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NOTES

NORPLANT AND THE NEW PARADIGM OF INTERNATIONAL POPULATION POLICY

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Until recently the fundamental tenet of United States and international population policy has been to limit the number of people in the developing world. International population control policy has given priority to the reduction of birth rates and neglected the goals of empowerment, reproductive rights, and quality of life. The organizing principle of population control has dominated the provision of family planning services and in doing so has distorted the goals of both empowerment and fertility decline.2

Current population trends justify concern about the effects of rapid population growth. The population of the Earth is now 5.6 billion and will reach 6 billion by the end of the century.3 The world is adding 93 million people each year,4 and Africa is experiencing the fastest population growth in human history.5 No one can accurately predict how long these population trends will continue;6 however, many scientists argue that continuing rapid population growth without the concurrent development of social structures may play a role in many of the problems facing humankind.7 Rapid population growth may contribute to environ-

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2. Id. at 56-57.
4. MOFFETT, supra note 3 at 9.
6. Gaston Fischer, The Population Explosion: Where Is It Leading?, 15 POPULATION & ENV'T: J. INTERDISCIPLINARY STUD. 139, 149 (1993). The United Nations (UN) projects that replacement fertility, or an average of two children per family, will “most likely” be reached between 2030 and 2050, causing population to peak at about 11.5 billion during the twenty-second century. See MOFFETT, supra note 3, at 8-9. In contrast, the UN projects stabilization at 6 billion as its “best case” scenario. Id.
mental degradation,⁸ and may act as an impediment to economic development, but the exact relationship between population growth and development is unknown.⁹ Whatever the empirical dynamic between population and development, "governments everywhere have come to see rapid population growth in third world countries as an obstacle to development."¹⁰

The international community's attentiveness towards the impact of population growth on development and the environment is laudable, as these critical issues require international action. Unfortunately however, many policymakers, driven by fears of the effects of rapid population growth, have adopted population control as the exclusive rationale for family planning in developing nations.¹¹ Since the 1960s the perceived need to control the number of births in developing nations has governed the population policies of the United States, the United Nations (UN), and the World Bank.¹² The belief that population control should be the primary purpose of family planning programs has become "so deeply ingrained in the culture that it profoundly shapes the

⁸ of the World's Scientific Academies, reprinted in 20 POPULATION & DEV. REV. 233, 235 (1994) [hereinafter Science Summit]. It is important to note, however, that there is no absolute consensus over the negative impact of overpopulation. Moffett, supra note 3, at 4. Some economists, notably Julian Simon, argue that there is no such thing as "overpopulation" and that population growth is valuable for its role in driving technological change. See generally JULIAN L. SIMON, POPULATION MATTERS: PEOPLE, RESOURCES, ENVIRONMENT, AND IMMIGRATION (1990). At the other end of the spectrum, some population experts believe that the earth has overshot its carrying capacity and is already doomed to widespread disaster brought on by overpopulation. See, e.g., David Price, Energy and Human Evolution, 16 POPULATION & ENV'T: J. INTERDISCIPLINARY STUD. 301, 301 (1995) ("A collapse of the earth's human population cannot be more than a few years away."). More moderate population experts believe that the carrying capacity of the earth is finite, but unknown. See Vaclav Smil, How Many People Can the Earth Feed?, 20 POPULATION & DEV. REV. 255, 255-57 (1994). Accordingly, "the vast majority of experts believe that any prudent strategy for dealing with the future must include measures to slow projected population growth." Moffett, supra note 3, at 5. See generally Science Summit, supra.

⁹ Science Summit, supra note 7, at 235.


culture's world view. As a result, international population policies have measured the success of family planning in terms of demographic impact rather than the improvement of the quality of life for people living in the developing world. Family planning has emphasized averting births, not increasing the choices available to women. This population control strategy has rested on three assumptions: (1) population growth is the primary cause of developing nations' problems; (2) people must be persuaded or forced to have fewer children; and (3) efficacy in preventing pregnancy should take priority over health and safety concerns.

Activists recently have begun to challenge the doctrine of population control on several fronts. Even as religious and ethical objections to family planning programs have begun to subside, feminists from developing and Western nations have criticized existing family planning programs and the philosophies that underlie those policies. Feminist critiques of population policy stress that the goal of family planning must be to provide women with the social power necessary to control their own reproductive capacities in the context of broader social and economic change. If population control, rather than the need to expand opportunities for women, is the motivation behind family planning programs, the programs will fail both objectives. The policies are not only detrimental to women's health and well-being but their implementation will not necessarily lower birth rates.

In 1989 the UN Economic and Social Council called for an International Conference on Population and Development (Cairo Conference). After several preparatory conferences, in September 1994 the Cairo Conference, which initiated a shift in the world

13. BETSY HARTMANN, REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL 4 (rev. ed. 1995) (arguing that rapid population growth is a symptom rather than a cause of development problems); see DIXON-MUELLER, supra note 1, at 56; see also Ringel, supra note 11, at 225 (pointing out that the Western media frame population issues in terms of the “limits to growth”).

14. HARTMANN, supra note 13, at xix.


16. DIXON-MUELLER, supra note 1, at 192.

17. HARTMANN, supra note 13, at xix-xx.
population policy paradigm, was finally held. The new paradigm "focuses not on controlling numbers but on providing broadly defined reproductive health services and on acknowledging women's reproductive rights and their need for empowerment." The Cairo Conference changed the terms of population policy discourse from an exclusive emphasis on the number of births in the developing world to a concern for the health and welfare of the people living in those developing areas. The Conference gave priority to women's empowerment, reproductive health and rights, and disengaged itself from a focus on demographic targets.

Despite the contention of some commentators that the new ethic of empowerment for women is empty rhetoric, the Cairo Conference represents a significant turning point in world population policy. Much, however, remains to be done. The Cairo Conference Program of Action is not legally binding on participating governments and will require funding and resources to accomplish its goals. In addition, the international community has not yet recognized all of the implications of the Cairo principles. Some elements of the population control agenda surfaced at the Cairo Conference. For example, the Conference stressed the contraceptive implant Norplant as a means of birth control for women in the developing world. Norplant is a contraceptive that must be implanted surgically for a predetermined amount

21. See, e.g., Alexander Cockburn, Real U.S. Policy in Third World: Sterilization, L.A. TIMES, Sept. 8, 1994, at B7. "Cut through all the reassuring lingo about 'empowering women' and consider the realities of U.S. population policy today in Haiti. As revealed in an internal U.S. Agency for International Development report, the fundamental goal of the American government is to keep the natives from breeding." Id.
24. Id.
of time, thereby stripping women of control over their reproductive lives. The decision to use Norplant as a means of birth control in much of the developing world is not the result of an evaluation of the needs of women. The decision is instead a product of the population control strategy adopted by pharmaceutical companies and international population planners.

This Note will discuss Norplant as a contraceptive for women in developing nations from the perspective of a feminist critique of population policy. In the first section, this Note will present a history of population policy. In the second section, this Note will briefly describe the paradigm shift that is taking place as a result of recent policy changes. In the third section, this Note will critique the policy of population control in terms of its endorsement of the use of contraception like Norplant.

