Rethinking the ‘International’ in the Politics of Women’s Health: An Ethnographic Excursion Through the Story of the Anti-Fertility Vaccine and Beyond

Using my own experiences travelling between feminisms in Australia and India, I argue that there has been a lack of interrogation into the ‘internationalisms’ that operate in the politics of women’s health, resulting in the perpetuation of a chasm among feminists on issues such as contraception and reproductive rights. I consider the chasm in feminist perspectives a productive analytic site and use this as a framework for exploring the concept of the ‘international’ in a campaign that has been deemed a success in the realm of international women’s health politics: the campaign against the Anti-Fertility Vaccine. I examine the various ‘internationalisms’ that operate in the narratives of the campaign from different standpoints, comparing ‘international’ commentary to the perspectives elicited by Indian activists. By viewing the campaign in the context of the Indian women’s health movement I demonstrate how dominant versions of internationalism serve to marginalise other more inclusive feminist internationalisms. In doing so, I seek to uncover some of the stumbling blocks that prevent the synchronisation of feminisms in the field of women’s health politics.

Like numerous other feminist engagements that seek to transcend national borders, the domain of the ‘international’ in the politics of women’s health is vibrantly contested. For this special issue on Feminist Engagements in Other Places, I would like to think about how experiences of ‘other’ places might lead us to more critically reflect on the ‘international’ in a way that enables us to go beyond an enquiry into the universal goals of feminisms. Feminist theory has been exploring the tension between universalist claims to female oppression and differences within the category of ‘women’ since the late seventies. There is a well-established literature tracking the specificities and relational histories of various feminisms (eg. ‘Western’ feminism, feminist politics of ‘women of Colour’ and ‘Third World’ feminism) and the power differentials entailed in them (Mohanty 1988; Grewal and Kaplan 1994; Basu 1995; Ram 1998a; Mohanty 2003). However, the recognition of differences in a feminist politics that seeks to cross national borders does not easily
resolve the inequalities entailed in them. Power relations run deeper than feminist theories that misguidedly neglect the ‘Third world’ perspective, and difference is produced by the fact that women are variously located in a range of social and political positions.

Each of these factors contributes to what Mary John (1999: 195) has noted as “the elusiveness of ‘internationalism’ as a concept and a goal” for feminisms. She stresses that as we look beyond the borders of the national, “dominant transnational (global?) forces” predispose us to view feminist concerns from certain angles. This became utterly apparent to me as I travelled between Australia and India, doing ethnographic fieldwork on reproductive health politics. Moving between feminisms, I encountered contradictory views on the subject of population control and family planning:

It is Thursday, the last Thursday I will spend in Delhi before returning home to Sydney. I have travelled beyond the perimeter of Delhi to a region known as Gurgaon – at once commercial hub and reminiscent of suburbia – it is a place that does not fit easily into my previous notions of peripheral city zones. I am meeting with an activist-academic to discuss a contraceptive campaign that occurred nearly a decade ago and my interest perplexes her. I encourage her to reflect on the political outcomes of the campaign and we begin to speak more generally about the shift in focus of the Indian women’s movement. She takes pause and then tells me that the political focus of the movement has begun to go beyond the politics of contraception that targeted the population control establishment. She suggests that this is partly because the problem of ‘population’ is no longer discussed in middle-class circles the way it once was; given India’s place in the world today, it is no longer such a negative asset.

The following Thursday I find myself in the heart of Sydney talking to some feminists who lobby the Australian government on reproductive health issues. One of the women tells me that she has always seen ‘family planning’ and the ‘environment’ as issues of importance. She laments that ‘family planning’ is no longer an aid priority due to the visibility of HIV/AIDS and tells me how she has to remind politicians of the importance of family planning. But once you explain to them, she says, about the ticking bomb, the population explosion that is right on our doorstep, they scratch their heads and say, ‘oh yes!’ And then they get it.

