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***Reproductive Health and the Millennium
Development Goals: Politics, Ethics, Evidence
and an 'Unholy Alliance'***

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Abstract

This paper provides a chronological account of the evolution of the concept and policy of reproductive health and its initial entry, and subsequent exclusion, from UN declarations. In the 1990s effective lobbying by sexual and reproductive rights activists established reproductive health for all as a UN goal. However, at the Millennium Assembly of 2000 and in the Millennium Development Goals (MDGs), an 'unholy alliance' of the Holy See and a handful of conservative Muslim governments managed to keep reproductive health off the agenda. This was successful political manoeuvring for the short-term, but the alliance fell apart and the power of the theoretical and empirical case in support of reproductive health saw it return to the MDGs in 2005. The moral standing of religious institutions, such as the Holy See, is undermined by such opportunistic, short-term political behaviour and, in particular, the ambiguous legal status of the Holy See at the UN is called into question.

Keywords: Reproductive health, Sexual and reproductive rights, Millennium Development Goals (MDGs), UN, Development ethics, Religion and development, Holy See, Abortion

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1 Introduction

The Millennium Development Goals (MDGs) are the world's biggest promise – a global agreement to reduce poverty and human deprivation at historically unprecedented rates through collaborative action.¹ They differ from all other global promises for poverty reduction in their comprehensive nature and the systematic attempts taken to finance, implement and monitor them. While the MDGs have a comforting aura of global harmony and solidarity around them – '[t]hey envelop you in a cloud of soft words and good intentions and moral comfort'² – there have been and are heated arguments around them. The processes from which they emerged³ – UN conferences and summits, meetings of OECD's Development Assistance Committee (DAC), the Millennium Summit and UN General Assembly meetings – were scenes of overt and covert contestation. Different countries, non-governmental organisations (NGOs), social movements, faiths and leaders formed shifting coalitions to shape the goals according to their moral positions and political interests. What should be included in an authoritative list of global goals, and what should be excluded, taxed the analytical, bargaining and negotiating skills of tens (perhaps hundreds) of thousands of technical specialists, social activists, policy makers and politicians around the turn of the millennium.

In this myriad of proposals and counter-proposals, drafting of text and 'square bracketing'⁴ of text, clashes of values and interests, the processes surrounding the issue of reproductive health (see Box 1) stand out as the most heated. The strong initial advances made by this concept, development goal and policy in the mid-1990s were undone in 2000 and 2001.⁵ The progress made by reproductive health was grounded in skillful and unremitting moral and empirical argument and social mobilisation by the international women's movement and women's health specialists from around the world. By contrast, the opponents of reproductive health (the Holy See, a small number of conservative Islamic states and, later, conservative Christians and the Bush administration) mixed their moral reasoning with judicious political manoeuvring. Ultimately, they managed to block reproductive health from becoming an MDG not by

¹ For a full listing of the MDGs, targets and indicators, see www.un.org/millenniumgoals.

² Saith, A. (2006). 'From universal values to Millennium Development Goals: Lost in translation'. *Development and Change* 37(6), 1167.

³ For a history of the MDGs, see Hulme, D. (2007). 'The making of the Millennium Development Goals: Human development meets results-based management in an imperfect world'. *BWPI Working Paper 16*, BWPI, The University of Manchester; and Hulme, D. (2009). 'Global poverty reduction and the Millennium Development Goals: A short history of the world's biggest promise'. *BWPI Working Paper 100*, BWPI, The University of Manchester.

⁴ In UN documents when a member 'square-brackets' text this means that, unless the text is modified or removed, the member concerned will formally register reservations.

⁵ The framing of the issue varies over time and between interest groups. Originally this was the problem of 'population and development'. Social activists reframed the problem as 'sexual and reproductive rights'. After negotiations and compromises, the terms 'reproductive health' and/or 'reproductive health for all' became most common.

the persuasiveness of their case, but by the effectiveness of their political gamesmanship.⁶

Box 1: Defining reproductive health

Reproductive health is the complete physical, mental and social wellbeing in all matters related to the reproductive system. This implies that people are able to have a satisfying and safe sex life and that they have the capacity to have children and the freedom to decide if and when to do so. Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problems. (Source: UN, Cairo Programme of Action, available at www.unfpa.org/icpd/summary.cfm).

This paper describes and analyses the processes behind this important example of global public policy making. Subsequently, it presents a short assessment of the impacts of the exclusion of reproductive health from the MDGs by drawing upon the findings of the Millennium Project.⁷ There is a strong case that those who worked so effectively to block the reproductive health goal have obstructed human development and potentially slowed the pace of global poverty reduction. In particular, the number of women dying as a result of ‘unsafe abortion’ almost certainly increased. By concentrating on using political devices, rather than the power of their ethical and empirical arguments, the coalition of opponents of reproductive health implicitly fell back on the grounds that ‘the end justifies the means’. In the short term this was an effective strategy – it achieved their objective over the period 2000–2005. In the longer term, however, this seems an untenable position for faiths and faith-based groups, as (i) a dependence on temporary and opportunistic political alliances ultimately weakens their claims to an ethical position, and (ii) it calls into question the historically privileged but ambiguous status of the Holy See at the United Nations.

2 The Millennium Development Goals

The Millennium Development Goals are a nested set of eight goals, 21 targets (i.e. sub-goals) and 60 indicators.⁸ They were first presented at the UN General Assembly in September 2001 in Kofi Annan’s *Road Map Towards the Implementation of the United*

⁶ Gamesmanship seems appropriate, as most of these opponents were males.

⁷ UN Millennium Project (2005). *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (London: Earthscan).

⁸ The original list in 2001 was of 18 targets and 48 indicators, but this has been amended.

Nations Millennium Declaration.⁹ According to the official record, they were drawn up by technical experts from an inter-agency group (IMF, OECD, UN, World Bank) from Section III of the *Millennium Declaration* – ‘Development and poverty eradication’. They are held to have unique legitimacy, as the *Millennium Declaration* was approved by the UN’s 189 member states in September 2000.

Once one moves away from the official account, however, it is clear that in terms of both content and format the MDGs bear a much closer relationship to the International Development Goals (IDGs) drawn up by the OECD’s Development Assistance Committee (DAC), and approved by OECD development ministers in May 1996 in *Shaping the 21st Century: The Contribution of Development Cooperation*, than they do to the UN’s *Millennium Declaration*.¹⁰ Both the MDGs and IDGs can point to a similar source – the UN conferences and summits of the 1990s. They also have common overarching conceptual frames. Both view poverty reduction (or eradication) from a broad human development perspective, and both are constructed as tools for results-based management to make public policy more effective.¹¹

However, there are two significant differences between the 2001 MDGs and the IDGs. First, the MDGs include a Goal 8, to establish a ‘global partnership for development’. This identifies a set of policy and institutional changes, particularly for rich countries, needed to deliver Goals 1 to 7. Second, the 2001 MDGs did not include the goal of ‘...access...to reproductive health services for all...by 2015’. This was a core component of the IDGs and other authoritative declarations. This omission, or more accurately exclusion, is the focus of this paper.

Before proceeding, it is important to note that an analytical focus on the MDGs runs the risk of exaggerating the role of the MDGs in global poverty reduction. The MDGs are only one of many mechanisms and processes shaping patterns of poverty reduction (or poverty creation). All of the MDG goals were being pursued in some countries/localities before the 1990s. Many goals not included in the MDGs have and are being pursued by private and official agencies. For example, during the years that reproductive health was ‘off’ the MDG list (2001–2005) the UN’s World Health Organisation (WHO), United Nations Population Fund (UNFPA), governments and NGOs were extending access to reproductive health services in many countries. While the MDGs are important for poverty reduction, they are far from being the only game in town.

⁹ See UN (2001). *Road Map Towards the Implementation of the United Nations Millennium Declaration: Report of the Secretary-General* (New York: UN).