I. THE HISTORY OF INTERNATIONAL POPULATION POLICY

During the 1927 World Population Conference organized by Margaret Sanger and held in Geneva, Switzerland, the international community first addressed population policy concerns. Officials of the League of Nations privately supported the 1927 Conference, although the League was not officially represented at the Conference because the League considered the issue too controversial. The League of Nations later established a committee to study the relationship between population and socioeconomic problems; however, the committee met only once before World War II disrupted the League. Before its termination, the League sponsored the publication of a study that examined the connection between population dynamics and socioeconomic development in the European community.

Soon after its creation, the United Nations established a Population Commission to study the issue of population growth at the suggestion of the United States and Great Britain. The
Population Commission established a Population Division within the United Nations itself. The Population Division was not a policy organization, but a research organization that coordinated much of the research that would direct future population policy determinations. The Population Commission’s and Population Division’s orientations toward research, rather than policy, characterized international population thinking as a whole in the 1950s. Although the United Nations sponsored a World Population Conference in 1954, the Conference was largely a scientific forum. Support for birth control policies grew slowly throughout the 1950s. In 1959 the Population Commission set the stage for the policies of the 1960s when it suggested that population growth may impede the economic progress of developing countries. At the same time some of the specialized UN agencies were voicing concerns over rapid population growth.

The U.S. government first officially confronted the population issue in 1958 under the President’s Committee to Study the United States Military Assistance Program. Although population was not an explicit area of consideration under the Committee’s mandate, the Committee did advocate programs to counter population growth as part of U.S. aid packages. President Eisenhower did not support the Committee’s findings, however, and prevented the recommendations from taking effect.

The beginning of the 1960s marked a new era in population policy. Both the United States and the United Nations began implementing activist population policies that sought to limit births in developing nations. Congress authorized “research into the problems of population growth” as an element of development


32. Id. at 9.
33. Id. at 12-13.
34. Id.
35. Finkle & McIntosh, supra note 10, at 6.
37. Id. President Eisenhower later changed his position on family planning and expressed his new view that, “[i]f we now ignore the plight of those unborn generations which, because of our unreadyiness to take corrective action in controlling population growth, will be denied any expectations beyond abject poverty and suffering, then history will rightly condemn us.” 113 CONG. REC. 6490, 6494 (1967) (letter to Senator Gruening).
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research in the Foreign Assistance Act of 1963. President Johnson stated in his 1965 State of the Union Address that the United States must act to slow the growth of world population, and thus rhetorically committed the U.S. to a strategy of population control. President Johnson continued the theme of population control throughout his administration.

Congress addressed the concerns of President Johnson in the Food for Peace Act of 1966, which authorized the use of foreign currency for "activities ... related to the problems of population growth" by any presidentially approved agency. In 1967, when Congress did not believe that the U.S. Agency for International Development (USAID) was devoting sufficient resources to its population control obligations, it amended the Foreign Assistance Act to broaden USAID's population mandate. A passage from Senator Fulbright's speech to introduce the amendment demonstrates the exclusive focus on averting births:

We in the industrialized nations bear a considerable share of the blame for the population explosion. Modern public health programs, malaria eradication, vaccinations and the like, often made possible through our aid, have reduced mortality rates appreciably in the developing nations. Yet there is little virtue in saving people from malaria and dysentery to let them die slowly of malnutrition. The commonsense answer is clear—we need to provide help for voluntary birth control needs as we have already provided help for death control.

After Congress allowed USAID to distribute contraceptives directly, a new director, Dr. R.T. Ravenholt, took over the Population Branch of USAID and concentrated the agency's efforts on fertility control. The United States also began to offer assistance to governmental and non-governmental organizations

40. See 113 Cong. Rec. 6490, 6494-96 (1967) (collecting President Johnson's statements on population control).
42. 113 Cong. Rec. 6490, 6493-94 (1967) (statement by Senator Fulbright).
43. Id. at 6493.
44. HARTMANN, supra note 13, at 107.
who wanted to carry out population control programs. This period marked the emergence of strong support for population control programs as a matter of U.S. policy, rather than as an occasional interest of the government.\textsuperscript{45} The political, military, and economic dominance of the United States during this time allowed the U.S. government to assume world leadership on the issue of population control.\textsuperscript{46}

As the United States became more active, UN involvement in population control also increased. As early as 1962, the United Nations invited its member nations to formulate their own population policies. In General Assembly Resolution 1838, the United Nations framed the population issue in terms of both economic development and the health and welfare of the family.\textsuperscript{47} The United Nations established the United Nations Fund for Population Activities (UNFPA) in 1966.\textsuperscript{48} The UNFPA grew quickly. By 1971, the world community had recognized UNFPA as the driving force behind UN population activities.\textsuperscript{49}

Policymakers at the Population Branch of USAID saw the work of UNFPA as a necessary complement to the initiatives of USAID.\textsuperscript{50} The creation of UNFPA, however, was important because it legitimized population programs that previously did not exist. By endorsing the goal of fertility control, the United Nations gave credibility to population programs that developing nations often viewed with suspicion.\textsuperscript{51} The United States hoped that channeling money through the UN would shield population control programs from charges of genocide and imperialism.\textsuperscript{52} Following the lead of the United States and the United Nations, in 1968 the World Bank under the leadership of newly inaugurated President Robert McNamara began to accept a population

\textsuperscript{45} WORKING GROUP ON FACTORS AFFECTING CONTRACEPTIVE USE, NATIONAL RESEARCH COUNCIL, FACTORS AFFECTING CONTRACEPTIVE USE IN SUB-SAHARAN AFRICA 134 (1993) [hereinafter WORKING GROUP].

\textsuperscript{46} Finkle & McIntosh, supra note 10, at 7-8.


\textsuperscript{48} Finkle & McIntosh, supra note 10, at 9; see G.A. Res. 2211, U.N. GAOR, 21st Sess., U.N. Doc. A/6604 (1966) (enabling the Secretary General to create a fund for addressing population goals).


\textsuperscript{50} HARTMANN, supra note 13, at 108.

\textsuperscript{51} WORKING GROUP, supra note 45, at 134.

\textsuperscript{52} Finkle & McIntosh, supra note 10, at 9.
control philosophy. McNamara spoke on population issues in his inaugural address and continued to stress population issues throughout his tenure as World Bank president.\(^{53}\)

Both internal actors and the developing world placed limitations on U.S. population policy in the mid-1970s. In 1973 Congress passed the Helms Amendment to the Foreign Assistance Act of 1961.\(^{54}\) The amendment provided that no U.S. funds could be used to directly finance abortion services or abortifacient drugs.\(^{55}\) The largest opposition to U.S. population objectives occurred at the 1974 World Population Conference in Bucharest where the U.S. position in favor of demographically oriented population policies came under heavy criticism. Marxists and nationalists who supported population growth, as well as others who believed population control policies were a part of a U.S. strategy of imperialism, castigated the U.S. delegation.\(^{56}\) After revision, the World Population Plan of Action reflected the conviction, widely supported by the United States, that social and economic development could slow rapid population growth.\(^{57}\) This development-oriented strategy, however, did not instigate a shift away from the doctrine of fertility control, which remained the primary goal of population policy.