(Extracted from author’s field notes)

There are numerous ways which these extracts from my field notes could be read as illustrative of the multiplicity of perspectives that
emerge from women’s varying experiential worlds: the perplexity that I, a young Australian researcher, inspire among activists in India when I enquire about the proceedings of a campaign on which the door has been effectively shut, is just one indication of this. Taken together, these conversations acquire significance through their relational perspectives on the meaning of ‘population’ in the context of feminist politics. There is commonality in that both women sense that the emphasis on population control has shifted out of the international political gaze. And yet, there is a radically different perspective on what this means in terms of political strategy and new directions for women’s health politics. For the first it means a forward movement, turning attention to newer and more pressing battles; for the second, it represents a political loss that must be reclaimed.

In both instances, the women I spoke to considered their views to be fairly uncontroversial among fellow women’s activists in their respective places. By this I do not mean to imply that these views are representative of all women/feminists in India or Australia. Instead I wish to point out that each perspective grows out of different and unequal philosophical persuasions, resulting in opposing political strategies that are evidenced on the topic of population control. Were it not for my own exposure to Indian feminist literature, as well as my experiences doing fieldwork in India, I may not have thought the remarks of the Australian feminist to be anything extraordinary. However, the disorientation I experienced whilst talking to (Australian) women with whom I share a feminist cultural tradition, served to draw my attention to the persistence of a chasm in the politics of women’s health as one travels across experiential boundaries of place and culture.

I acknowledge this chasm in the politics of women’s health not to dwell on the much belaboured point of ‘difference’ among feminist perspectives, but rather to ask how such divergent perspectives are possible in a political world that has embraced international collaboration in the form of the International Women’s Health Movement among other things. The chasm reminds us that theories of feminisms do not always solve the dilemmas of political practice. However, I also see this chasm as a productive analytic site, from which we might better understand how ‘internationalism’ in the field of women’s health politics continues to reinscribe dominant perspectives, even as it claims to recognise difference. In order to do so, I take an ethnographic approach to the question of ‘internationalism’ in the politics of women’s health. I draw on archival material and field-based research in relation to a campaign that has been deemed a success in the realm of international women’s health politics: the campaign against the Anti-Fertility Vaccine (AFV). The campaign in question was part of a broader campaign against hazardous contraceptives, but was also distinguished by a barrage of focused campaign activities during the 1990s in which activists called for “a halt to research on antifertility ‘vaccines’” (WGNRR 1993a). Field research for
This campaign was conducted primarily in Delhi, and consisted of discussions and interviews with a range of people who are politically engaged in women’s health issues in India. The archival material is drawn from resource centers of women’s groups in Delhi who were active during the campaign against the AFV. This approach allows a shift from a purely theoretical debate on such questions to one that is based on closer attention to feminist political practices.

This shift is in keeping with the imperatives that keep surfacing within feminist debates. Building on the project of *Feminism and Internationalism*, a volume in which the editors seek to work through “the productive tension between the centrifugal force of discrepant feminist histories and the promising potential of political organising across cultural boundaries” (Sinha, Guy and Woollacott 1999: 1), John argues from the perspective of India:

One of the more positive outcomes of all these developments is that we are being forced to take a fresh look at ‘pluralism’ and ‘diversity’, both within the nation and beyond. If feminism is not singular, neither is internationalism. It has become more important than ever to understand the different stakes involved in laying claim to local, national, and international arenas... If there is a common condition that feminism must address, it is one of unequal patriarchies and disparate genders. The imperative, then, is to recognise how asymmetries and structures of privilege may have prevented solidarities; and to fight on many fronts to enable the development of more viable feminisms. (John 1999:199-200)

John is not alone in her call for feminism to interrogate the broader structures of inequality that may have impeded “viable feminisms”. Chandra Mohanty (2003) has refigured her influential critique of Western feminist theory that called into question the production of the “average Third World woman” (Mohanty 1988) to argue for an “inclusive paradigm for thinking about social justice”:

Perhaps it is no longer simply an issue of Western Eyes, but rather how the West is inside and continually reconfigures globally, racially, and in terms of gender. Without this recognition, a necessary link between feminist scholarship/analytic frames and organising/activist projects is impossible. Faulty and inadequate analytic frames engender ineffective political action and strategising for social transformation. (Mohanty 2003: 236)

These debates point to the fact that feminist projects must consider a wider vision of social justice in constructing an analytic framework that
will enable productive solidarities across experiential borders.