¹⁰ See DAC (1996). *Shaping the 21st Century: The Contribution of Development Cooperation* (Paris: OECD).

¹¹ See Hulme, ‘The making of the Millennium Development Goals’, for a discussion of the ways in which the concepts of human development and results-based management framed the MDGs.

3 From sexual and reproductive rights to reproductive health

Until the 1980s, international development agencies and the governments of developing countries conceptualised reproductive issues through the lens of population and demography. The main challenge was framed as understanding the links between population growth and economic development. The prevailing orthodoxy was that high rates of population growth hampered economic growth and threatened the global environment. As a result, population control was prescribed: low fertility rates were to be pursued, so family planning must be promoted and services delivered. The overarching aim was to reduce aggregate fertility rates rather than achieve responsible individual choices about fertility. In its most extreme forms, in India and China, this approach has forced people to use contraceptives, be sterilised and have involuntary abortions.

In the industrialised world a quite different concept was shaping public attitudes and policy. Feminist thought made rapid progress in the 1960s and 1970s and campaigns calling for sexual and reproductive rights for women spread across Europe and North America.¹² The diffusion of feminist ideas and the women's movement took this concept to developing countries and in 1984 the first International Reproductive Rights Conference '...legitimated reproductive rights as a global feminist concept'.¹³ Initially this radical concept had little impact on the orthodoxy and, for example, the UN's World Population Conference of 1984 in Mexico focused on family planning and population control (alongside the controversy of President Reagan's crusade against abortion).

The idea gained traction in developing countries in the late 1980s, however, as some of the social activists and women's NGOs activated by the UN Decade for Women (1976–1985) decided to prioritise reproductive rights and women's health in their programme design, research and advocacy. This prototype reproductive health movement rapidly honed its arguments, created a strong evidence base for policy lobbying and transferred technical advice and organisational skills across countries. Partly as a result of this social activism, the WHO adopted the concept of sexual and reproductive health at the end of the decade, creating a platform to take the idea forward as global public policy.

Despite this progress, proponents of reproductive health met with great opposition in many countries. At the local level, where orthodox family planning had tiptoed around the obstacles created by men (fathers, husbands, brothers, boyfriends, pimps) controlling women's sexual and reproductive behaviour, reproductive health confronted 'local tradition' head on. At the national and international levels, resistance to the concept and practice of reproductive health was spearheaded by religious conservatives

¹² See Correa, S. (2002). 'Sexual and reproductive rights', in V. Desai and R. B. Potter (eds.), *The Companion to Development Studies*, pp. 367–371 (London: Arnold).

¹³ *Ibid.*, p.369.

in the rich world (especially the Holy See and the Roman Catholic Church) and the developing world (particularly in conservative Islamic and Catholic countries). In addition, certain professional groups and epistemic communities – specialists in family planning service delivery and demographers focused on population control – had technical objections and felt personally sidelined by this new idea.

Fascinatingly, this opposition appears to have strengthened the resolve of people and organisations promoting sexual and reproductive health.¹⁴ Their feminist analytical framework predicted that a patriarchy, from husbands in remote villages to the Pope at the Vatican, would oppose women's rights and advised that women must constantly present and repeat their arguments until the moral power of their case was accepted.

In the late 1980s and early 1990s, two important elements of advocacy for sexual and reproductive health appear to have evolved in ways that would advance the case more rapidly. This re-framing of the problem may have been adopted for tactical reasons, but it had strategic significance in terms of policy emphases.

Framing the issue

The first set of changes relates to the way in which proposals were framed. Over time campaigners used the term 'sexual and reproductive rights' less and less, and the terms 'reproductive health' and/or 'reproductive health services' became the brands under which these goals and policies were to be advanced. While the concept of sexual and reproductive rights has intellectual coherence and was heavily drawn on in the 1980s, the resonance of this term varied greatly with context and audience. In much of the economically advanced world – Europe, North America and Japan – the term 'sexual' could be used in public without creating offence. Following the sexual revolution of the 1960s and 1970s the terms 'sex' and 'sexual' were in relatively common use in the mass media in these regions. The situation was quite different in many parts of the developing world, where it was, and often still is, highly offensive to use such terms in public, and where the mention of 'sex' may be interpreted as encouraging promiscuity, pre-marital and extra-marital sex or homosexuality.¹⁵

While the terms 'sexual and reproductive rights and/or health' remained in use, there is a marked preference over time to publicly frame approaches and policies as 'reproductive rights' or 'reproductive health'. This yielded at least two tactical benefits. First, in conservative societies, the new ideas were less likely to meet resistance because of concerns about the discussion of sexual issues in the public sphere. Men who would not

¹⁴ For example, the founding of the International Coalition for Women's Health (ICWH) was partly inspired by opposition to President Reagan's 'Mexico City or global gag rule' rule in 1984.

¹⁵ Despite the gravity of the global HIV/AIDS pandemic, many leaders in Africa and Asia have been, and remain, reluctant to talk publicly about the disease, because it is transmitted sexually.

let their wives or daughters discuss sexual matters with a health worker might let them discuss reproductive health.¹⁶ Second, dropping the term 'sexual' appeared to remove debates about homosexuality from the agenda.¹⁷ While from a rights-based perspective the sexual orientations of women and men are unjustifiable grounds for discrimination, entering into such debates in many developing countries would have been a tactical disaster for women's health and wellbeing. If opponents to the new agenda could claim it encouraged homosexuality, they would have mobilised widespread public support in many countries. As one advocate of a sexual and reproductive rights approach observes, '...developing "universal" ideas of sexuality is an exceedingly complex task'.¹⁸ Arguably it is a task that, had it been pursued, would have set back progress on reproductive health for decades.

Allied to reducing or dropping references to 'sexual' was an increasing ambivalence to the use of the term 'rights'. While the documents and debates of the last 15 years continue to make reference to reproductive rights and reproductive health rights (along with women's rights and human rights), increasingly the new agenda was framed as either 'reproductive health' or 'reproductive health for all'. One can identify a number of reasons for this shift. For pragmatic advocates of sexual and reproductive rights, promoting 'reproductive health' focused debates on practical improvements in the lives of women, children and men. Once 'rights' were introduced, then opponents could shift debates to more abstract issues and, for example, argue that Western values were being imposed on non-Western societies.¹⁹ Why trade under a label that empowers your opponents in countries where the need for a new agenda is greatest?

Another factor explaining the gradual shift from 'rights' to 'health' relates to the changing *agora* (locations and actors) of global policy making on this issue. In the early 1980s the main bases for discussion were amongst feminists and sexual and reproductive rights advocacy groups within civil societies. At such locations, and for such actors, rights-based arguments had legitimacy and authority. The early successes of these activists meant that over time more and more of the discussions and documentation moved to national arenas and agencies (health ministries, civil servants, training institutions and parliaments/national assemblies) and international arenas (UNFPA, World Bank, UN General Assembly and DAC). The pressures operating on such actors, and their behaviours, are quite different from those acting on social movements. Official actors are

¹⁶ The alliance between the Holy See and conservative Muslim countries at the ICPD was broken when proponents of reproductive health agreed to drop the term 'sexual rights' from the draft document (see later).

¹⁷ I say 'appeared', as in recent years the rights of gay couples to have children has become a moral and policy issue in some countries.

¹⁸ Correa, 'Sexual and reproductive rights', p. 370.