The development strategy was simply a different means to attain the same end. As feminist demographer Ruth Dixon-Mueller argues, the new approach merely targets women’s behavior rather than women’s bodies. “If biomedical engineering had not produced the ‘perfect contraceptive,’ perhaps social engineering could identify the ‘perfect social variable’ that might alter women’s reproductive aspirations and behavior.”\(^{58}\) In any event, USAID continued to treat fertility control as its primary goal, albeit with different tactics.\(^{59}\)

The population policy of the United States took a noticeable turn under the Reagan Administration. At the 1984 International Conference on Population in Mexico City, the United States announced that it no longer considered rapid population growth

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53. Jack Lyne, Robert McNamara: If We Don’t Change Soon, We’re Going to Have to Change, SITE SELECTION & INDUS. DEV., Feb. 1992, at 59; Ringel, supra note 11, at 223.
55. Id. The Helms Amendment thus denied women in developing nations the range of options that are available to American women. Dixon-Mueller, supra note 36, at 153.
57. See WORKING GROUP, supra note 45, at 134.
58. DIXON-MUELLER, supra note 1, at 70.
an obstacle to development and concluded that development problems were the result of market distortions and government policies.60 This shift in U.S. policy represented the institutionalization of the school of "supply-side demographics," an extension of the supply-side economics endorsed by Reagan.61 The United States also announced the "Mexico City Policy," which stated that the United States would no longer fund any population programs that involved coercive means or that supported abortion services, counseling, or referrals.62 Pursuant to the Mexico City Policy, USAID halted funding in 1985 for the two largest international family planning organizations: the International Planned Parenthood Federation (IPPF)63 and UNFPA.64 Although the Reagan Administration's policies changed who would receive USAID money, population aid in totem remained strong. Despite

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61. Ringel, supra note 11, at 228-29. For a more complete analysis of the institutionalization of supply-side demographics in the Reagan Administration, see id. at 220-22, 227-29. Members of the revisionist school of population, which argued that population growth is beneficial rather than harmful, used the phrase "supply-side demographics." See, e.g., Ben Wattenberg & Karl Zinsmeister, Introduction: The Argument About "Supply-Side Demographics," in ARE WORLD POPULATION TRENDS A PROBLEM? 1,1 (Ben Wattenberg and Karl Zinsmeister eds., 1985). This revisionist usage should not be confused with the "supply-side" strategy of USAID in the 1970s, which involved supplying large numbers of contraceptives to developing nations. Cf. Dixon-Mueller, supra note 36, at 155 (explaining USAID's shift from a "supply-side" to a "demand-side" approach).

The United States does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part.... Moreover, the United States will no longer contribute to separate nongovernmental organizations which perform or actively promote abortion as a method of family planning in other nations.

Mexico City Policy, supra note 60.
63. Camp, supra note 62, at 37-38. USAID defunded IPPF because IPPF could not enforce a policy that removed abortion from its central budget on its independent national affiliates. Although the IPPF only spent $400,000 to $600,000 per year on abortion-related activities, it lost a $12 million grant from USAID. Id. at 37; Rebecca J. Cook, U.S. Population Policy, Sex Discrimination, and Principles of Equality Under International Law, 20 N.Y.U. J. INT'L L. & POL. 93, 100 (1987).
the "supply-side" rhetoric, USAID provided $2.9 billion for population control activities in the 1980s. In addition, the U.S. influence at UNFPA continued and both the United States and UNFPA anticipated that funding would be resumed at a later date.

Ironically, while the U.S. government was outwardly advocating a decrease in support for population programs, the media and international community were extolling the need for population control. The 1984 World Development Report of the World Bank argued that population could not be stabilized in many developing nations without family planning policies. Since that time the World Bank has stressed fertility control in its development policies. During the 1980s UNFPA continued to be a vital force in the provision of family planning services. Following the lead of the United Nations and the World Bank, the developing world reversed its "development first" position at the 1984 Mexico City Conference. Underdeveloped countries declared that population growth must be slowed whether or not a new economic order came into existence.

II. POPULATION POLICY IN THE 1990s

In the 1990s the Clinton administration has taken a radically different approach to population issues. On his third day in office Clinton reversed several of the reproductive policies enacted by his Republican predecessors, particularly the Mexico City Policy. Clinton also announced the resumption of funding for IPPF and UNFPA as well as an increase in funding for population programs in general. In 1995 the United States spent $605 million on population programs. Today the United States is the largest source of funding for population programs in the world.
addition to providing $50 million in funding for UNFPA for fiscal year 1995, USAID sponsors bilateral population programs in thirty-seven countries.\textsuperscript{75}

For decades feminists have criticized the international population establishment for its emphasis on demographic goals rather than quality of life issues. Although the population control orientation of these international actors has enormous momentum, the voices of women are beginning to be incorporated into population policy.\textsuperscript{76} The policies of the Clinton Administration and the Cairo Conference both indicate the emergence of a new paradigm in population thinking.

Although Clinton inherited a State Department that was weak on population matters, he quickly signalled his commitment to population and sustainable development issues with the appointment of former Colorado Senator Timothy Wirth as Counselor in charge of population matters at the Department of State.\textsuperscript{77} In the first official Clinton Administration statement on population policy, Wirth declared to the Second Session of the Preparatory Committee for the International Conference on Population and Development (Prepcom II) that, “[o]verall, we must take a broader approach to sexual and reproductive health. We must recognize that advancing women’s rights and health and promoting family planning are mutually reinforcing objectives.”\textsuperscript{78} Wirth identified three priority population issues for the Clinton Administration: women’s health and status, population and the environment, and migration.\textsuperscript{79} He specifically rejected employing an exclusive focus on demographic targets, arguing that although regional goals should be developed to measure progress, “targets and quotas which apply penalties to failure ... [are] a self-defeating approach.”\textsuperscript{80} The Clinton Administration’s commitment to look beyond a narrow focus on population control has allowed the feminist population agenda to become a viable political alternative to the policies of the past.

Although the USAID’s Office of Population traditionally had concentrated its efforts on averting births, USAID moved in concert with the State Department to incorporate this new per-
spective into their policies. USAID held discussions with feminist groups in an attempt to introduce elements of the women's agenda into USAID programs. In March 1994 USAID released a document that outlined its revised approach to population policy. The document continued to advance Wirth's articulation of a dual focus on both women's rights and family planning. USAID pledged to "contribute to a cooperative global effort to stabilize world population growth and support women's reproductive rights."  

The USAID document was especially important because it treated women's health and rights as objectives in and of themselves, rather than as mere means to eliminate rapid population growth. USAID set out four principles it would follow when implementing programs:

- Promoting the rights of couples and individuals to determine freely and responsibly the number and spacing of their children.
- Improving individual health, with special attention to the reproductive health needs of women and adolescents and the general health needs of infants and children.
- Reducing population growth rates to levels consistent with sustainable development.
- Making programs responsive and accountable to the end-user.

In order to implement these principles, USAID committed itself to improving reproductive health care, guaranteeing infant and child health, and providing education for girls and women, as well as providing support for family planning programs.