Both John (1999) and Mohanty (2003) suggest that analytic frameworks are dependent upon the standpoint from which one views political projects seeking feminist solidarity. In my analysis of the analytic frameworks operating in the AFV campaign, I examine the AFV campaign from different standpoints, comparing “international” commentary from the standpoint of the centre to the perspectives elicited by Indian women’s groups involved in the campaign. I find John’s concept of the plurality of “internationalism” a productive means of elucidating the way in which numerous internationalisms circulate from various standpoints in the debates on international activism in the field of women’s health politics. I consider the ways in which these internationalisms compete within one another in making claims to represent the international in the AFV campaign. Mohanty argues that the standpoint of “marginalised communities” provides the potential for an “analytic anchor” from which to build an inclusive activist project. I build on this concept to show how dominant versions of internationalism serve to marginalise other, more inclusive feminist internationalisms in the AFV campaign, and more generally in the politics of women’s health.

**Contours of the Controversy over the Anti-Fertility Vaccine**

The story of the Anti-Fertility Vaccine has been narrated from numerous sociological, scientific, activist and feminist perspectives. Of all the contraceptives that were targeted by the women’s health movement against hazardous contraceptives (which included critiques of injectable contraceptives such as Norplant, Net-en and Depo-Provera), the AFV stands out for its technological novelty as an immuno-contraceptive. The biological premise of the AFV was inspired by the discovery that in some cases an immune reaction against sperm caused infertility; the aim was to replicate this natural occurrence through developing a vaccine that could induce infertility through the pathways of the immune system. The prospective contraceptive vaccine would work by inducing an autoimmune response whereby pregnancy hormones would be bound to disease cells, thus tricking the immune system into fighting off the hormones as if they were a disease (Fay Schrater 1992).

In a sociological study of science “in the making,” Viswanath and Kirbat (2000) have traced the “genealogy” of the controversy that surrounded AFV research. They show that as a new form of contraceptive technology without scientific precedence, the AFV generated debate among researchers from early on. AFV research began in the early 1970s and was taking place at numerous research facilities across the world, coordinated by a World Health Organisation Task Force, the Human Reproduction Programme (WHO/HRP). Debates over the risks of various designs of the vaccine began after tests on human subjects raised concerns for researchers. Women experienced side effects and variation
in levels of response to the vaccine, concerns that resulted in a rift developing between the National Institute of Immunology (NII) Indian research team headed by Dr Pran Talwar, and the other leading research team at Ohio State University in the United States. In the wake of the controversy, the WHO drew up regulatory safety guidelines for immuno-contraceptive research. Under these guidelines Talwar’s research was deemed to have conducted human trials with insufficient animal testing and international funding sources withdrew their support for the Indian team (Viswanath and Kirbat 2000: 719-720).

In light of the safety concerns regarding injectable contraceptives that had already been developed and distributed, activists seized on the opportunity to target the AFV during the research phase. This allowed activists to focus their critique not only on the health risks of the AFV, but also on research ethics and the research framework that determined the contraceptive design. While researchers claimed that the AFV would offer a simple, low cost contraceptive option that would be advantageous for widespread delivery (UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction 1992), activists argued that a faulty research framework resulted in technologies that gave the power of fertility control to health providers rather than to women themselves (WGNRR 1993a). The character of this contestation is demonstrated in *Vaccination Against Pregnancy: Miracle or Menace?*, a book put out by scientist-activist Judith Richter (1996), in which she elaborates upon the “potential for abuse” of the Anti-Fertility Vaccine. In other words, *narrating the story of the AFV became a deeply political act*.

The AFV campaign is remembered among a range of activists with whom I spoke as an exemplary moment of international solidarity. Co-ordinated by the Women’s Global Network for Reproductive Rights (WGNRR) in the Netherlands, the campaign unified a range of women’s groups from a wide range of places including Brazil, Canada, Zimbabwe, Germany and India. The campaign officially began in June 1993 with an International Action Workshop held in Germany. Representing India at this workshop were the Bombay-based Forum for Women’s Health (FFWH) and an autonomous local women’s group stationed in Delhi, the Saheli Women’s Resource Centre. The culmination of this workshop was the drafting of a petition, “Call for a Halt to Research on Antifertility ‘Vaccines’”, that was sent to major funding and research organizations (WGNRR 1993a). By November 8, 1993, the petition had been signed by 232 groups from eighteen countries around the world, including 32 groups from India. Five years later, WGNRR reported that the “Call for a Halt” had been endorsed by 487 groups and 579 individuals from 41 countries (WGNRR 2001).