¹⁹ In the 1990s this was a major issue in Southeast and Eastern Asia. National leaders championed 'Asian values' and argued that human rights were an attempt to foist European values on Asian societies. In many Sub-Saharan African countries there are strong prejudices against homosexuality, which is often seen as part of Western culture and not African culture.

often more focused on the short-term and resource allocation issues and have quite different forms of accountability. As advocacy for 'sexual and reproductive rights' shifted from groups of like-minded supporters to more diverse, and often suspicious, national and international agencies, it mutated into 'reproductive health'. Persuading governments and multilateral organisations to promote sexual and reproductive rights might be desirable, but was problematic. Persuading them to commit to providing reproductive health for all was desirable and more likely to gain their support. At UN meetings and conferences this shift facilitated the negotiation of progressive compromises. One could demand 'sexual and reproductive rights' in opening statements, and subsequently show a willingness to compromise in final documents and declarations by agreeing to 'reproductive health services for all'.

Making the case

The second set of changes relates to the forms and composition of argument used to support the case for reproductive health and/or sexual and reproductive rights. By the early 1990s there were three related but distinct arguments. The first was normative. The second and third required empirical support: this had been gathered over the 1980s and extending this knowledge base remained an important task over the 1990s.

- (i) *Rights* – Drawing from moral philosophy and building on the Universal Declaration of Human Rights (UDHR) of 1948, a powerful argument was developed that sexual and reproductive rights were core human rights. Allied to this was the argument that women's rights must be respected in the same ways as those of men.²⁰
- (ii) *Direct benefits* – An expanding evidence base was created and deployed to demonstrate that improved access to reproductive health services produced beneficial health outcomes – reduced maternal and child mortality, fewer spontaneous and unsafe abortions, improved child health and welfare. The launch of the journal *Reproductive Health Matters* in 1993 provided an important mechanism for rapidly sharing results about policies, methods and outcomes and creating a coherent epistemic community.
- (iii) *Indirect benefits* – Following the shifts in feminist thinking from women in development (WID) to gender and development (GAD) and women and development (WAD),²¹ evidence was gathered to demonstrate that improved access to reproductive health services contributed to broader development goals and, particularly, economic growth. Findings were collated to show that this approach led to higher productivity, reduced fertility and dependency rates and a higher quality workforce.

²⁰ Agreement on this was reached at the UN Human Rights Conference at Vienna in 1993 (see later).

²¹ See Young, K. (2002). 'WID, FAD and WAD', in V. Desai and R. B. Potter (eds.), *The Companion to Development Studies*, pp. 321–325 (London: Arnold).

With increasing sophistication, and building on the earlier experience of the women's movement, advocates for reproductive health tapered the composition of their arguments for different audiences. In Europe (particularly Northern Europe) and UN conferences, human rights and women's rights arguments would draw support; for meetings of medical and health professionals and policy makers the direct benefits of a reproductive health strategy over orthodox family planning had to be demonstrated; for economists, demographers and development policy makers (at the World Bank, IMF and ministries of finance) the third set of arguments had to be emphasised to justify the allocation of additional resources.

4 The MDGs and reproductive health

The UN Conferences and Summits of the 1990s

The Millennium Development Goals have many origins, but most analysts trace them back to the resurgence of UN conferences and summits that started with the Children's Summit of 1990.²² The international women's movement homed in on these meetings as an important mechanism for advancing gender equality. The movement now had effective structures to influence such events: a global network of NGOs and advocacy groups, who could operate at the national level in both developed and developing countries; and highly skilled lobbying groups in New York, Washington DC and other global centres. While proponents for sexual and reproductive rights, women's health and reproductive health were drawn from outside of the women's movement, particularly from health and medicine, the push for a paradigm change in population policy was spearheaded by the women's movement.

The movement was very effective at the UN Conference on Environment and Development (UNCED) at Rio in 1992 and managed to establish that '...women's issues are part of global agendas and must be incorporated there, rather than addressed separately'.²³ There were heated debates at Rio about the relative importance of population in poor countries *vis-à-vis* reduced consumption in rich countries. As a consequence '...a group of women decided to initiate an international campaign to build a consistent framework on population issues among women's groups and to bring women's voices to the upcoming conference on population and development'.²⁴ These women partnered with the well-established NGO the International Women's Health Coalition (IWHC), and in late 1992 women's health activists from around the world met to plan how to engage with the UN decennial conference on population planned for 1994 in

²² See Hulme, 'Global poverty reduction', for a full discussion.

²³ See Chen, M. A. (1995). 'Engendering world conferences: The international women's movement and the UN'. *Third World Quarterly* 16(4), 481–483 for an excellent review.

²⁴ *Ibid.*, p. 485.

Cairo. Out of this spin-off from the Rio conference emerged the Women's Voices '94 Alliance (WV94A). This alliance produced the 'Women's Declaration on Population Policy' to help activists find a common platform and it had significant influence at Cairo.

In addition to the WV94A initiative, the 'women's caucus' model was developed at Rio. This device was used at subsequent UN conferences. It involved the convening of a meeting early each morning at the NGO forum (the civil society event that runs parallel to the official conference) to review the previous day's results, share information and plan the strategy for the day in hand. It was a simple device, but it helped to focus activists on achieving specific changes in documents, agreeing priorities and allocating tasks (such as who would take the lead on lobbying specific delegates and delegations).

The momentum from Rio was taken forward to the World Conference on Human Rights at Vienna in 1993. The women's movement operated very effectively in the official preparatory meetings (PrepComs) and in Vienna achieved agreement that women's rights were integral to human rights. The women's caucus device was used and extended. In addition to the NGO Women's Caucus, a daily Governmental Women's Caucus was convened for official delegates by UNIFEM.

However, it was at the International Conference on Population and Development (ICPD) at Cairo in 1994 that '...a giant leap for womankind was achieved'.²⁵ From its inception the Cairo Conference had great promise as the UN's General Assembly had broadened the Conference's agenda from 'population', the 1974 and 1984 title, to 'population and development' signalling that debates must move beyond population control. By chance the Cairo conference was fortunate in its location and timing. It being based in a Middle Eastern country with a Muslim majority encouraged conservative Islamic countries, which were concerned about a population and development agenda, to participate. Having delegates from all UN member states gave the meeting global legitimacy. In terms of timing, it occurred when the international women's movement had worked out how to maximise its impact at conferences, before the 'conference fatigue' of late-1995 had set in, and during the early months in office of a pro-choice US President. And finally the ICPD was chaired by Dr Nafis Sadik, the executive director of UN Population Fund (UNFPA) and a medical doctor whose professional life had been dedicated to advancing family planning. She was a highly effective norm entrepreneur,²⁶ who had a command of all the relevant technical arguments but could also function exceptionally well at diplomatic levels.

²⁵ Ibid.

²⁶ For a discussion of norm entrepreneurs and Dr Nafis Sadik, see Fukuda-Parr, S. and Hulme, D. (2009). 'International norm dynamics and "the end of poverty": Understanding the Millennium Development Goals (MDGs)'. *BWPI Working Paper 96*, BWPI, The University of Manchester.

The Declaration from the WV94A stimulated at least 15 major meetings over 1993 and an unofficial 'feminist PrepCom' for the ICPD was organised in January 1994. This endorsed a collective statement and mandated the IWHC to lead a group targeting the drafting of the official conference documents. Massive efforts were mobilised on the ICPD preparatory processes to get pro-reproductive health candidates on official delegations, to influence the official PrepCom meetings, and to use the media to transmit the case for reproductive health.

As the conference opened at Cairo, the IWHC and WV94A were in a strong position and had the support of over 30,000 women's rights activists.²⁷ Following the Rio model, a Women's Caucus was organised each morning at the NGO forum. In the afternoon, representatives of the Caucus and NGO members of official delegations²⁸ and the media met at the official conference site. A small, core group of reproductive health lobbyists systematically met official delegations to press them to support specific changes to the draft Programme of Action and fight the 'battle of the brackets' (see later).