The Cairo Conference was an important outgrowth of this new approach to population policy. The Conference was unique in that women participated in the policymaking process at unprecedented

81. McIntosh & Finkle, supra note 22, at 241-42.
83. Id. at 484.
84. Id. at 485.
85. Id. at 486-87. Of course, institutional change is slow. For a description of USAID's instrumental use of health services to promote population control, see Soheir A. Morsy, Deadly Reproduction among Egyptian Women: Maternal Mortality and the Medicalization of Population Control, in CONCEIVING THE NEW WORLD ORDER: THE GLOBAL POLITICS OF REPRODUCTION 162, 163 (Faye D. Ginsburg & Rayna Rapp eds., 1995).
levels. Women's organizations from both the North and South engaged in an intense international lobbying effort to include their concerns in the final draft of the Cairo Conference Program of Action. At the same time that Wirth was announcing the U.S. position, feminists at Prepcom II demanded the inclusion of empowerment language within the Program of Action. The debate at Prepcom II resulted in the addition of two new chapters, "Gender Equality and the Empowerment of Women" and "Reproductive Rights, Reproductive Health, and Family Planning." Prepcom III prompted the further development of a feminist agenda and the incorporation of such issues as development, migration, and the needs of the age groups outside the ordinary range of population policies. The Cairo Conference brought together more than 10,000 participants from 1500 organizations, with more than 150 countries represented.

The official document of the Cairo Conference, the Program of Action, opens with a recitation of the reasons why action needs to be taken on population issues, such as rapid population growth, increasing world poverty, and accelerating environmental decline. The Preamble also points out that the implementation of the Program of Action is the responsibility of individual nations, a theme to which the document returns in Chapter II on Principles.

Chapters IV-VIII represent the core of the Program of Action. Chapter IV, "Gender equality, equity, and empowerment of women," explains that "[t]he empowerment and autonomy of women and the improvement of their political, social, and economic and health status is a highly important end in itself," as well as "essential for the long-term success of population programmes." This approach reemphasizes the U.S. position that women's rights and family planning are mutually reinforcing. The Program of Action declares that women's needs are important and that women and their concerns are not simply a means to an end. Chapter IV also outlines a variety of actions necessary

86. Sen, supra note 19, at 11, 15.
87. McIntosh & Finkle, supra note 22, at 238.
88. Sen, supra note 19, at 11.
89. Chen et al., supra note 20, at 6.
90. Program of Action, supra note 22, ¶ 1.2-1.3.
91. Id. ¶ 1.11, 1.15, and para. 2.1.
92. Id. ¶ 4.1.
93. See supra notes 78, 85 and accompanying text.
to empower women, support girls, and provide for male responsibilities.94

Chapter V, "The family, its roles, rights, composition and structure," examines ways in which families can be protected. Most importantly, the Program of Action discusses the vast diversity of family structures that exist within different social and cultural systems.95

Chapter VI outlines the structure and growth of population. This chapter documents those population trends which are expected to occur over the next century.96 The Program of Action then sets forth its recommendation regarding "Fertility, mortality and population growth rates" in Paragraph 6.4:

Countries should give greater attention to the importance of population trends for development. Countries that have not completed their demographic transition should take effective steps in this regard within the context of their social and economic development and with full respect of human rights. Countries that have concluded the demographic transition should take necessary steps to optimize their demographic trends within the context of their social and economic development. These steps include economic development and poverty alleviation, especially in rural areas, improvement of women's status, ensuring of universal access to quality primary education and primary health care, including reproductive health and family-planning services, and educational strategies regarding responsible parenthood and sexual education.97

This paragraph clearly indicates the shift of focus that occurred at Cairo. Paragraph 6.4 employs some of the weakest language in the document to support population control policies.98 The weakness of the population control message in the Program of Action accentuates the emerging dominance of feminist concerns.

94. Program of Action, supra note 22, ¶ 4.4-4.29.
95. Id. ¶ 5.1.
96. Id. ¶ 6.1.
97. Id. ¶ 6.4.
98. Compare id. ¶ 4.18 ("[A]ll countries are urged to ensure the widest and earliest possible access for girls and women to secondary and higher levels of education.") and id. ¶ 9.7 ("Governments should strengthen the capacity for land management, including urban planning, at all levels ....") with id. ¶ 6.4 ("Countries should give greater attention to the importance of population trends for development."). For an example of an argument that this language is too weak, see Charles Westoff, International Population Policy, Soc'y, May/June 1995, at 11, 11.
Chapter VII addresses the goals of "[r]eproductive rights and reproductive health." Part A sets forth a broad range of actions designed to improve the policymaking aspects of population policies, such as including women in decisionmaking, increasing community participation, and providing a broader range of options for women.99 Other sections describe the roles of family planning, human sexuality and gender relations, and prevention of sexually transmitted diseases.100 Chapter VIII stresses health care for women and children, particularly in the childbirth context.101 The strength of the feminist perspective especially influenced the drafting of paragraph 8.25, which included the first mention in a UN document that abortion could be legal and safe.102 Other chapters deal with population distribution within countries, migration, education, technology, and implementation of the recommendations.103

The Cairo Program of Action changed the meaning of international population policy. In response to the Cairo Conference, the international community has demonstrated that it is willing to view population problems of developing nations in terms of quality of life objectives, rather than demographic quotas. In developing nations, reproductive rights and health directly affect women's quality of life.104 Standing alone, however, the Program of Action is just a piece of paper with no legal effect.105 The leaders of the new paradigm must convince others in the population establishment to take the goals of Cairo seriously. Shortly before the Cairo Conference, a population researcher in Cairo wrote:

On one side, there is the population establishment, that has stood strongly in support of family planning policy, beginning to change the terminology of its discourse to incorporate the concepts of health and reproductive health. We find, however,
that such changes generally remain cursory while in substance the population establishment stays strongly wedded to the traditional concerns of family planning programmes focusing its attention on number of acceptors, prevalence of use and, now, with the new concept of unmet demand for contraception.\textsuperscript{106}

The next step for the international community is to implement the goals and policies set forth in the Program of Action. Implementation measures that advocate the use of such methods as the Norplant contraceptive, however, have no place in the new paradigm of feminist population policy.

III. THE FEMINIST CRITIQUE OF NORPLANT

The population control agenda of many population planners has distorted the provision of family planning services to the developing world and steered family planning away from serving women's needs.\textsuperscript{107} The population control philosophy treats women as if they were reproductive machines, instead of human beings with individual desires and needs.\textsuperscript{108} The continuance of the population control ideology remains a critical factor in the support for such methods as the contraceptive implant Norplant. Norplant is a contraceptive consisting of six matchstick-sized rods that are surgically implanted in a woman's arm using a local anesthetic.\textsuperscript{109} The rods slowly release low levels of the synthetic progestin levonorgestrel, which inhibits ovulation and thickens cervical mucus.\textsuperscript{110} Although versions with a shorter duration are being developed,\textsuperscript{111} Norplant renders a woman infertile for five years, or until the implant is removed.\textsuperscript{112}

\textsuperscript{106} Huda Zarayk et al., \textit{Rethinking Family Planning Policy in the Light of Reproductive Health Research}, 141 INT'L SOC. SCI. J. 424 (1994).

\textsuperscript{107} Id.; see also Hartmann, supra note 13, at 37-38 (explaining that family planning has been inextricably tied to population control goals); Dixon-Mueller & Germain, supra note 15, at 214 (charging that some family planning programs treat women as instruments of population control); cf. supra part I (explaining the evolution of family planning policy).

\textsuperscript{108} Nirmala Sathe, \textit{Women's Health Is Women's Concern}, in 2 THIRD WORLD/SECOND SEX 233, 234 (Miranda Davies ed., 1987); see also Moffett, supra note 3, at 189-90 (pointing out that the emphasis on fertility control leads to treating women as merely contraceptive acceptors); Madeline Henley, \textit{The Creation and Perpetuation of the Mother/Body Myth: Judicial and Legislative Enlistment of Norplant}, 41 BUFF. L. REV. 703, 711 (explaining that judges and legislators view women as functions of their reproductive capacity).


