Opening Windows to Gender: A Case Study in a Major International Population Agency

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Abstract

This article presents the experience of the International Planned Parenthood Federation, Western Hemisphere Region, as an example of the social transformation of the family planning paradigm into model interventions in sexual and reproductive health. This is framed within the literature on gender and bureaucracies to assess the strategies and limitations followed when gender perspectives are institutionalized.

The literature about the role of gender in organizations has evolved from an early denunciation of sexism within bureaucracies—depicted mostly as male-created and male-dominated structures that oppressed women—to a more subtle understanding of how power is exercised, as well as the extent of its transformative potential. Ferguson (1984), in *The Feminist Case against Bureaucracy*, shows how male power is mystified and constructed through an abstract discourse based on rationality, rules, and procedures. Kanter (1975) sets out to show how gender differences in organizational behavior are due to structure rather than to the characteristics of women and men as individuals. Staudt (1985) identifies institutionalized male privi-

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lege as a fundamental principle of organizations. These groundbreaking articles, mostly written in the late 1970s and 1980s, unveiled different theoretical perspectives regarding the seemingly gender-neutral nature of institutions. As these authors argued, such neutrality obscured prevalent features of organizations such as sex segregation or the embodied nature of work within bureaucracies.

By the 1990s, Acker (1990) provided a comprehensive framework for dismantling the seemingly gender neutral character of bureaucratic organizations while also identifying the limitations of existing approaches to the analysis of the location of male power. In a similar direction, Calás and Smirich (1999) contextualized the gender and bureaucracy literature in the broader context of contemporary cultural analysis, taking as their point of reference the different schools of feminist studies: liberal, Marxist, psychoanalytic, postmodern, and postcolonial. Additionally, recent writings focus on the obstacles that impede the structural transformation of institutions to incorporate women in decision-making positions and/or implement gender policies. These writings call attention to the need to understand the extent to which gender programs can be institutionalized both in developed and in developing contexts. For example, authors like Kabeer (1998) and Incháustegui (1999) explain that institutionalization might only happen when a crystallization of agreements translates in the administration of a social value that emerged as a result of a political consensus.

Condensing decades of theorizing and defining the problem of gender relations, together these contributions helped foster energetic cross-disciplinary scholarship with a plurality of feminist theories aimed at rethinking the grounds of knowledge. Additionally, they provided the theoretical ground for the actions undertaken by feminists in different parts of the globe to move first international and recently national organizations or state agencies, to incorporate the notion of gender. For example, UNIFEM (the United Nations Development Fund for Women),[1] which can be characterized as the leading UN agency created to advance the social status of women, has crafted its own definition of gender relations. According to UNIFEM, gender can be defined

> as the ways in which roles, attitudes, values and relationships regarding women and men are constructed by all societies all over the world. Historically, different cultures construct gender in different ways so that women's roles, the value that their society places on those roles, and the relationship with men's roles may vary considerably over time and from one setting to the other. However, almost invariably gender constructs func-

> tion in a way that subordinates and discriminates against women to the detriment of their full enjoyment of all human rights. This discrimination is not only reflected in individual relationships but also permeates all institutions. (UNIFEM 1995, 105)

In light of the quote, this article represents an effort to create an ongoing dialog between theory and practice not only to highlight the role institutions can have in shaping ends and providing the space to formulate strategies but, more important, to highlight the role that building knowledge around gender can have in promoting technical innovation, selection, and policy design. A recent review of the process of organizational change concludes that to incorporate gender awareness into an organization, action needs to take place on at least four fronts: (1) the adoption of policies and programs that promote equality for women; (2) the inclusion of women in positions of management and decision making; (3) the building of supportive constituencies outside the organization; and (4) the cultivation of a climate, internal and external, that promotes the elimination of discrimination against women, greater respect and collaboration between men and women, and the equitable redistribution of resources (Itzin and Newman 1995).

An exploration of the case of International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR), suggests not only that including each one of these steps was critical for the inclusion of gender perspectives but additionally that the coding of gender as an arena of technical expertise was critical. The article suggests that such developments, starting in the late 1980s, were possible thanks to the fact that three historical factors coincided: (1) the momentum gained by the contemporary feminist movement worldwide during those years, (2) the appointment of "in-house feminists" to key staff and board positions, and (3) the building of close alliances with women's health networks and movements outside the organization. We argue that strategies unfolded at the level of policies, programs, and people, thus triggering a social change, which ultimately opened the door for the limited but tangible institutionalization of a gender perspective.