Not everyone, however, was happy about what the draft document called 'the new concept of reproductive health'. In particular, the Holy See and its leader Pope John Paul II, were deeply concerned and claimed that the draft Programme of Action '...encouraged abortions on demand, approved of adolescent sexual activity and condoned homosexuality'.²⁹ Like the international women's movement, the Holy See approached Cairo in a systematic fashion. However, its status as a Non-Member State Observer to the UN gave it significant institutional advantages.³⁰ Although the Holy See cannot vote at the UN General Assembly or UN Committees, it can participate in UN conferences '...almost on an equal footing with members'.³¹ It has full access to all official conference meetings and documents, can re-draft and/or bracket text and can engage directly with member-state delegations.

The Holy See's efforts began well before the conference. It actively participated in the three official PrepComs and at regional meetings, where the draft Programme of Action was reviewed by member-states. More publicly, five months before the conference, Pope John Paul II wrote to all heads of UN member states with a warning that the ICPD

²⁷ Friedman, E. J. (2003). 'Gendering the agenda: The impact of the transnational women's rights movement at the UN conferences of the 1990s'. *Women's Studies International Forum* 26(4), 313.

²⁸ Many governmental delegations included NGO personnel and, for example, the US delegation was 50 percent NGO secondees.

²⁹ Abdullah, Y. (1996). 'The Holy See at United Nations Conferences: State or Church?' *Columbia Law Review* 6(7), 1846. See this excellent work for a detailed analysis of the status of the Holy See at the UN.

³⁰ The only other observer with this status is Switzerland.

³¹ Sybesma-Knol, R. G. (1981). *The Status of Observers in the United Nations* 24, p.63 (Leiden, thesis), quoted in Abdullah, 'The Holy See', p.1840.

could produce ‘... a serious setback for humanity’.³² The Holy See also made a concerted attack on the position of the US administration. This attempt to mobilise Roman Catholic and conservative Christian groups against Clinton led to the President visiting the Pope at the Vatican in May 1994 to try to reach a compromise. He was not successful, however, and the attacks continued.³³

At the same time, the Holy See covertly negotiated to form an alliance with conservative Islamic states, such as Iran and Libya.³⁴ Initially this strengthened its position as it had UN member states that would also support the bracketing of text. However, this ‘unholy religious pact’³⁵ broke up during the conference, when proponents of reproductive health agreed to drop the expression ‘sexual rights’ from the draft document. While the concerns of the Holy See and conservative Islamic states overlapped, they also differed. The Holy See was most concerned about abortion, while the Islamic states focused on blocking access to family planning services for adolescents and the ideas of sexual health and sexual rights. At the third and final PrepCom in April 1994 the Holy See made its position very clear. It ‘square-bracketed’ the term ‘reproductive health’ 112 times and bracketed around ten percent of the full draft document, with little or no support from member-states.³⁶

And then came the conference. The Holy See was an active participant, with 17 official members to its delegation, one of the largest at the ICPD. Kennedy reveals the scale of the Holy See’s influence – at one stage in the Cairo Conference it summoned 120 resident foreign ambassadors to a meeting to ‘convey its opinions’.³⁷ Despite the efforts of the conference chair, Nafis Sadik, to keep things calm – and opening comments from US Vice President Al Gore that abortion was not a right and was not a method of family planning – sharp lines were soon drawn between the Holy See and the vast majority of other delegations. Gro Brundtland, Prime Minister of Norway, accused the Holy See of ‘many misrepresentations’ and Egypt’s Population Minister, Maher Mahran, asked ‘...is the Vatican ruling the world?’.

The press in the UK and US (and other countries) ran numerous articles accusing the Holy See of hijacking the conference. The *Financial Times* reported that the Holy See was in a quite different position to all other delegations: ‘Unlike all other states which have to govern people with health problems and formulate population policies, the

³² Woodward, K. L. *et al.* (1994). ‘A heavyweight contest’. *Newsweek*, 6 June, p.82, quoted in Abdullah, ‘The Holy See’, p.1846.

³³ Cowell, A. (1994). ‘Vatican attacks population stand supported by US’ *New York Times*, 9 August, at A1, quoted in Abdullah, ‘The Holy See’, p.1847.

³⁴ Tagliabue, J. (1994). ‘Vatican seeks Islamic allies to UN population dispute’, *New York Times*, 18 August, at A1, quoted in Abdullah ‘The Holy See’, p.1847.

³⁵ ‘A rather unholy religious pact’. *The Independent*, 11 August (1994).

³⁶ Woodward, ‘A heavyweight contest’, p.83.

³⁷ See Kennedy, P. (2006). *The Parliament of Man: The United Nations and the Quest for World Government* (London: Allen Lane), p.308.

Vatican was in Cairo principally to defend the tenets of religion'.³⁸ This sole focus on a moral position grounded in religious belief, without the moderating influences of a domestic polity or the pressures to maintain friendly economic or political relations with other states, permitted the Holy See to stick to its isolated position until virtually the end of the conference. At the very last moment, the Holy See announced that it would join the final consensus in a '...partial manner'.³⁹ It did not support plans for the ICPD's implementation and recorded its reservations on the term 'reproductive health'.

By the time of its capitulation, many reproductive health activists saw the Holy See's decision to compromise as irrelevant. They had reached agreement with almost every UN member apart from a small group of ageing men at the Vatican (who had 'no-member' status). They celebrated '...a watershed...that sealed a paradigm shift that had been gradually taking shape in international and national thinking on population issues'.⁴⁰

Reproductive health was energetically on the ascendant as a concept, as a policy priority and as a practice. In 1995 the ICPD Programme of Action was re-affirmed at the UN Social Summit in Copenhagen and the Fourth World Conference on Women in Beijing. The Holy See took a much lower profile at these events, although at Beijing it pushed to have terms such as 'unsafe abortion' and 'reproductive health' excised from draft documents. However, activists who thought that the Holy See was vanquished made a great strategic error: the Holy See was down but not out (see later).

The OECD-DAC's International Development Goals

In 1996 reproductive health made another breakthrough, though at the time the full significance of this advance was not recognised. This occurred at a quite different forum from the vast and diverse UN conferences. Aid agencies had a bad time in the first half of the 1990s. With the end of the Cold War the US had reduced its budgets and interest in foreign aid. Most other rich countries followed this lead. Allied to this, public opinion in most countries placed a low priority on aid. The OECD's Development Assistance Committee (DAC)⁴¹ was casting around for ways of re-energising public support and increasing aid budgets. As part of this exercise it launched a document in 1996, entitled *Shaping the 21st Century*. This included a list of seven International Development Goals

³⁸ Nicholson, M. (1994). 'Vatican makes waves at Cairo Conference'. *Financial Times*, 8 September, p.4.

³⁹ United Nations (1994). *Report of the International Conference on Population and Development* (New York: UN), p.147.

⁴⁰ Standing, H. (2004). 'Towards reproductive health for all?' In R. Black and H. White (eds.), *Targeting Development: Critical Perspectives on the Millennium Development Goals*, p.239 (London: Routledge).

⁴¹ The DAC is the association of the aid agencies and ministers of international development of OECD countries.

(IDGs),⁴² selected and adapted from recent UN conferences. Amongst these goals was 'access through the primary health-care system to reproductive health services for all individuals of appropriate ages as soon as possible and no later than the year 2015'.⁴³ The DAC, comprised mainly of middle-aged men from rich countries, had no difficulties in agreeing this goal.⁴⁴ In most OECD countries reproductive health was not a controversial issue and in the one advanced country where it was an issue – the US – the Clinton administration had committed to the Cairo Agenda. With no Muslim countries in the OECD and with strong women's movements operating in most member countries, including reproductive health on the list was an easy decision for OECD members.

The IDGs themselves had relatively little impact on policies or action in the short term. While some countries, such as the UK, promoted them with great energy, for others they were just another international document to be filed away. For proponents of reproductive health, it was pleasing to see the goal on this list – but no big deal. Their energy was increasingly focused at the national level in getting the ICPD Programme of Action implemented.