\textsuperscript{110} Id.

\textsuperscript{111} George F. Brown, \textit{Long-Acting Contraceptives: Rationale, Current Development, and
The influence of the population control ideology was still present at the Cairo Conference although it was not reflected in the Program of Action. The U.S. manufacturer of Norplant, Wyeth-Ayerst, was one of the sponsors of the Cairo Conference. At the Conference, Norplant was considered a promising new contraceptive. The Conference praised countries with strong Norplant programs, such as Bangladesh and Indonesia, and identified them as models for the developing world.

An international emphasis on Norplant translates into the actual implantation of Norplant into women's bodies. Birth control clinics often offer only one or two long-term methods despite the claim that they provide a variety of contraceptive options. UNFPA does not contend that Norplant is the ideal solution to population problems; rather, it asserts that women should be able to choose from a range of contraceptive options. However, UNFPA's rhetoric is sometimes empty. In reality the clinics frequently deny women the choice between Norplant and other contraceptives. For example, the only birth control choices offered to women through a 1988-90 USAID population program in Peru were the contraceptive Norplant and sterilization.

The endorsement and use of Norplant in the developing world reveals the serious flaws of a population control agenda and its underlying disrespect for women's rights and safety. This section will critique three elements of Norplant use: the lack of women's control over their reproduction, the drive for effective fertility control at the expense of health and safety, and government coercion of women.

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112. Thomas & LeMelle, supra note 109, at 130.
115. Betsy Hartmann, Population: Bangladesh Is No Model, INT'L HERALD TRIB., Sept. 30, 1994, available in LEXIS, NEWS Library, CURNWS File; When 'Voluntary' Isn't, ROCKY MNT. NEWS, Sept. 15, 1994, at 54A; see Kabeer, supra note 56, at 195 (“[C]oercive measures are brought to bear on targeted populations in ... hidden ways: through the highly selective promotion of contraceptive technology, through the use of incentives and disincentives, or through the selective dissemination of particular methods.”).
116. HARTMANN, supra note 13, at 64-65.
118. Id. (citing Sumati Nair, an Indian women's rights activist).
119. Id.
A. Women's Control of Reproduction

Many Westerners, particularly Americans, desire quick, technical solutions to complex problems. When evaluating the provision of family planning services, however, the question should not be the effectiveness of the technology, but whether the chosen form of fertility control empowers those women who use it. Norplant is a type of contraception that strips women of control. Its use can be appropriate for women in developing nations only if those women make a fully informed choice to use Norplant and have access to removal facilities.

Many contraceptive methods are user-controlled. Male or female users must insert or fit barrier method contraceptives such as condoms (male or female), diaphragms, and cervical caps before they are effective. Likewise, users must take oral contraceptives daily in order to prevent conception. The advantage of barrier or oral contraceptives is also the disadvantage, because with freedom comes responsibility. Barrier methods and oral contraceptives require constant maintenance or reapplication.

Norplant, as well as other long-term methods, such as intrauterine devices (IUDs), Depo-Provera, or the newly developed contraceptive vaccine, eliminate the user's day-to-day control over fertility. When using Norplant, women cannot control their fertility for five years, the life of the implant, or until the implants are removed.

In the words of one Brazilian feminist, “[w]hen a woman uses Norplant, she is [i]n the hands ... of the provider.

125. See id.
She is quite defenseless. This is a method over which she has no control at all."\textsuperscript{328}

The philosophy of population control, which has dominated family planning services for the past thirty years, has led to a disproportionate emphasis on long-term birth control, like Norplant, over user-controlled contraceptives, like barrier methods or natural family planning.\textsuperscript{129} Population planners who hope to curtail birth rates favor long-term contraceptives because, unlike barrier and natural methods, such contraceptives remain under the provider's control and are thus more reliable.\textsuperscript{130} A population planner who has a quota is more concerned with the number of women who accept Norplant than the quality of life of those who do.\textsuperscript{131}

Limited user control is preferable in some contexts.\textsuperscript{132} Norplant and other similar contraception do not require maintenance and daily use; nor do they cause inconvenience during sex or struggle with a sexual partner.\textsuperscript{133} Before a woman takes on such a long-term commitment, however, she must have the chance to make an informed decision that includes patient counseling, a proper examination, and detailed information about the risks.\textsuperscript{134} For instance, Norplant is contraindicated for women with heart problems, high cholesterol, high blood pressure, diabetes, acute liver disease, breast cancer, or a history of blood clots.\textsuperscript{135} The fact that comprehensive health care and counseling must accompany the use of Norplant makes it an inappropriate contraceptive for much of the developing world. Counseling, screening, and follow-up facilities are inadequate in most developing nations.\textsuperscript{136} The scarcity of physicians and good medical care makes developing countries particularly susceptible to the abuses associated with Norplant.\textsuperscript{137} Moreover, the likelihood that family planning workers

\begin{itemize}
  \item \textsuperscript{128} Searching for Solutions, supra note 121 (quoting Jacqueline Pecandi, Brazilian women's rights activist).
  \item \textsuperscript{129} HARTMANN, supra note 13, at 179.
  \item \textsuperscript{130} See Sylvia Chant, Gender and Reproduction in Urban Areas, in WOMEN IN THE THIRD WORLD: GENDER ISSUES IN RURAL AND URBAN AREAS 188, 197 (Lynne Brydon & Sylvia Chant eds., 1989).
  \item \textsuperscript{131} Reena Shah Stamets, Women's Bodies, Women's Rights, St. PETERSBURG TIMES, Sept. 25, 1994, at 1D.
  \item \textsuperscript{132} See Ballard, supra note 122, at 142-43.
  \item \textsuperscript{133} See id. at 142.
  \item \textsuperscript{135} Ballard, supra note 122, at 142-43.
  \item \textsuperscript{136} DIXON-MUELLER, supra note 1, at 209.
  \item \textsuperscript{137} Ballard, supra note 122, at 144.
\end{itemize}
may hide side effects of long-term methods from women in order to meet their contraceptive acceptance quota is great.\textsuperscript{138}

Finally, in order for Norplant to adequately serve women's needs, facilities for removal must be available.\textsuperscript{139} The surgery required for Norplant removal makes it inappropriate for women living in almost all rural areas of developing nations.\textsuperscript{140} Given the general lack of access to health care in these areas, many women find it difficult to have the Norplant removed.\textsuperscript{141} In some nations Norplant providers do not even keep track of women who have received Norplant so that the implants can be properly removed after five years.\textsuperscript{142} The only control that a woman using Norplant retains over her fertility is the ability to remove the implant. If a woman cannot remove the implant, however, she is powerless. Unfortunately, "Norplant's lack of user control enables it to be used to remove as much or more of a woman's control over her reproduction as it gives."\textsuperscript{143}

B. Valuing Fertility Control over Health

There is a great need for safe and accessible contraception in the developing world.\textsuperscript{144} As in so many other spheres, however, women have no role in the production and distribution of reproductive technology.\textsuperscript{145} The goals of population control and profit have influenced the research and development of contraceptive technology more so than women's needs for safe and affordable birth control.\textsuperscript{146} Emphasis on fertility reduction has compelled researchers to concentrate on long-term contraception and to neglect the development and usage of other forms of contraception that allow women to exercise more control over their reproductive lives.\textsuperscript{147}