Institutional Framework

The work of IPPF/WHR in Latin America and the Caribbean can be seen as the most dynamic of the six worldwide regions in terms of the use of contraception and access to sexual and reproductive health. This is explained as a result of the high rates of urbanization and increase in education as well as in public health systems, when

compared to the regions of Asia or Africa or when contrasted to areas such as Europe, Canada, or the United States, where the rate of development is higher, and thus, social change more stable.

The case of IPPF/WHR is relevant because it seeks to illustrate how the rooting of a systematic intervention in the fields of family planning and sexual and reproductive health required the coding of gender as an arena of technical expertise, because the participation of IPPF/WHR in a social process to transform ideas from within and in close connection to the major international events served to give feminists higher public visibility. Second, it illustrates the concrete limitations that alliances built by feminists and in-house advocates have had to face as conservative ideas still prevail in the world seeking to limit feminist influence. In this sense, the case of IPPF/WHR represents a testing ground that proves the difficulties of translating feminist theory into practice, for example, demonstrating that sometimes the most conventional idea (such as seeking parity between men and women) remains in practice a highly contested notion.

The study is carried out within the complex interaction of three factors: first, the shift of IPPF from being an international family planning network to becoming a global bureaucracy focused on integrated service delivery within a quality of care framework. Second, a time in which family planning resources are increasingly leaving Latin America and the Caribbean in favor of countries in Eastern Europe and Africa (Finkle and Crane 1990). Third, the growth and consolidation of the international feminist movement, particularly the women's health movement, has become an important participant in population policy discussions worldwide (Germain and Ordway 1989). This movement successfully elaborated the principle that every woman has a right to reproductive health, including the right to regulate her fertility safely and effectively; understand and enjoy her own sexuality; remain free of disease, disability, or death associated with her sexuality and reproduction; and to bear and raise healthy children. Finally, a growing conservative backlash, partly reflecting the success of the movement in articulating reproductive rights issues, has made both feminists and family planners aware of the need to build alliances to protect and expand women's right to sexual and reproductive health.

Regional and Historical Overview

The origins of IPPF/WHR can be traced to 1952 when the founding of the global IPPF was first proposed at Bombay and ratified at Stockholm a year later. In 1954, Margaret Sanger and Ellen Pillsbury brought together twenty-nine volunteers from Barbados, Bermuda,

Canada, Haiti, Jamaica, Mexico, Puerto Rico, and the United States to found the WHR in New York City (Suitters 1973).

IPPF was founded by a leading nurse and activist, Margaret Sanger, who foresaw the need to legalize contraception and spoke out on the ability to control one's fertility as vital to women's freedom and autonomy. Sanger believed that how women perceive their own self-interest is as important to decisions about childbearing as broader social and economic conditions. Toward the end of her life, when asked how she wanted to be remembered, Sanger said she hoped she would be remembered for helping women (Suitters 1973; Chesler 1992). Nonetheless, as strong social opposition to the massive use of contraception prevailed, Sanger calculated that it was necessary to forge alliances with physicians, academics, and social engineers, thereby giving birth control "an aura of scientific and medical respectability" (Petchesky 1990, 92). Such alliances were undoubtedly helpful in making and advancing her cause, but as critics have pointed out, Sanger reinforced the prevailing medical model of birth control dissemination, limiting it to the supervision of licensed doctors for disease prevention (Petchesky 1990; Gordon 1990). Thus, from its inception, IPPF's leadership was composed of doctors, nurses, and community organizers, eventually establishing IPPF affiliates grouped into six regions: Africa, East and Southeast Asia and Oceania, Europe, Western Hemisphere, the Arab World, and South Asia.[2] For this reason, the case of IPPF provides a paradoxical scenario for the exercise of male power given that this organization was originally founded by a historical female figure and that its mission is highly connected to serving women (low-income women in particular).[3]

Starting in the 1960s, IPPF modified its focus and structure from an international family planning network to a global bureaucracy of service delivery, incorporating many of the same principles as the feminist movement. In the late 1960s, government support for family planning increased exponentially, as the U.S. Agency for International Development (USAID) gave priority to helping Latin American nations deal with population problems and the Japanese government included family planning initiatives as part of its medical aid program.[4] In this context, the WHR became a privileged space to test ideas. The favorable flow of resources lasted until the mid-1990s and today, IPPF/WHR has affiliates (family planning associations, FPAs) offering sexual and reproductive health services in forty-six countries. Over 9 million visits are made to clinics each year, for a wide range of needs; the WHR contributes about one-third of the clinical visits offered by all the IPPF affiliates worldwide.