Despite the expansive international reach of the WGNRR “Call for a Halt”, the agenda to stop research on the AFV was distinct from that of
another major group in the International Women’s Health movement, the International Women’s Health Coalition (IWHC). Members from the IWHC and other international women’s health advocates aimed to work together with the WHO to create “common ground” on women’s health issues and the development of reproductive and contraceptive technology (WHO/HRP/ITT 1991). The WGNRR campaign against the AFV and their strong stance against long-acting, provider-controlled contraceptives has thus marked the WGNRR position as more “radical” than the position of other “moderate” international women’s health advocates (Harden 1997). While it has been argued that these divisions served to strengthen the AFV campaign (Harden 2006), my analysis seeks to view these divisions in terms of competing “internationalisms”. My aim is not to measure the impact of the AFV campaign in terms of achieving its stated goals but to try and understand how competing internationalisms have contributed to the diverging feminisms that were evidenced during my fieldwork in Australia and India.

Whilst the research framework of the AFV scientists has been carefully scrutinised and deconstructed (Harden 1997; Harden 2006; Richter 1994; Richter 1996; Van Kammen 2000; Viswanath and Kirbat 2000; WGNRR 1993a), the analytical frameworks operating in the narratives of the AFV campaign have received comparatively little attention. Anita Harden (1997, 2006) an anthropologist-activist involved in the AFV campaign, has produced an analysis of the campaign from her central standpoint as an “international” activist. However, the analytical framework operating in Harden’s conception of the AFV controversy seems unable to fully capture the perspective of the activists I met during my fieldwork in Delhi. Harden (2006:616) unreflexively uses her own perspective on health and contraceptive technology as a reference point for “shared solidarity” during the AFV campaign. Viswanath and Kirbat (2000: 724) hint at a disjuncture between the views of Indian activists and the international activists’ perspectives on the AFV controversy, pointing out that the Indian women’s groups were more critical of the WHO research than were women’s health advocates “in the west.” I would like to pursue this disjuncture more fully. What does the AFV campaign look like from the perspective of Indian women’s groups who were deeply involved in the movement? How does their position as part of the Indian women’s health movement predispose them to conceive of “internationalisms” in the context of the AFV campaign? More importantly, how does the perspective of such groups illuminate the dominant forces that structure Harden’s perspective of the AFV campaign?

The distinctions between Harden’s internationalism and the internationalism of Indian women’s groups may seem subtle compared to the chasm with which I opened the paper. However, understanding the subtle distinctions in the internationalisms of the AFV campaign is instructive for uncovering the seemingly immovable stumbling blocks
that reproduce chasms in the field of women’s health politics, chasms that prevent effective feminist solidarities. As I travel between feminisms in Australia and India, I have used my own mental stumbling blocks that arise from my standpoint as a researcher from Australia as a guide for understanding how a belief in one’s own cultural logic can blind one to the ways in which such logic can reproduce inequalities, feminist or otherwise. I begin the process of uncovering subtleties by moving between Hardon’s “moderate” internationalism to the “radical” internationalism enunciated by Saheli activists who worked directly with the WGNRR on the AFV campaign.

**AFV Internationalisms**

Today in India, the AFV is conspicuous for its absence on women’s health radar. After nearly 3 decades of scientific pursuit, AFV research activity seemed to dissolve in the late 1990s. Talwar, the head of the Indian AFV research team at the NII, has been quoted as saying, “our research has been stopped by the women dictating... because they were so persistent I got a low priority” (Hardon 1997: 75). Some activists question the logic of this statement, pointing instead to the low efficacy of the AFV, which never reached above the 80%-threshold in clinical trials. In any case, the primary objective of the AFV campaign was to “Call for a Halt” to research on the AFV. Therefore the cessation of clinical trials for the AFV represented a victory for activists and signalled that the AFV campaign could also suspend its activities.