\textsuperscript{138} HARTMANN, supra note 13, at 65.
\textsuperscript{139} Moskowitz et al., supra note 123, at S6.
\textsuperscript{140} HARTMANN, supra note 13, at 209.
\textsuperscript{141} Id.
\textsuperscript{142} See infra note 238 and accompanying text.
\textsuperscript{143} Henley, supra note 108, at 771.
\textsuperscript{144} JULIA CLEVES MOSSE, HALF THE WORLD, HALF A CHANCE: AN INTRODUCTION TO GENDER AND DEVELOPMENT 139 (1993).
\textsuperscript{145} See STAMP, supra note 120, at 46-47.
\textsuperscript{146} Judy Wajcman, Delivered into Men's Hands? The Social Construction of Reproductive Technology, in POWER AND DECISION: THE SOCIAL CONTROL OF REPRODUCTION 153, 170 (Gita Sen & Rachel C. Snow eds., 1994); see KABEER, supra note 56, at 208 ("In general, the population establishment have [sic] used efficacy of method as the main criterion guiding research and dissemination . . .").
\textsuperscript{147} See HARTMANN, supra note 13, at 179-80; see Carmen Barroso & Sonia Correa,
The contraceptive research establishment has deemphasized barrier and morning-after methods because they are less effective in serving the long-term goals of population control. The male bias that pervades medical, particularly contraceptive, research compounds the effects of population control priorities on birth control research. The overwhelmingly male field focuses on birth control for women because it perceives contraception as a women's concern. Men prefer to require that women take the pills, endure the injections, and receive the implants. The scientific community has developed most current contraceptive technology, including Norplant, within this technological framework.

Sexism and population control objectives have engendered research biases that have a devastating effect on women. The international establishment targets the developing world for the introduction of inferior long-term contraceptives such as Depo-Provera and the Dalkon shield. Researchers and scientists often test birth control technology in developing nations before introducing it into the West. Women have been deliberately exposed to unsafe reproductive technologies both in the West and in developing nations. In pursuing the goal of reducing birth rates as quickly as possible, the contraceptive industry has neglected health and safety concerns.


148. Wajcman, supra note 146, at 170.
150. HARTMANN, supra note 13, at 179; see Wajcman, supra note 146, at 170 ("Most of the research into medical contraceptive methods is done by men on techniques for use by women.").
151. Cohen, supra note 149, at 155 (citing Joan E. Steinman, Women, Medical Care, and Mass Tort Litigation, 68 CHI.-KENT L. REV. 409, 412 (1992)).
152. CORREA, supra note 15, at 6.
153. Pamela Bolton et al., Health Technologies and Women of the Third World, in 1 THE WOMEN AND INTERNATIONAL DEVELOPMENT ANNUAL 57, 59 (Rita S. Gallin et al. eds., 1989); Chant, supra note 130, at 196; KABEER, supra note 56, at 208-09. Norplant was promoted in developing nations before it was approved in the United States. Chant, supra note 130, at 196.
155. Cohen, supra note 149, at 155; see Bolton et. al., supra note 153, at 58.
156. See HARTMANN, supra note 13, at 180-84.
Contraceptive research organizations have allocated less than ten percent of their budgets for questions of safety. Given the historically poor record in the area of contraceptive research, it is not surprising that numerous women have complained about Norplant. In a U.S. study conducted one year after implantation, seventy-eight percent of the women reported side effects, including seventy percent with bleeding pattern changes. Other common side effects are nausea, dizziness, and nervousness. In the United States, the Judicial Panel on Multidistrict Litigation recently consolidated twenty federal lawsuits against Norplant's American manufacturer, Wyeth-Ayerst, into a class action in the Eastern District of Texas. The Norplant cases allege side effects associated with Norplant, such as enlargement of the ovaries or fallopian tubes, dermatitis, acne, migration of the device, appetite changes, weight gain, blood vessel abnormalities, mastalgia, hirsuitism or alopecia, skin discoloration, infection, numbness or pain at site, arm, or hand, and nerve damage.

The most serious complaints about Norplant involve removal. According to one complaint, up to four surgeries may be required to remove implants that migrate or become covered in scar tissue. At the Cairo Conference, a Bangladeshi woman showed her arm, which had been rendered useless after Norplant removal. Infection can occur with even the best health care;

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157. Id. at 180.
161. California Women, supra note 160.
162. Class Complaints Filed, supra note 160.
therefore, removal infections are likely to be much more widespread and dangerous in developing nations where health care services are of a substantially lower quality.\textsuperscript{164}

The outlook for safer and more convenient contraception is mixed. Norplant was the first new contraceptive approved in the United States in thirty years.\textsuperscript{165} Contraceptive research has been extremely slow,\textsuperscript{166} and only one U.S. company is presently conducting contraceptive research.\textsuperscript{167} Some advancement is noticeable, however. The scientific community has introduced a new barrier method, the female condom, and also will soon make available a stronger plastic condom.\textsuperscript{168} RU 486 is currently distributed in four countries and could be used as a once-a-month pill.\textsuperscript{169} Also under development are contraceptive vaginal rings that would release hormones that remain under the control of the user and are easier to fit than diaphragms.\textsuperscript{170} Finally, researchers and scientists are investigating the possible use of microbicides and contraceptive vaccines.\textsuperscript{171} As promising as some new methods may appear, scientific advancement does not exist in a vacuum. Social prejudices will continue to thwart true advancement in the reproductive area. Unfortunately, "[a]s long as contraceptive technology is perceived ... as a technical fix for the population problem[,] contraceptive research is likely to be misdirected and misapplied."\textsuperscript{172}

\textbf{C. Governmental Abuse of Norplant}

Family planning programs that focus on population control have a long history of abusing women's rights.\textsuperscript{173} Population policies driven by contraceptive acceptor quotas, rather than by a philosophy that seeks to give women control over their repro-

\begin{thebibliography}{99}
\bibitem{hartmann13} Hartmann, supra note 13, at 209.
\bibitem{hearing74} Hearing, supra note 74, at 10 (statement of Dr. Samuel Preston, Professor of Demography at University of Pennsylvania).
\bibitem{whatever-happened-to-the-contraceptive-revolution} Whatever Happened to the Contraceptive Revolution, WASH. POST, Dec. 13, 1994, at Z12, HE.
\bibitem{brown} Brown, supra note 111, at S14.
\bibitem{id} Id.
\bibitem{id} Id.
\bibitem{hartmann124} Hartmann, supra note 124, at 267.
\bibitem{lindgren} Lindgren, supra note 163, at A1.
\end{thebibliography}
ductive lives, have resulted in systematic violations of women’s bodily integrity. Between 1.5 and 2 million women use Norplant worldwide, with most users in the United States and Indonesia. In developing countries, the public sector is the exclusive provider of Norplant. Norplant can take virtually all control over reproduction from women and “it is this lack of control that makes Norplant an attractive coercive device.” Several nations already have been involved in abuse of the Norplant device. Given the growing concern about overpopulation and ecological scarcity, nations are likely to give increased attention to long-term contraceptives like Norplant. This section will examine the impact of Norplant policies adopted in Bangladesh, the United States, and Indonesia on women in those countries. This examination, however, transcends geographical borders. Feminist population policy critic Rachel Snow proffers that, “[w]hile the nature of abuse may differ in Indonesia and Atlanta, and vary by race and class, the stories of such abuse are uniformly sobering.”