Each FPA is an autonomous national agency, run by and for citizens of its country. The regional bureau is not a corporate head-

quarters dictating to its branches but a secretariat responding to the needs of its member affiliates and trying to serve as a two-way intermediary for information flow. Each FPA determines its own mix of methods of contraceptives, based on local demands and according to basic IPPF standards of informed choice and client rights. Worldwide, there is a wide range of contraceptive method mixes; the general consensus is that there is no perfect method mix because women's preferences differ for a wide variety of reasons.

The IPPF offers various types of support to its member FPAs. One very valuable contribution is unrestricted core support, which can be used to help cover the general operating costs or specific projects. Every grant-receiving FPA must submit documentation to IPPF of all its sources of income (local and international) and all of its expenses to justify its request for core support. IPPF thus has an unusual, institutional perspective on every aspect of FPA activities, as well as on the quality of its governance structure, prospects for sustainability, dedication to gender issues, and so forth. An annual staff review results in recommendations to the WHR board of directors about the amount of the following year's core grant.

In addition to the core support, IPPF and IPPF/WHR serve as intermediaries to raise restricted funds for specific projects in certain areas, including gender training, gender-based violence, male involvement, HIV/AIDS and other sexually transmitted diseases, work with young people, new contraceptive technologies, and other cutting-edge topics. The selection of recipient agencies for these grants may be competitive, may flow from a given FPA's interests and the opportunity it represents to contribute to lessons learned on the subject, or may result from a donor's priorities.

In the past fifteen years, the organization has not only redefined its mission to better empower clients to take responsibility for family planning decisions but also has refined the content of technical assistance in poor countries. In Latin America, FPAs have struggled to serve the very poor as donors reduce subsidies and Latin America ceases being a privileged area for resources in the post–cold war era. Additionally, during the 1980s the international women's health movement lobbied in favor of the transformation of the traditional family planning approach based on massive contraceptive distribution. By the end of the 1980s, the momentum of the feminist movement, together with the need for international agencies to reach new populations, resulted in important transformations. Thus, although interest in the improvement of the status of women began to accompany family planning initiatives by the early 1970s, population agencies, like development agencies, focused primarily on strategies for the incorporation of women into traditional forms of demographics-

driven development. IPPF/WHR was no exception (Helzner and Shepard 1990).

Up until the mid-1980s, IPPF/WHR and its FPAs were not at all attuned to gender issues, focusing on traditional family planning service delivery and a limited income-generating program called Planned Parenthood: Women's Development, which had little impact on fertility regulation. But over the next decade, beginning in 1987, this slowly began to change. An international feminist movement challenged traditional forms of decision-making bodies within IPPF/WHR and began to lobby in favor of an agenda oriented toward the provision of sexual and reproductive health service provision. At IPPF/WHR, leaders sought equal representation of men and women on national conference delegations or elected assemblies.

Opening a Policy Window: Promoting Change from the Top

By the end of the 1980s, IPPF at the worldwide level was experiencing an identity crisis, resulting partially from the paradigm shift in the field of family planning (Foley 1989). In this context, the IPPF/WHR assessed its long-term strategic options. Among other changes, the male-only senior staff of IPPF began to open up, albeit with some resistance, to the promotion of women to positions of power. The Canadian association took the lead and actively demanded parity for women within IPPF/WHR. In 1988, a Regional Council Resolution acknowledged the need to seek "at least parity" between men and women in the WHR board of directors and all its committees in future elections.

The adoption of the gender parity principle, although limited to IPPF/WHR, was critical in bringing about several changes. In May 1989 the first regional Task Force on Women was appointed, composed of IPPF/WHR staff at the New York office, the (male) president of IPPF/WHR, selected members of other organizations within the population establishment, such as the UN Fund for Population Activities, and Latin American feminists. These meetings themselves built momentum, creating a forum for articulating policies to which the organization had to respond. The task force also legitimized efforts by in-house advocates to build networks with feminists—which in turn strengthened the clamor for gender consciousness.

