Rights* 7/2 (2004): 179-192.
69. M. Alcid (see note 43).
70. P. Saunders (see note 67), p. 186.
71. Ibid.; A. Macklin, "At the Border of Rights: Migration, Sex Work and Trafficking," in N. Gordon (ed), *From the Margin of Globalization: Critical Perspectives on Human Rights* (New York: Lexington Books, 2004), pp. 161-194.
72. P. Saunders (see note 67), pp. 183-186.
73. M. El Rabat and M. Alcid, "Public Health Issues in Sex Trafficking: Neela's Story," in *Learning to Dance* (see note 1).
74. Ibid.
75. United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act (Global AIDS Act), H.R. 1298, May 27, 2003, cited in Saunders (see note 67), p. 188.
76. P. Saunders (see note 67), p. 189.

77. L. P. Freedman, "Finding our Feet, Standing Our Ground: Reproductive Health Activism in an Era of Rising Fundamentalism and Economic Globalization," in C. W. Howland (ed), *Religious Fundamentalisms and the Human Rights of Women* (New York: St. Martin's Press, 1999), p. 189.
78. See M. Parveliet, "Considering Truth: Dealing with a Legacy of Gross Human Rights Violations," *Netherlands Quarterly of Human Rights* 16 (1998): 142.
79. For example, Physicians for Human Rights has pioneered the use of epidemiological surveys in human rights work, while the American Association for the Advancement of Science, among others, has developed advanced statistical methods for analyzing patterns of massive violations of human rights. See, e.g., P. Ball, H. Spierer, and L. Spierer (eds), *Making the Case: Investigating Large-Scale Human Rights Violations Using Information Systems and Data Analysis* (Washington, DC: American Association for the Advancement of Science, 2000).
80. See M. L. Heilborn et al. (see note 12).
81. *Ibid.*
82. See, e.g., J. Jacobson, "Transforming Family Planning Programs: Towards a Framework for Advancing the Reproductive Rights Agenda," *PATH Dialogue* (see note 5), pp. 53-66; A. Rosenfield, "Maternal Mortality as a Human Rights and Gender Issue," *PATH Dialogue* (see note 5), pp. 9-14.
83. See V. Lin, S. Gruszyn, K. Silburn, et al., "Main Report: Comparative Evaluation of Indicators for Gender Equity and Health," presented at WHO Workshop on Indicators for the Right to Health (Geneva, April 1-2, 2004).
84. World Health Organisation, *Reproductive Health Indicators for Global Monitoring*, Report of an interagency technical meeting, WHO/RHT/HRP/97.27 (1997); World Health Organization reproductive health indicators database, available at www.softgeneva.ch/RHR/RHRmainpage.htm.
85. Millennium Development Project Task Force 4, *Interim Report on Child Health and Maternal Health* (see note 59). See also "Critical Issues and Topics in Sexual and Reproductive Health Indicator Development: An Annotated Bibliography," Paper prepared for the Indicators Committee of the Reproductive Health Affinity Group of the Ford Foundation (2002); Pan-American Health Organization, *Quality of Care in Women's Reproductive Health: A Framework for Latin America and the Caribbean* (Washington, DC: PAHO, 1994); *Family Care International, Meeting the Cairo Challenge: Progress in Sexual and Reproductive Health* (New York: FCI, 1999); UNFPA, *Indicators for Population and Reproductive Health Programs* (New York: UNFPA, 1998).
86. See, e.g., A. Miller (see note 42).
87. See P. Hunt (Special Rapporteur of the Commission on Human Rights), *The right of everyone to enjoy the highest attainable standard of physical and mental health*, UN Doc. A/58/427 (2003) [Hunt 2003 Report]; *id.*, UN Doc. A/59/27 (2004) [Hunt 2004 UNGA Report], para. 58 [Hunt 2004 Report]
88. Hunt 2004 UNGA Report (see note 86).
89. See G. Tamayo (see note 41) and A. Kamara (see note 39).

90. M. Berer and T. K. Sundari Ravindran, "Preventing Maternal Mortality: Evidence, Leadership, Resources, Action," in M. Berer and T. K. Sundari Ravindran (eds), s(London: Blackwell Science, 1999), pp. 3-12.
91. See note 1.
92. For discussion of availability and accessibility, see ESCR Committee General Comment No. 14 (see note 27), para 12.
93. D. Maine, T. W. Wardlaw, V. Ward, et al., *Guidelines to Monitor the Availability and Utilization of Obstetric Services*, UNICEF/WHO/UNFPA (1997) [UN Guidelines].
94. A.E. Yamin and D. Maine, "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations," *Human Rights Quarterly* 21 (1999): 563-607.
95. See A. E. Yamin and D. Maine (see note 92). Cf. L. P. Freedman, "Finding Our Feet, Standing Our Ground: Reproductive Health Activism in an Era of Rising Fundamentalism and Economic Globalization," in C. W. Howland (ed), *Religious Fundamentalisms and the Human Rights of Women* (New York: St. Martin's Press, 1999) p. 189.
96. Much of the work in health since Cairo has been on integrating services, e.g., reproductive health with primary health care or family planning with maternal health. But see Transforming Health Systems (see note 6), p. 4.
97. E.g., M. L. Heilborn (see note 12); M. Gupte (see note 20); J. G. Figueroa (see note 57). See also R. Petchesky and K. Judd (eds), *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (New York: Zed Books, 1998).
98. S. Gruskin (see note 5), p. 2.