1. Bangladesh

Bangladesh considers population control to be a “number one priority” and has had vigorous population control programs since the early 1970s. Backed by the World Bank and USAID, Bangladesh instituted a heavy-handed campaign that has focused on long-term population control and has overlooked user-controlled methods and basic health care. In 1989 Bangladesh incorporated Norplant into its birth control policy and began to distribute the implant through its government-funded clinics. The Cairo Conference promoted Bangladesh as a population model, despite the

175. Albiston, supra note 25, at 11; see supra part III.A.
176. Albiston, supra note 25, at 11; see also Ballard, supra note 122, at 144 (“The loss of user control associated with the Norplant implant holds some worrisome possibilities for abuse on a systemic level.”).
177. Henley, supra note 108, at 763 (“Lack of user control has enabled Norplant to be abused in some countries, usually in the name of population control.”); see infra parts III.A., III.B., III.C.
fact that its programs are coercive and neglect women's health.\footnote{183}

According to the World Development Organization, a London charity, Bangladeshi population programs often coerce women into making certain reproductive choices.\footnote{184} Bangladeshi programs that utilize incentives and disincentives are coercive because poor women face a choice between accepting birth control or forfeiting government-sponsored economic benefits that they need for their survival.\footnote{185} For example, Bangladeshis usually do not have access to basic health care; however, the government gives women preferential treatment in health care programs if they accept birth control.\footnote{186} Also, the government sometimes denies women access to agricultural cooperatives when they do not participate in a birth control program.\footnote{187} The Bangladeshi women's group UBINIG reports that clinic workers have forced Bangladeshi women to use Norplant.\footnote{188} The clinic workers failed to offer alternative forms of birth control and did not warn the women of the side effects associated with Norplant.\footnote{189} This policy encourages government abuse when it elevates the desire for reduced birth rates above health concerns. In order to meet quotas, family planning workers feel compelled to offer only the most long-term contraceptives and hide the side effects from women.\footnote{190}

UBINIG claims that the clinics in many instances have refused to remove the implants from women who experienced side effects or from those who wanted to have more children.\footnote{191} One Bangladeshi Norplant removal study showed that one year after implantation, thirty-three percent of those studied had requested removal of Norplant.\footnote{192} Of those with more than one request for removal of the implant, health officials advised sixty-one percent to retain the implant and to allow doctors to treat the side effects.\footnote{193} Officials told the others that doctors were too busy to

\footnotesize{\begin{itemize}
\item \footnote{183} Hartmann, supra note 115.
\item \footnote{184} The Scotsman, supra note 127.
\item \footnote{186} The Scotsman, supra note 127.
\item \footnote{187} Lindgren, supra note 163, at A1.
\item \footnote{188} The Scotsman, supra note 127.
\item \footnote{189} Id. For a description of some of the side effects of Norplant, see supra notes 158-161 and accompanying text.
\item \footnote{190} HARTMANN, supra note 13, at 62-63.
\item \footnote{191} The Scotsman, supra note 127.
\item \footnote{192} Karen Hardee et al., Contraceptive Implant Users and Their Access to Removal Services in Bangladesh, 20 INT'L FAM. PLAN. PERSP. 59, 65 (1994).
\item \footnote{193} Id. at 66.
\end{itemize}}
remove the implants or that it was medically impossible to remove the implants before the five year duration had expired.\textsuperscript{194} These women thus lost all control over their reproduction. In addition to not being able to personally regulate their fertility, they were unable to remove the birth control device through the government clinic. By denying them access to removal services, the government coerced these women into the continued use of birth control that they no longer wanted.\textsuperscript{195}

2. The United States

In the United States, Norplant has attracted a great deal of attention because judges and legislators have attempted to use Norplant as an expedient solution to social problems.\textsuperscript{196} Two days after Norplant's approval by the Food and Drug Administration (FDA), the \textit{Philadelphia Inquirer} printed an editorial advocating the implantation of Norplant in African American women on welfare as a way to reduce the welfare rolls.\textsuperscript{197} The newspaper quickly apologized, but the debate had begun.\textsuperscript{198} In the United States the abuse of Norplant has taken two main forms: Norplant use as a condition of probation and financial incentives and disincentives to use Norplant.\textsuperscript{199}

The judiciary has quickly recognized ways in which Norplant could be used to control women's behavior.\textsuperscript{200} Judge Howard Broadman made headlines across the United States when he ordered Darlene Johnson, an African American woman, to use Norplant as a condition of her probation for a child abuse conviction.\textsuperscript{201} Johnson violated other probation conditions before her appeal; therefore, the court of appeals did not review her sen-

\textsuperscript{194} Id.
\textsuperscript{195} See Wilinski, \textit{supra} note 185, at 372.
\textsuperscript{197} \textit{Poverty and Norplant: Can Contraception Reduce the Underclass?}, PHILA. INQUIRER, Dec. 12, 1990, at A18.
\textsuperscript{199} See Henley, \textit{supra} note 108, at 731-32.
\textsuperscript{200} See id. at 734-36.
Despite the fact that the use of Norplant as a condition of probation is widely condemned as racist and sexist, as well as unconstitutional, judges have continued to offer such a condition as an alternative to prison. In fact judges have
sentenced at least seven women to receive Norplant as a part of their probation.\textsuperscript{207} Norplant probation orders use the machinery of the state to coerce women into surrendering control over their reproductive lives.\textsuperscript{208}

State legislators in the United States also have considered Norplant as a means to control women's behavior.\textsuperscript{209} Norplant has been the focus of at least twenty welfare reform bills in thirteen states.\textsuperscript{210} A number of these unsuccessful bills would have required women, who receive Aid to Families with Dependent Children (AFDC) payments, to accept Norplant.\textsuperscript{211} Some bills, such as one introduced in Florida in 1993, provide bonus payments to those women receiving AFDC payments who use Norplant.\textsuperscript{212}

A few of these welfare reform bills have become law. In the state of Washington, a law provides that family planning services, including information on Norplant, must be given to mothers receiving maternity care assistance.\textsuperscript{213} Tennessee goes further and mandates that the state give written information on Norplant to all people who receive public assistance.\textsuperscript{214} As of November 1, 1995, women receiving AFDC in California will not receive more benefits for additional children unless the woman was using Norplant or other long-term birth control.\textsuperscript{215} According to one commentator, "[t]he cultural stereotype of the female-headed

\textit{from Child Abuse and Fetal Abuse?}, 33 SANTA CLARA L. REV. 1017, 1050 (1993) (arguing that Norplant orders are not unconstitutional for repeat offenders because less restrictive alternatives have been exhausted).

\textsuperscript{206} Moskowitz et al., \textit{supra} note 123, at S2.


\textsuperscript{208} Emily Campbell, \textit{Birth Control as a Condition of Probation for Those Convicted of Child Abuse: A Psychologcal Discussion of Whether the Condition Prevents Future Child Abuse or Is a Violation of Liberty}, 28 GONZ. L. REV. 67, 101-02 (1992-93); Burke, \textit{supra} note 205, at 233-34.