The UN General Assembly, the ICPD+5 and the Millennium Summit

The next major date in the diaries of those promoting reproductive health came in 1999, with the five year follow-up meeting to Cairo (ICPD+5) at a special session of the UN General Assembly. Member nations reiterated their support for the Cairo Agenda following the efforts of '...countless nongovernmental organizations and committed government delegations', according to Stan Bernstein of UNFPA.⁴⁵ However, the language of parts of the declaration reveals a watering down of some elements of the reproductive health agenda and the 'unholy alliance' was more active and effective.⁴⁶

Shortly after this meeting things began to go wrong for the international lobby for reproductive health. In part this may be because after the ICPD+5 meeting activists became complacent and believed that the paradigm shift from population control to reproductive health had been institutionalised. It may also have been that 'The Millennium Summit process did not loom large enough on people's radar screens'.⁴⁷ This was not the case for those opposed to the Cairo Agenda. The Millennium Summit was at the centre of their radar screens and they were working actively to ensure that

⁴² The DAC was keen on goals and targets, as many of its members were pursuing results-based management (see Hulme, 'The making of the Millennium Development Goals').

⁴³ DAC, *Shaping the 21st Century*, p.2. In addition, the IDGs included reducing infant and child mortality by two-thirds and reducing maternal mortality by three-fourths by 2015.

⁴⁴ They did have difficulty in agreeing on a gender equality goal, however (see Hulme, 'Global poverty reduction').

⁴⁵ Crossette, B. (2004). *Reproductive Health and the Millennium Development Goals: The Missing Link*. Commissioned by the Population Program of the William and Flora Hewlett Foundation, pp.8–9.

⁴⁶ Personal communication, Lauchlan Munro, 16 September 2007.

⁴⁷ Quotation from Sam Bernstein of the UNFPA, in Crossette, *Reproductive Health*, p.9.

reproductive health was not mentioned in the Millennium Declaration that would be agreed at the Summit.

What has been labelled an 'unholy alliance'⁴⁸ was mobilizing, and would prove highly effective. According to Gita Sen this was spearheaded by the Holy See and included the UN delegations of conservative Islamic countries and conservative, evangelical Christian groups from the US.⁴⁹ The latter were growing in size, becoming increasingly effective in political terms and had developed a strong case challenging reproductive health. They claimed that it encouraged abortion on demand and sexual promiscuity. As an alternative they proposed sexual abstinence.

Gita Sen argues that since its involvement in the Rio Summit in 1992:

...the Holy See...project[ed] itself as a 'moral' authority for the world, espousing poverty and debt reduction...on the one hand, and opposing gender equity and sexual and reproductive health and rights on the other... the Holy See, though only an observer state at the UN, has played a key role in developing both strategy and tactics for the opposition to gender equality and women's human rights. By creating alliances with conservative governments across traditional religious divides, and by bringing its skills to bear on coalescing a non-governmental opposition as well, the Holy See played a critical role throughout the first decade after the ICPD.⁵⁰

The influence of the Holy See was amplified through its interactions with a small number of conservative Islamic countries in the G77 (the UN's informal association of developing countries, which then numbered around 130 members). For the most conservative Islamic countries of the G77⁵¹ – led by Sudan and with the active involvement of Libya and Iran – this meant ensuring that the G77 blocked the reproductive health goal out of the draft Summit document being prepared by the UN (*We the Peoples*). The G77 '...was internally split on the issue but opted [as is its norm] for a consensus that would not offend its most conservative members'.⁵² A handful of G77 members were thus able to ensure that the group's 130 members opposed reproductive health goals. This message was forcefully relayed to the Secretary-General. No Secretary-General, and particularly one from the developing world, could ignore the G77 message. The concerns of these conservatives, that 'reduced maternal mortality' was a covert means of

⁴⁸ Berer, M. (2001). 'Images, reproductive health and the collateral damage to women of fundamentalism and war'. *Reproductive Health Matters* 9(18), 8.

⁴⁹ Sen, G. (2005). 'Gender equality and human rights: ICPD as a catalyst?', in UNFPA (ed.), *The ICPD Vision: How Far Has the 11-Year Journey Taken Us?*, p.49 (New York: United Nations Population Fund).

⁵⁰ Ibid.

⁵¹ Saudi Arabia might be expected to take part in this group, but it is reported as generally not engaging actively at the UN.

⁵² Crossette, *Reproductive Health*, p.3.

promoting reproductive health, meant that even this goal was also excluded from *We the Peoples*.

Several other factors contributed to this blocking out of the reproductive health goal from the Millennium Summit agenda. First, political changes in the US meant that by 2000 the US delegation at the UN was not prepared to push the case for reproductive health. Al Gore was now running for President and faced a strong right-wing, anti-abortion lobby from Republicans. 'Many in this lobby sought to boil down reproductive rights to the single issue of abortion and they see this lurking behind every reference to such rights or choices'.⁵³ Gore could not risk being accused of promoting abortion in a UN resolution. Second, observers⁵⁴ report that the case against reproductive health was strengthened by the powerful advocacy of Sudan's representative on this issue – an eloquent woman, who powerfully and persistently argued the conservative line of culture, tradition and the need to discourage young people from having sex outside marriage. Third, changes in the leadership of the UNFPA during this period meant that this key agency lost the momentum it had gained in the mid-1990s. The person in charge of discussions on targets and indicators at UNFPA at this time came from an orthodox family-planning background and had not been actively involved in the ICPD paradigm shift.⁵⁵ Finally, as observers of multilateral processes point out, the key people negotiating about what went into *We the Peoples* about population and development (as on all other specialist issues) were not people with professional backgrounds in this field (as had been the case at Cairo). They were diplomats, who prioritised geo-political and strategic considerations over the role of reproductive health in poverty reduction. In particular, the UN Secretary-General's senior advisor who was drafting *We the Peoples*, John Ruggie, was a 'message entrepreneur'. His priority was to achieve a progressive package of goals in the final Millennium Declaration that would be acceptable to all member countries. Losing the reproductive health goals was no big deal from this perspective.⁵⁶

European countries and the World Bank argued strongly that reproductive health was an essential component of a strategy for poverty reduction and that other Declaration goals could not be achieved if reproductive health was omitted. But the Secretary-General and Secretariat were not going to risk producing a document that the G77, the majority of UN members, would not approve. To the chagrin of reproductive health proponents around the world – and most poverty reduction specialists – the April 2000 Report of the Secretary-General to frame the Millennium Summit, *We the Peoples*, avoided mention of the Cairo Agenda. Odd references to relevant issues occur – but, the reproductive health goals agreed at Cairo (1994) and re-affirmed at Beijing (1995) and New York (1999) were missing.

⁵³ Ibid. p.11.

⁵⁴ Interview with Phil Evans, DFID (10 January 2007).

⁵⁵ Interview with John Hobcraft (24 October 2006).

⁵⁶ For a discussion of message entrepreneurs and norm entrepreneurs, and an examination of John Ruggie's role, see Fukuda-Parr and Hulme, 'International norm dynamics'.

This might have appeared to have been the death knell for reproductive health in terms of the UN's *Millennium Declaration*. However, unobserved by most development experts, the target setting mania of the 1990s had left the world with a twin-track process. While the UN Secretariat was negotiating its way to an approved set of UN development goals, the OECD was sticking to its original set of International Development Goals (IDGs). The two organisations had started with the same inputs – the agreements from the UN summits and conferences of the 1990s – but their quite different political processes had yielded two different lists. These lists had a number of similarities, but also differed in a number of ways – especially on reproductive health. Confusingly, Kofi Annan was backing both of these lists. Only eight weeks after publishing *We the Peoples*, he signed and launched *2000 A Better World for All: Progress Towards the International Development Goals*, a joint UN, OECD, IMF and World Bank document. This promised that the UN would support the IDGs – the sixth of which was an unequivocal goal to provide reproductive health for all by 2015. The Secretary-General was backing both tracks of the twin-track approach to goal setting that was underway. As head of the UN, he would lead the process for the *Millennium Declaration's* goals, but he was happy to sign up to the somewhat different goals that the OECD had generated.