The space of almost ten years since the flurry of campaign activities calling for a “halt” thus provides activists with a measure of distance from the AFV campaign. Both Hardon (2006) and Saheli (2006) reflect on the campaign as a moment of successful international collaboration but there are key differences in how they articulate international solidarity. Hardon argues that the AFV campaign, along with the broader campaign against hazardous contraceptives, represented the successful merging of activists from the ‘north’ and the ‘south’ on the basis of a “collective oppositional identity”:

> Each organization has its own collective identity, relevant to the position of women and the specific women’s health concerns that shape their lives. Through international networking and common concerns, a movement identity is forged, which is at stake in the controversies around contraceptive technologies. Underlying the campaigns in the domain of contraception is a basic solidarity identity as healthy women, with shared health and reproductive concerns and a common mistrust of population control efforts by states. (Hardon 2006: 616)

Hardon’s efforts to synthesize a theoretical identity that captures the
“shared solidarity” engendered by the AFV campaign are worthwhile. However, the identity of “healthy women” with common concerns seems to boil down the historical complexities of the campaign to the lowest common denominator, instead of elucidating the creative ways in which women’s activists of radically different experiential backgrounds came together to co-ordinate their response to the AFV. The deployment of “healthy” as a representative marker of commonality seems to be an effort by Hardon to distinguish the movement against hazardous contraceptives in relation to other social movements involving “patient groups” (Hardon 2006: 615). Yet deploying this referential device also has the effect of overlooking activisms within the movement that stem from a concern about the impact of hazardous contraceptives in places where both health care facilities and the health of women are less than optimal (see for example Sathyamala 2000).

Further, when Hardon (2006: 616) gestures at the “common mistrust of population control efforts by states,” she glosses over the distinct histories of population control measures, and the strategic critiques developed against the coercive nature of these measures in places such as India. For Delhi-based Saheli, the united front against ‘population control’ seems to mark the AFV activities apart from those directed at other hazardous contraceptives as a “truly international campaign”:

While the international women’s movement has always been supportive of our efforts in campaigning against hazardous contraceptives, they have not had to deal with the problem of ‘overpopulation’, coercive population control except with the ‘undesirable’ segments of their population (blacks, Hispanics, mentally retarded etc.). However, since developments on the AFV were taking place simultaneously around the world, indeed India seemed to be leading the pack, the response of the women’s movement was also more synchronised. (Saheli 2006: 49)

From the point of view of Saheli activists, internationalism is thus not based on a “collective identity” but instead is viewed as the ‘synchronisation’ of multiple feminisms. Synchronicity, in this instance, was achieved through international developments that highlighted the issue of “coercive population control”. The point I wish to make is that the notion of a “synchronised” women’s movement provides an expansive framework for international feminist solidarity. Instead of reducing the numerous AFV internationalisms into a “collective oppositional identity” which only makes sense from the standpoint of the centre, synchronicity acknowledges the multiplicity of perspectives that exist alongside one another. The key difference is that Hardon’s “collective oppositional identity” subsumes competing internationalisms by making a dominant claim to represent the international, as though the central standpoint was not a site of contestation itself. Hardon
acknowledges the divisions among “moderate” and “radical” strands of the campaign, but claims that these *strengthened* the movement against hazardous contraceptives. In doing so, she fails to recognise that her argument effectively erases the strategic critiques of other internationalisms in the politics of women’s health.

What we glean from Saheli’s internationalism that is not apparent from Hardon’s argument is that the issue of overpopulation has been extremely divisive in the realm of international women’s health. As one Saheli activist shows, opposition to “population control” is not a given in the world of international activism:

> Working with international activists is always a mixed bag. One has to push for validation of a “Third world” perspective in every campaign strategy. Western women’s groups, with their focus on abortion rights and “reproductive rights”... at first had a hard time understanding the manner in which population control policies operated on the ground. The realities of Indian women were different. And then post-Cairo, the “feminist population policy”... began to also have an influence in India, and a lot of funding came to groups that followed this “line”, thus diluting a strong stand against all population policies, which by definition can not be “feminist”. Yet, there were also some radical women’s activists in international networks, and it has been enriching working with them, sharing information and strategising together.