\textsuperscript{209} See Henley, \textit{supra} note 108, at 749-52.

\textsuperscript{210} \textit{Id.} at 731.

\textsuperscript{211} Moskowitz et al., \textit{supra} note 123, at S2.


\textsuperscript{213} WASH. REV. CODE \textit{§} 74.09.800 (West Supp. 1994).

\textsuperscript{214} TENN. CODE ANN. \textit{§} 71-5-133 (Michie 1995).

\textsuperscript{215} ANN. CAL. WELF. \& INST. CODE \textit{§} 11450.04 (West Supp. 1993-94).
household receiving public assistance has evolved from the image of the white widow to the image of the black welfare mother." Playing on the myth of the "brood sow," the welfare Norplant proposals target women, especially African American women, as the source of society's problems. Furthermore, these proposals violate women's constitutional rights by requiring that they forfeit reproductive control in order to receive economic assistance. It is unconstitutional to condition benefits on the surrender of constitutional rights.

3. Indonesia

Indonesia presents the most egregious examples of Norplant abuse. Indonesia, the world's fifth most populous nation, has been cited as a success story of population control by USAID, UNFPA, and other agencies. The 1.97% population growth rate, however, has come at the expense of women's reproductive rights. According to one member of the Indonesian women's group "SP," "[a]lthough the [program] ostensibly underline [sic] the health conditions of the mother and child, [its] narrow emphasis on birth control targets overcomes the needs of women for complete information and health protection."
A contraceptive program that involves both encouragement and coercion has been instrumental in implanting over one million Indonesian women with Norplant.223 The World Bank and UNFPA finance these efforts.224 In the city of Bogor, the contraceptive choice of government employees affects their payment schedules.225 Employees who use long-term birth control, such as Norplant or sterilization, receive their salary on time, while those who use oral contraceptives or barrier methods receive their salaries three days late.226 Employees who are not part of the contraceptive program at all will not get paid until a week later.227 Also, women cannot work on Indonesia’s tea plantations unless they have a registration card confirming the fact that they have agreed to use the favored form of birth control,228 which is now Norplant.229

Since 1987 the Indonesian government has been conducting “Norplant safaris.”230 During these safaris, population control staff descend on villages with troops and village leaders to recruit women for Norplant use.231 One expert describes these campaigns, which reportedly have included threatening women at gunpoint, as “a very heavy form of persuasion.”232 The government gives the safari teams strict quotas as to how many women must accept Norplant233 and military and public health officials make it clear that the villagers will be punished if the women do not “voluntarily” meet these quotas.234

The indifference of the safari teams towards women’s health needs only compounds the trauma that women endure during these safaris.235 The safari teams pressure women into accepting

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224. THE SCOTSMAN, supra note 127.

225. Makabenta, supra note 220.

226. See id.

227. Id.


229. Makabenta, supra note 220.


231. Caplan, supra note 223, at A13; see also Makabenta, supra note 220 (describing the campaigns to threaten people into accepting contraceptives); Todd, supra note 228, at H10 (describing the safaris in Indonesia’s remote regions).

232. Todd, supra note 228, at H10 (quoting Ines Smyth of Oxford University’s Applied Social Studies and Social Research Department).


234. Todd, supra note 228, at H10.

235. Id.
Norplant without informing them of the risks associated with the contraceptive. Also, the safari workers do not ensure that the implanted women are not pregnant, which creates the risk of ectopic pregnancies. Likewise, no adequate program exists to keep track of women with implants or remove those implants when necessary, and the safaris take place in areas with poor communication, transport, and health infrastructures. Some groups have alleged that the Indonesian government has used long-term contraceptives as part of its genocidal campaign against East Timor. According to some reports, health officials inject Depo-Provera into schoolgirls who believe that they are being vaccinated.

Coercive policies aside, Norplant is an inappropriate contraceptive for most Indonesian women. Indonesia does not have a strong health infrastructure and cannot conduct the supervision and follow-up necessary for successful Norplant use. Indonesia lacks the facilities required for the removal of the spent Norplant capsules. Additionally, many Indonesian women are subject to strict menstrual taboos. Norplant, which causes irregular bleeding for most of its users, "can play havoc with their personal and social lives." By adopting a policy of Norplant use, family planners have ignored the health and personal needs of those women who are forced to participate in such a program.

IV. CONCLUSION

For more than thirty years demographic goals have directed and dominated international population policy. The Cairo Confer-
ence, however, represented the beginning of the emphasis on the
quality of life of those women affected by population policies.
The Cairo Conference's Program of Action marks a move from
an international obsession with population control toward the
provision of broadly defined reproductive health services.246 The
road ahead, however, is long and difficult.

This Note has examined from a feminist perspective the results
of a population control focus as exemplified in the use of the
long-term contraceptive Norplant. In order to move beyond such
a narrow focus, the international community must seek solutions
to the social, reproductive, and economic problems faced by
women around the world.247 As Ruth Dixon-Mueller writes:

Reproductive policies that are genuinely supportive of human
rights recognize that personal freedoms and social entitlements
are essential to the advancement of human welfare. They
respond not to a crisis mentality about the perils of overpop-
ulation, which can trigger damaging and ultimately self-defeating
efforts at massive population control. Rather, they evolve
from a thoughtful engagement of the difficulties women face
around the world in their struggle to take control over their
own fertility and their own lives.248

The principles espoused by the international consensus at Cairo
outline a population policy that properly reflects the reproductive
needs of women and men around the world. As stated in Principle
Four of the Program of Action, "women's ability to control their
own fertility [is the] cornerstone of population- and development-
related programmes."249 If population planners followed this prin-
ciple, then they would critically examine the role of Norplant in
population policy. An essential part of this analysis would be the
determination of whether Norplant's use in a specific country
would increase or decrease women's control over their fertility.

Similarly, the Program of Action contains a variety of recom-
endations to correct the abuses associated with the application
of Norplant in the population policies of many countries. The
Programme of Action seeks to eliminate discrimination based on
proof of contraceptive use,250 promote a full range of health and

246. Sen, supra note 19, at 37.
247. See DIXON-MUELLER, supra note 1, at 192.
248. Id.
249. Program of Action, supra note 22, para. 2.7.
250. Id. § 4.4(f); see supra notes 225-29 and accompanying text (describing Indonesia's
government employee contraceptive program).
family planning options,251 and expedite development of safe and effective contraceptives that take users’ needs into account.252 If individual nations and the UN seriously consider the principles and recommendations for action from the Cairo Conference, they could alleviate many of the problems that are a part of international population policy.

Improvements are possible. The United States under the Clinton Administration already has taken many steps to include women’s needs in population policy. Similarly, the United Nations may feel bound by the Program of Action in ways that individual countries are not. In order to promulgate this new feminist thinking, family planning must abandon the myopic goals of population control and adopt a sensitivity to women’s rights and health needs. The Cairo Conference has taken a promising step in that direction and hopefully the world community will incorporate the ideals of the Conference into international population policy.

251. Program of Action, supra note 22, ¶ 7.6; see supra notes 119, 136-38 and accompanying text (describing the limited range of contraceptive and health options in the developing world).

252. Program of Action, supra note 22, ¶¶ 12.12, 12.16; see supra notes 144 to 156, 165-72 and accompanying text (describing problems in current contraceptive research).