Over summer 2000 there were frantic negotiations about what should finally go into the *Millennium Declaration*. To deal with these last-minute compromises, the UN civil servants involved appear to have used a classic diplomatic device. They divided the 'development and poverty eradication' goals resolutions into two main paragraphs.⁵⁷ Paragraph 19 – 'We resolve further' – includes those goals that are fully agreed and that are to go forward to the plan of action. Paragraph 20 – 'We also resolve' – lists goals on which there is widespread agreement but where some UN members still have reservations. In effect, these goals stay on the agenda but there is no guarantee they will be part of a plan of action.

For reproductive health there are two main points to note when contrasting the IDGs (in *2000 A Better World for All*), *We the Peoples* and *the Millennium Declaration*.

- (i) Reproductive health does not appear in the *Declaration*. The 'unholy alliance's' grip on the G77, and the growing opposition to the idea from conservative Christians in the US, meant that the powerful backing that lay behind this goal (most OECD countries, the majority of developing countries, the International Financial Institutions, specialised UN agencies and vast civil society networks) had to back down. Reproductive health was the deal maker or breaker – to achieve approval of the *Millennium Declaration* at the General Assembly, reproductive health had to be omitted.
- (ii) On a more positive note, the *Declaration* included the goals of '...reduced maternal mortality by three-quarters, and under-five child mortality by two-

⁵⁷ In addition, the goals for rich countries were identified in Paragraphs 15 and 16.

thirds, of their current rates'. These were 'copied' from the IDGs and indicated that maternal and child health, if not reproductive health, would be a policy priority.

On 8 September 2000 the *Millennium Declaration* was approved, with the support of 189 countries and 147 heads of state and government. The General Assembly tasked Kofi Annan with preparing a 'road map' for the implementation of the *Declaration's* poverty eradication goals.

Concordance: Merging the IDGs and the Millennium Declaration

Before Annan could develop this implementation plan, he needed final agreement from all of the key official players in international development on what the exact goals and targets would be. The Declaration provided a variety of resolutions, scattered around four different paragraphs, but not a precise statement in the results-based management format now favoured by aid donors and multilateral agencies.

The UN's statisticians were already liaising with co-professionals at the DAC in Paris about indicators and sources of data. As the UN agencies had to follow the *Declaration*, and as the OECD saw no reason to drop the IDGs (and had UN, World Bank and IMF agreement on them), there were two possible ways that the twin-track process might run:

1. **Continue with a twin-track process.** This would mean that the UN and OECD both got their own way, but would make the job of programming global poverty reduction (plans, structures, financing, monitoring) complex for implementing agencies and confusing for politicians and publics.
2. **Reconcile the two sets of goals.** This was the logical thing to do, but was problematic. How could Annan explain to the General Assembly that he had modified an agreement that 189 countries had approved? On the other hand, why should the OECD change the IDGs – in June 2000 the UN, World Bank and IMF had endorsed them?

This issue was brought to a head in March 2001, at a World Bank convened meeting attended by more than 200 delegates from the multilaterals, bilateral donors and more than a dozen developing countries.⁵⁸ It opened with a proposal from Mark Malloch Brown, Head of UNDP, that the UN should be given the task of finalising the 'Millennium Declaration Goals' from the *Millennium Declaration*. Several delegates pointed out that this would mean that key components of the IDGs would be lost (most obviously reproductive health) but Malloch Brown dismissed this:

⁵⁸ The content and processes of this meeting are reported in Hulme, 'Global poverty reduction'.

...my view is that the International Development Goals were a step towards a process which has now culminated with a unique act of endorsement... at the Millennium Summit... my view is that it is a step back to a less universally, less high-level endorsed set of goals.⁵⁹

A US delegate, Colin Bradford, argued that 'concordance' could be achieved and, after much private negotiation, it was agreed that a technical task force be set up to merge the two sets of goals – with members from the DAC (representing OECD), World Bank, IMF and UNDP. It was this task force that finalised the MDGs, in what was claimed to be a purely technical exercise, in Annan's *Road Map Towards the Implementation of the United Nations Millennium Declaration*.⁶⁰ Even this authoritative listing was carefully qualified, however: 'The list of millennium development goals does not undercut in any way agreements on other goals and targets reached at the global conferences of the 1990s'.

It is clear from both the content and format of the 'final'⁶¹ version of the MDGs that the IDGs, as presented in *A Better World for All*, were taken as the primary source.⁶² Many points from the Millennium Declaration were subsequently negotiated into the MDGs, but as lower level targets or indicators. Only two major changes were made to the IDGs as they transmuted into the MDGs. First, a Goal 8 was added – laying out the sorts of policy and process changes needed in rich countries to facilitate global poverty reduction. Second, the IDG goal of reproductive health for all disappeared.

While reproductive health was an explicit goal in the IDGs, and a central component of a human development conceptualisation of poverty reduction (as both a means and an end), the UN could not entertain this because of the continued reservations of a small number of its members (see earlier). The US position had also changed. Although the new US president showed little interest in the UN or global poverty reduction, the members of the task force drafting the MDGs fully understood that the Bush administration was committed to an aggressive anti-abortion stance.⁶³ It was also strongly influenced by conservative Christians, who opposed the sexual and

⁵⁹ Miller Reporting Company (2001). *Transcript of Proceedings, the World Bank – From Consensus to Action: A Seminar on the International Development Goals* (Washington DC: Miller Reporting Company), pp.42–43.

⁶⁰ UN, *Roadmap*, p.55.

⁶¹ I say 'final' as the *Road Map* reported that some indicators still needed finalising and changes have been made in the mid-2000s (see later).

⁶² See IMF, OECD, UN, and World Bank (2000). *A Better World for All*. (Washington DC: IMF, OECD, UN and World Bank).

⁶³ One of George W. Bush's first acts as President was to re-introduce President Reagan's Mexico City/global gag rule. This required all recipients of US foreign aid to ensure that no element of their programmes was associated in any way with performing, or advising on, abortions. As a result, US funding for many family planning programmes was immediately stopped.

reproductive rights principles underlying the reproductive health goal.⁶⁴ Exactly how the decision to axe reproductive health was taken has not been documented, but during interviews in New York several UN insiders (all of whom wish to remain anonymous) used the same expression – ‘it was crossed out on the 38th floor’ (referring to where the Secretary General’s office is located). There was a consolation prize for reproductive health advocates in the final agreement, however, as ‘improved maternal health’ became a full MDG goal, separate from child health.

5 Implementing the MDGs

With the goals finally agreed, the agenda shifted to implementation. This meant preparing a plan and finding the finance to implement the MDGs. The finance issue was to be thrashed out in Monterrey, Mexico at the UN Finance for Development (FFD) meeting in March 2002. Prospects for the FFD were not good, as global ‘Millennium fever’ had waned and the US seemed suspicious of the MDGs. Neither President Bush nor any of his advisors had been part of the IDG or MDG process, and their neo-conservative stance made global poverty reduction a marginal issue. They had little time for the UN and thought that the FFD might be an attempt to get the US to foot the bill for other countries’ promises. The Bush administration was not embarrassed to state that all of its decisions would be based purely on the US national interest, and it made this point forcefully by refusing to collaborate in international processes to curb climate change – indeed by saying climate change was not happening.