(activist interview with author)

In this statement, the Saheli activist transports us through numerous internationalisms, taking us beyond the AFV campaign and into the broader political debates of the international women’s health movement. She articulates the political divide that separates an internationalism that adopts an approach to women’s rights from within a perspective of the need to control ‘population’, and internationalism where ‘population’ policies are viewed as the antithesis of feminist ideals. These internationalisms are drawn roughly along the lines of ‘Western’/‘Third World’ perspectives. However, due to the fact that the “feminist population policy” internationalism holds the power of funding, these internationalisms are clearly not on an equal playing field. Funding opportunities serve to marginalise the competing internationalism “against all population policies” that emerged from the standpoint of “the realities of Indian women”. Thus, it is the power of capital, rather than feminist principles, that encourages groups to adopt the “feminist population policy” within the Indian context. From the perspective of the Saheli activist, we begin to understand how broader inequalities operate within the diverging perspectives on ‘population’ that I encountered in my fieldwork.
Internationalism from the Standpoint of the Indian Women’s Health Movement

In order to better understand the Saheli standpoint on feminism and population control, I would like to consider how this internationalism resonates with the strategic critique of family planning developed within the Indian women’s health movement. The critique of population control measures and coercive family planning policies has been a defining feature of the Indian women’s health movement since its inception in the 1970s (Viswanath 2001, Ram forthcoming). This critique has aimed to puncture the smooth logic that supports the ‘myth’ of population control (for a recent in-depth example of this see Rao (2004)), a centrepiece of the WGNRR co-ordinated AFV campaign narratives. As well as challenging the logic of population control, this critique also shatters the myths of modernity, as shown by Viswanath:

In the dominant discourse, India is seen as having too many people, and too many poor people at that. Controlling our population is prescribed as a national duty, which unfortunately the poor and marginalised peoples are not performing. The middle and upper class are presented as the beneficiaries of the gains of smaller families. The official propaganda is that the fewer children you have, the happier and wealthier you will be. But if the spoils of modernity are so clear and linear, why isn’t everyone running after them? (Viswanath 2001)

In this way, the Indian women’s health movement has performed a kind of ‘watchdog’ role, calling attention to what Ram (forthcoming) terms the “silent practices” of state population policy. Based on the philosophical underpinning of a left agenda (Kumar 1995) that envisages a wider vision of social justice, this feminist critique has scrutinised the Indian state’s commitment to the liberal democratic values of choice and rights in the context of the implementation of the family planning policies. Ram describes this as a strategy in which the falsehoods of the state’s liberalist rubric are revealed through a critique that demonstrates that state family planning policy unevenly pushes a restricted range of contraceptive “choices” along the lines of both gender and class. The coercive nature of these “choices” has been well documented (Vicziany 1982-3; Tarlo 2003; Van Hollen 2003) and persists in both public and private hospitals in spite of efforts to introduce ‘informed consent’ procedures for sterilisation (Rajalakshmi 2007a; Rajalakshmi 2007b). In her ethnographic exploration of the Emergency Period of 1975-77, Emma Tarlo (2003) has described the family planning drive as operating “less through physical coercion, than through inviting participation in a particular kind of deal in which human infertility was traded off against a whole range of basic amenities” (Tarlo 2003: 145). Whilst Tarlo is attempting to capture the “ethos” of the State policies that characterised
the Emergency, the critiques developed by the Indian women’s movement show that the spirit of this “ethos” has continued long after democratic rule returned to India in 1977.

These feminist critiques are more than just an interrogation of the state’s coercive practices. They serve to challenge the patriarchal discourses engendered in the state population policy that exclusively views women in terms of their maternal reproductive roles as well as the discourse of modernity in which liberal notions of ‘choice’ clash with a development agenda that seeks to control population through controlling poor women’s bodies (Ram 1998a; Ram 1998b; Viswanath 2001). Feminism in this context sees patriarchy and modernity as intertwined forms of oppression that are manifest in the population control agenda. From this standpoint, women - particularly those who are poor and marginalised - stand doubly oppressed by an internationalism that pursues population control.