However, the 9/11 attack on the Twin Towers modified this unilateral stance for a time. It led to the reconsideration of the role of ‘soft power’ and, to the surprise of many observers (both supporters and opponents), Bush turned up at Monterrey and promised a large increase in US foreign aid.⁶⁵ The European nations also agreed to significant aid increases and the ‘Monterrey Consensus’ was forged. There were two main ways that these additional resources might be channelled to MDG achievement. The first was by rich countries independently programming their bilateral aid towards the MDGs. This is what most countries preferred and what many have done. The second was to develop a UN plan towards which countries could commit resources. This led to the initiation of the Millennium Project.

Shortly after the ‘Monterrey Consensus’, Kofi Annan appointed the economist Jeffrey Sachs⁶⁶ of Columbia University as his Special Adviser on the MDGs to head the

⁶⁴ Sen, ‘Gender equality’.

⁶⁵ See Hulme, ‘Global poverty reduction’, for a discussion. Bush’s decision was taken very rapidly after a meeting with Bono.

⁶⁶ Sachs is probably the most publicly recognised economist in the world, although he lacks a Nobel laureate. He is also a controversial figure and is both renowned and reviled. While his

Millennium Project. Sachs assembled more than 250 development experts into ten task forces and they set about drafting plans for MDG achievement. The Project, like its leader, was highly ambitious. It sought to identify the technologies and actions that could achieve rapid poverty reduction, identify the institutional requirements, estimate the finances required and contribute to the mobilisation of these resources. Such an exercise might appear to be irrelevant for reproductive health – it was not an MDG. However, the reports that Sachs and his specialist teams assembled argued that reproductive health was central to any plan to achieve the MDGs. The MDGs could not be achieved unless reproductive health was energetically promoted.

The reports of three of the Millennium Project's task forces highlighted reproductive health (Child and Maternal Health, Education and Gender Equality, and HIV/AIDS) and the Main Report, published in January 2005, built on their message very forcefully. In its discussion of 'why the world is falling short of the goals', it identified 'sexual and reproductive health' as one of the three 'areas important for development – and for achieving the Goals – [that] are not included in the formal Goals framework'.⁶⁷ Its analysis is free of concerns about the beliefs of conservative Muslims and Christians or the Holy See. It states that '...promoting reproductive health requires more than simply delivering services and information...It includes...Postabortion care and access to safe abortion, where permitted by law'. In relation to gender equality, it recommends 'Universal access to sexual and reproductive health information and services and protection of reproductive rights...and to expand access to safe abortions (where permitted by law) and review the legal status of abortion in order to improve public health while respecting national sovereignty, cultural values, and diversity'.⁶⁸

Kofi Annan certainly got the message and his March 2005 Millennium Report to the UN General Assembly, *In Larger Freedom*, cites the centrality of 'ensuring access to reproductive health services' to achieve the gender equality goal.⁶⁹

The Millennium Project Report was intended to be one of the ways in which a renewed commitment to the MDGs would be ignited, in both rich and poor countries, at the UN 'Millennium plus 5' Summit in September 2005. While it failed in this respect,⁷⁰ and there

commitment to global poverty reduction is clear, he is accused of trying to downplay his role in Russia's catastrophic privatisation programme. Critics also fear that he projects an image of development as 'white men' coming to rescue other races.

⁶⁷ The others were energy and transport.

⁶⁸ See UN Millennium Project, *Investing in Development*, pp.82–84 and 277.

⁶⁹ Annan, K. (2005). *In Larger Freedom* (New York: UN).

⁷⁰ The efforts of the UK government, particularly Tony Blair and Gordon Brown, and like-minded colleagues from other countries, failed. The US wanted to focus the summit on counter-terrorism. The run-up to the Summit was thrown into confusion when the US Ambassador to the UN, John Bolton, tabled more than 700 amendments to the draft final agreement at the last moment. The event itself was then upstaged by Hurricane Katrina and the world's amazement at the Bush administration's failure to provide humanitarian support for its own citizens.

has been limited direct action on the grand project it specified, it did help to re-ignite debates about the role of reproductive health in strategies for global poverty eradication. Its impacts were amplified by calls for support from reproductive health advocates to ensure that ‘...references to sexual and reproductive health and/or reproductive rights’ be made in the documents produced by international meetings leading up to the 2005 Summit.⁷¹ How the Holy See, and its allies in conservative Islamic countries, reacted to this renewed support for reproductive health is not documented, but this time supporters of reproductive health were successful.⁷² In September 2005 the UN General Assembly committed to ‘...Achieving universal access to reproductive health by 2015...integrating this goal in strategies to attain the internationally agreed development goals’ and ‘...to promote gender equality and eliminate pervasive discrimination by:...Ensuring equal access to reproductive health...’.⁷³ The US government registered a reservation⁷⁴ to this agreement, as did the Holy See. After a period of protracted technical and political wrangling, the UN’s Expert Group placed a reproductive health target and four indicators on the official list in January 2008 (Table 1).

Table 1: The MDG target for reproductive health

Goal 5: Improve maternal health	
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate 5.4 Adolescent birth rate 5.5 Antenatal care coverage (at least one visit and at least four visits) 5.6 Unmet need for family planning

Source: UNStats, *Millennium Indicators*, <http://mdgs.un.org/unsd/mdg/Default.aspx> (accessed 20 May 2008).

⁷¹ Haslegrave, M. and Bernstein, S. (2005). ‘ICPD goals: Essential to the Millennium Development Goals’. *Reproductive Health Matters* 13(25), 106–108.

⁷² Sakiko Fukuda-Parr (personal communication, March 2009) reports that some UN insiders explained the reinvigorated support for reproductive health as arising because of changed sentiments in the Muslim world. By 2005 the Muslim world’s disenchantment with the Bush administration had reached such levels that almost anything that annoyed the Bush administration was seen as desirable. As a result the conservative Islamic states that had originally blocked reproductive health within the G77 no longer exercised their veto. That made it possible for the General Assembly to approve the new target, much to the annoyance of conservative Christians in the US, many of whom were enthusiastic supporters of President Bush.

⁷³ UN (2005). ‘Resolution adopted by the General Assembly: 60/1 2005 World Summit Outcome’, paras 57 and 58 (UN document A/Res/60/1).

⁷⁴ John Bolton placed on record that ‘...the use of the phrase “reproductive health”...do[es] not create any rights and cannot be interpreted to constitute support, endorsement or promotion of abortion’ (UN document A/60/PV.8, p.46).

6 Keeping reproductive health out of the MDGs: An assessment

Much of the debate about the inclusion/exclusion of reproductive health from the MDGs has been of a moral or religious nature. Whether such activities are wrong from a theological perspective (and must be universally blocked), or right from a human rights and gender equality perspectives (and must be universally promoted), has been a key focus. In this section I move beyond these abstract debates and, in line with the principles underpinning the MDG exercise, ask 'what have been the results achieved by those who managed to stop reproductive health becoming an MDG goal in 2000 and kept it off the official list of targets until 2008?' Assessing this in quantitative terms is very difficult, as: (i) the blocking was only partial, as during this period reproductive health policies have been pursued by many countries and official agencies; (ii) other factors have impacted on reproductive health services (most notably Bush's re-introduction of the 'Mexico City/global gag rule' in 2001); and (iii) data on many of these factors are very weak (e.g. maternal mortality) or non-existent (numbers of unwanted pregnancies).

The MDGs provide a human development format for such an assessment and the Millennium Project⁷⁵ a summary of the consequences of reduced access to reproductive health services at household and national level (also see Appendix 1).

Goal 1 Eradicate extreme poverty and hunger. More parents have larger families than they desire, and child spacing intervals are shortened. As a result family investment in each child's nutrition and health is lowered and poverty and hunger for all members of the family becomes more likely and/or more severe. In addition, at the national level, population growth rates are higher than they would be if services could be better accessed: this impacts negatively on national social and economic development.

Goal 2 Achieve universal primary education. Reduced access to reproductive health services means that families are larger, and children closer together, than parents would have chosen. As a result investment in education per child is reduced. In most societies this impacts particularly on girls, who are regarded as having a lower priority. At the national level, education budgets have to be spread across a larger number of schoolchildren, reducing the quality of education. This has negative implications for educational attainment, as a goal in its own right, and for patterns and rates of economic growth.

Goal 3 Promote gender equality and empower women. Controlling whether and when to have children is a critical aspect of women's empowerment that is greatly curtailed when reproductive health services are not easily accessible. Women who cannot plan the timing and number of their births have more limited opportunities at work, in education and in economic and social life.

⁷⁵ UN Millennium Project, *Investing in Development*, pp.82–84.

Goal 4 Reduce child mortality. Lack of access to prenatal care and reduced ability to avoid high-risk births (especially for very young women and when births are close together) increases the probability of infant and child deaths. Children in large families are likely to have reduced health care, and national health expenditures per child decrease when fertility levels are high.

Goal 5 Improve maternal health. Lower levels of access to reproductive health services lead to more unwanted births, more higher-risk pregnancies and reduced levels of care in pregnancy, childbirth and post-delivery. All of these raise maternal mortality rates. A particular problem in many societies is an increased rate of unsafe abortion (often provided outside of medical facilities) and associated mortalities. For the early 2000s these were estimated at more than 68,000 deaths per annum.⁷⁶

Goal 6 Combat HIV/AIDS, malaria and other diseases. Lack of access to reproductive health services raises rates of sexually transmitted diseases and HIV infection rates through reduced levels of knowledge and access to medical services.

Goal 7 Ensure environmental sustainability. Constraints in the provision of reproductive health services lead to increased fertility rates and population growth. This makes it more likely that natural resource use will exceed sustainable levels and increases rates of urban migration and international migration.

As a result of the arguments outlined above, the blocking or obstruction of access to reproductive health services for five years by the 'unholy alliance' seems almost certain to have reduced progress towards the MDGs, and have increased poverty and human deprivation. While the exact reductions in MDG achievement cannot be estimated, the causal links between reduced access to reproductive health services and slower progress towards the MDG targets are clear.

From a conservative, religious perspective, such an analysis may appear irrelevant – any action that might make abortion more accessible and/or promotes contraceptive use and/or recognises the legitimacy of homosexuality and/or might facilitate/encourage pre-marital or extra-marital sexual activity is morally wrong and must be opposed, regardless of the outcomes. However if, as I do, you believe it is immoral for progress in reducing poverty to be slowed down – reducing extreme income poverty, lowering the number of hungry people, moving towards gender equality, letting child and maternal mortality rates remain high, slowing down progress in preventing HIV/AIDS incidence rates and raising the probability of environmental sustainability – then the consequences of the political manoeuvring of the Holy See and its temporary allies to block reproductive rights for all, and impose its moral stance on an unconvinced world, merit condemnation.

⁷⁶ UN Millennium Project, *Investing in Development*, p.82.

7 Conclusion

This paper has charted the evolution of reproductive health as a component of the Millennium Development Goals. It explains the rise of reproductive health as a new paradigm for the framing of population and family planning issues. This rise was dependent on energetic support from the women's movement, the establishment of specialist NGOs and networks, and the development of an epistemic community (comprised of medical and health specialists, demographers and social scientists) determined to research and document the benefits of a reproductive health approach and identify 'best' practices.

However, the rise of reproductive health for all as a global goal was challenged by a small part of the UN's membership, in alliance with the Holy See (a non-member state observer at the UN). This opposition believed that a reproductive health approach was, and is, morally wrong as it promotes 'abortion on demand' (the main concern of the Holy See and other Christian conservatives), homosexuality, pre-marital and extra-marital sexual relations, and greater control for women over sexual and reproductive behaviours (concerns for conservative Muslim groups and some conservative Christians). This small group, in global terms, successfully blocked the listing of reproductive health as an MDG goal in 2000 and 2001. Belatedly in 2005 – through advocacy from the women's movement, highly effective work by the reproductive health epistemic community within the Millennium Project and the UN, and the break-up of the alliance between the Holy See and conservative Islamic UN member states – reproductive health has returned to the MDGs. But now it is a target (i.e. lower level objective) and its formal entry was stalled for a further two years by debates about the precise specification of indicators.

Moving beyond the moral debates around reproductive health, the paper presented an assessment of the consequences accruing from blocking reproductive health as an MDG. While precise estimates cannot be made, the case that the direct costs of this action (in terms of increased numbers of unwanted pregnancies and increased rates of child and maternal mortality) and the indirect costs (increased income poverty and hunger, slower progress with universal primary education and gender empowerment) have been negative seems unassailable. Those who obstructed access to reproductive health services in the developing world have imposed a burden on the poor and especially on poor women.

The capacity of a small component of humanity (the Holy See, three or four conservative Islamic states and, belatedly, conservative Christians in the US) to obstruct access to reproductive health services for hundreds of millions of people (mainly poor women) was not a moral victory, in which the strength of the ethical reasoning won the day. Rather, it was a triumph of political manoeuvring. The opponents of reproductive health did not

waste too much of their time publicly debating and detailing their moral case and exploring its empirical consequences. Rather, they focused on covert political negotiations and bargaining. They achieved their immediate objective – blocking reproductive health as an MDG goal – for more than five years, but the ‘unholy alliance’ that was forged has fallen apart and their moral stature has been weakened. Reproductive health will remain a contentious issue in some parts of the world, but the power of its theoretical and empirical case (contrasted with the guile and political horse-trading tactics of its opponents) should ensure its advance over the medium and longer term.

Appendix 1: MDG targets and reproductive health⁷⁷

Awareness of, and access to, reproductive health services contributes to MDG attainment in the following ways.

Goal 1, Target 1 Reduced income poverty

Enables women and men to plan their families, leading to lower fertility rates and reduced income poverty.

Goal 1, Target 2 Reduced hunger

Enables women and men to plan their families and space their children. This improves child and maternal nutrition.

Goal 2, Target 3 Universal primary education

Promotes progress towards universal primary education, due to reduced rates of withdrawal of girls from school to care for (i) siblings caused by unplanned parenthood, and (ii) their own unplanned pregnancies.

Goal 3, Target 4 Gender equality

Allows women to plan their fertility and improves women's participation in economic, social and political spheres.

Goal 4, Target 5 Reduced child mortality

Permits women and men to plan their families and space their children, so that child health and nutrition are improved.

Goal 5, Target 6 Reduced maternal mortality

Reduces the number of unwanted and ill-timed pregnancies, reducing life-time exposure to the risk of maternal mortality and reducing recourse to abortion.

Goal 6, Target 7 Reduced HIV/AIDS prevalence

Linking reproductive health and HIV/AIDS programmes increases effectiveness, coverage and efficiency of service delivery.

Goal 6, Target 8 Reduced prevalence of malaria and other diseases

Enables improved child spacing and reduced fertility. This permits parents to improve their own and their children's access to and usage of health services.

Goal 7, Target 9 Reverse loss of environmental resources

Permits effective use of family planning services, reduces total fertility rates to the levels people desire, and mitigates population pressure on the environment.

Goal 7, Target 10 Improved access to water and sanitation

Permits effective use of family planning services, reduces total fertility rates to the levels people desire, and reduces pressure on water and sanitation services.

Goal 7, Target 11 Improve the lives of slum dwellers

Reduces the burden of ill-health for slum dwellers (especially women).

⁷⁷ Source: UN Millennium Project, *Investing in Development*, pp.281–293.

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The Brooks World Poverty Institute (BWPI) creates and shares knowledge to help end global poverty.

BWPI is multidisciplinary, researching poverty in both the rich and poor worlds.

Our aim is to better understand why people are poor, what keeps them trapped in poverty and how they can be helped - drawing upon the very best international practice in research and policy making.

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