**Dominant Internationalism in the Politics of Women’s Health**

Armed with a better understanding of the standpoint from which the Saheli perspective on internationalism emanates, we can now return to the debates within the field of international women’s health with fresh eyes. To reiterate, the “strong stand” of Saheli activists “against all population policies” was also adopted by the WGNRR agenda in the AFV campaign, enabling a “synchronised” internationalism in the women’s movement. However, alternative internationalisms were also operating in the sphere of international women’s health politics during the AFV campaign. Those subscribing to an internationalism that was grounded in a “feminist population policy” appear to have been genuinely confounded by the strong opposition to population policies.

From the standpoint of the centre, international women’s health advocates became frustrated by the WGNRR resistance to the AFV on the grounds of staunch opposition to population control. Marge Berer, a prominent figure in the international women’s health movement, argued for “a more realistic and broader attitude toward existing methods of birth control.” She urged feminists to acknowledge “the world cannot sustain an unlimited number of people, just as women’s bodies cannot sustain unlimited pregnancies… we have a responsibility to define what a good population policy is” (Berer 1991, cited in Cohen 1993: 64). In the context of the AFV campaign, Hardon (1997) also grappled with the “radical” nature of the WGNRR demands, and questioned the claims of women’s health activists to “represent the majority of users in an unbiased manner”. She cites the WGNRR postcard campaign as evidence of this:

In early 1996, an informal telephone conversation took place between Beatrys Stemerding at WGNRR and Griffin (head of...
WHO taskforce) at HRP, in which he reportedly said that the Human Reproduction Programme would consider stopping research on the anti-hCG vaccine if it were shown in an unbiased manner that 'the majority of potential users would not want the method'. In response, the 'Call for a Stop' campaign launched an international postcard action. The postcards were addressed personally to Griffin at HRP, and state:

'I do not support the development of immunological contraceptives. Women and men alike need contraceptives that enable them to exercise greater control over their own fertility, without sacrificing their integrity, their health, or their well-being. In addition, the potential for abuse is simply too great with immunological contraceptives, which could easily become tools for population control.' (Stemerding, 1996, cited in Hardon 1997: 76)

Hordon argues that focus group studies presented to the WHO/HRP show that women from numerous countries are dissatisfied with existing methods of contraception, and goes on to say:

Based on longstanding concerns about the history of eugenic abuse and coercive population programmes, and coming largely from positions of opposition to all long-acting contraceptives which depend on provider delivery, the views of the women's health advocates calling for a stop to the research will not easily be changed. Their radical opposition has had adverse effects, in my view, as it has also prevented more constructive dialogue between these women's health advocates and researchers on the design of clinical trials of safety and efficacy, and criteria used to determine acceptability to users. (Hordon 1997: 77)

I cite these reflections from Hordon because they concisely demonstrate the locus of the chasm that divides the internationalisms operating in the AFV campaign narratives. In order to counter the "radical" claims of the WGNRR postcard campaign to "represent the majority of users in an unbiased manner", Hordon presents her argument as the rational alternative. She weighs the evidence of WHO/HRP focus group studies against the "longstanding concerns about the history of eugenic abuse and coercive population programmes" and the latter emerge as stultified and unable to overcome bias. Her own view, which serves as the referent for this alternative perspective, is presented as untainted with bias and in clear favour of the needs of the "majority" of users.

The rational aura of Hordon’s internationalism in this instance is highly persuasive from the standpoint of a liberal choice perspective. So much
so, that the power relations involved in laying claims to the representation the “majority of users,” as well as the subordination of concerns about “eugenic abuse and coercive population programmes,” are barely perceptible. However, if we consider Mohanty’s warning of how “the West is inside and continually reconfigures globally, racially, and in terms of gender,” and examine Hardon’s argument in terms of the strategic critiques developed by the Indian women’s health movement, the relations of inequality become more apparent. Just as WGNR activists cannot literally gauge the needs of the “majority of users”, nor can focus group studies from several countries capture the structural inequalities that constrain the choices of women in poor, marginalised communities. Saheli reinforce this point in their discussion of Reproductive Rights in the Indian Context:

In a situation where women have no ‘right’ to clean drinking water, basic facilities, health care or education; where society decides where women will live, how they will live (and often, how they will die), who they will marry, whether they will study; where the State (and international development and aid agencies) believe they have the ‘right’ to determine how many children women will bear, when they will get sterilised and what form of contraception women must ‘opt’ for; it is apparent that the struggle for Indian women’s reproductive rights needs to go further than reproductive freedom, and enter the arena of social, economic and political rights (Saheli 2001: 1).

Thus, to view the needs of the “majority of users,” purely in terms of desires for additional methods to control reproduction, as measured by focus group studies, is to view these ‘users’ in a reproductive vacuum, ignoring a broad range of other ‘rights’ denied to women such as those described by Saheli.

In order to more fully grasp the difference between Hardon’s perspective and the perspective of Saheli, I return to the notion of standpoint. In light of Mohanty’s argument that the standpoint of “marginalised communities” provides the potential for an “analytic anchor” from which to build an inclusive activist project, Hardon’s argument appears to contain its own exclusionary biases. As Hardon lays claim to the needs of the “majority of users”, she builds her analytical framework on the AFV from the standpoint of “the user’s perspective” on contraceptive needs. We are not given the socio-economic profile of the users in the focus group studies, because this information is irrelevant to the synthesis of Hardon’s critique of the WGNR postcard campaign and “radical” opposition to the AFV. Saheli’s argument on reproductive rights on the other hand, is built upon a standpoint that begins from those women who lack the most basic of life’s necessities. From this standpoint, concerns about “eugenic abuse and coercive population
programmes” are based on an analytic framework that considers the use of the AFV in the context of marginalised communities. In contrast, Hardon’s politically potent claims to “the majority of users” shore up her argument for an internationalism that remains indifferent to the social, economic and political inequalities which continue to structure the nature of ‘choice’. In so doing, she serves to reinforce these inequalities by invoking politically dominant notions of liberal choice that circumvent the critiques made by alternative, inclusive agendas for internationalism.

**Conclusion**

In exploring the AFV internationalisms, I have focused my critique on the internationalism elicited by Hardon’s reflections on the AFV campaign. This is partly because her arguments enjoy a virtual monopoly in the international academic literature on the campaign. It is also because her arguments are highly persuasive unless they are examined from the perspective of larger structural inequalities. Her arguments draw their persuasiveness from the liberal ‘choice’ philosophy that maintains political dominance in the field of women’s health politics, and sidesteps a whole range of problems entailed in the provision of health-care technologies among marginalised communities in places such as India. This dominant internationalism is bolstered through the funding capacities of the international institutions from which it emanates. By making claims to represent the international, Hardon and the dominant internationalism proceed from an analytical framework that undercuts potentially inclusive paradigms for synchronising women’s health activism in the international field of politics.

There are numerous ethnographic facets of the AFV campaign that are beyond the scope of this paper, but are equally important in contributing to a more inclusive story of the vibrant political activism involved. The ways in which the WGNRR campaign was able to strategically synchronise numerous international activists is just one. Moreover, I have not explored the heterogeneity of the Indian women’s health movement in relation to the AFV campaign specifically, and the International Women’s Health Movement more generally. In this sense, I have articulated but one of numerous internationalisms that operate within India concerning such issues. However, in the space provided here, I have aimed to construct an argument about the manner in which claims to representation of women are made in the field of women’s health politics. I have argued that the manner in which these claims are made is at least as important as the claims to represent ‘women’s’ perspectives. When Hardon (2006: 625) concludes her reflections on the campaign against hazardous contraceptives, she notes the success of the movement in achieving a “reproductive choice” agenda, “at least on paper”. My argument has sought to make some headway in demonstrating why this agenda exists more on paper than in practice.
As my fieldwork experiences show, the shift away from a 'population' agenda may have occurred in official discourse but demographic logic still holds considerable sway among feminisms that have the capacity to influence funding priorities. A lack of understanding of the nature of the chasm that exists in international women's health politics enables the perpetuation of inequalities in the political field, the effects of which continue to play out among the more marginalised communities of women. Faulty analytic frames in the sphere of international women's health politics have seen certain dominant versions of internationalism circumventing rather than addressing issues raised by alternative, inclusive internationalisms. It is imperative that we uncover the philosophical standpoints that structure these distinctive internationalisms if we are to see how hegemonic conceptions of liberal rationalist choice can be used to marginalise political strategies for a potentially broader vision of social justice. It is only from this basis that the 'international' in the women's health movement can move forward in a meaningful way.

References


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