In July 1989, WHR task force members called attention to the need to increase women's decision-making ability at all levels of IPPF. The rationale was that the empowerment of female clients at the grassroots level was contingent on working at the political level through advocacy, lobbying, networking, as well as using such means to encourage and assist women to engage in decision making within IPPF/

WHR. In short, IPPF was obliged to get its own house in order before it could influence others with regard to gender dynamics.

In 1989, the worldwide IPPF's Members' Assembly voted to incorporate the proposal to increase women's decision-making ability at all levels into the organization's next three-year plan (1990–92). Recommendations going beyond simply hiring and promoting women to training in management and gender awareness were assigned to a subcommittee of the International Program Advisory Panel, known as the Working Group on Women.

That same year, at the WHR's 1989 Regional Council meeting, the most important avenue for exchange among associations and regional staff members, the newly appointed secretary general of IPPF worldwide, Halfdan Mahler, addressed the need to improve women's position within IPPF and in society at large. In 1992, under Mahler's leadership, a strategic plan, titled *Vision 2000* (IPPF 1992), set out a new policy agenda for IPPF. This landmark document specified, for the first time, the empowerment of women as one of six challenges for the organization, along with unmet need in the areas of family planning, sexual and reproductive health, unsafe abortion, youth, and quality of care. The explicit reference to the sexual and reproductive health framework reflected some of the most urgent demands of the feminist movement, namely, the need to transform family planning.

Within the Central Office in London, in-house advocates used the document to promote the transformation of the Working Group on Women to a permanent body, and in 1992 the Members' Assembly voted to establish an International Woman's Advisory Panel (IWAP), composed of one member from each of the six IPPF regions. Its objectives included drafting a policy that could help operationalize the goal of empowering women, guaranteeing their participation at the staff and volunteer (board) level.

IWAP defined its tasks as follows: (1) assess the status of women in decision making (within IPPF) and devise strategies to increase their participation; (2) provide expertise on ways to ensure gender sensitivity and incorporate women's perspectives in the design, implementation, and evaluation of programs; (3) assess global trends affecting the status, reproductive health, and rights of women, in order to advise IPPF on policy matters; and (4) provide advice on relevant gender issues facing the federation. In addition, IWAP sought to address the "forgotten" issues of the family planning agenda, including abortion, collaboration with men to transform traditional gender roles, women's sexual and reproductive rights, and a holistic approach to women's health that addresses physical, mental, occupational, sexual, and reproductive concerns throughout the life cy-

cle. Mahler legitimized this initiative by challenging IWAP to become the "conscience of the organization," and promote gender perspectives.

Between 1994 and 1995 IWAP's work focused on two major UN conferences, the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing, emphasizing the need to expand the conceptualization of women's rights as human rights and to continue building bridges with the women's movement. At its second meeting, in 1994, IWAP drafted recommendations to help ensure that abortion would be treated as a public health problem at the Cairo conference and urged FPAs to work in collaboration with national women's groups in preparing for the Beijing meeting. In 1996, IPPF outlined a conceptual context for reproductive health and family planning within the context of women's rights as human rights (IPPF 1996).

The *Draft Policy on Equal Opportunities for Women: Gender Equity,* approved by the Members' Assembly in fall 1995, urged equal representation of women on all IPPF governing boards. It stated that henceforth offices could not justify the exclusion of women on the basis of tradition or culture. As a result, it generated considerable resistance from some national and regional governing boards, requiring a year of discussion before it was approved and another year of discussion about implementation. Finally in fall 1996 the Central Council extended the time frame for achieving the gender equity policy's provisions to 2000.

Additionally, in-house advocates in the WHR worked their board members to encourage country-level affiliates to look at the gender composition of their senior staff and board of directors. Gradually, the all-male leadership began to change; in 1987 there were only two women executive directors of Latin American FPAs, a decade later, nearly half of the directors were women. (Women leaders were already common among FPAs in the English-speaking countries of the Caribbean and North America.)

In short, appointing women to decision-making positions within IPPF governing bodies became an important step as the rate of replacement of men by women in decision-making positions accelerated, particularly in the WHR. This happened during the second half of the 1990s, when major UN conferences around population, development, and women were organized, leading to the feminization of family planning discourse. However, while approving policies and programs that promote equality for women as well as the inclusion of women in positions of management and decision making were significant steps, they were not necessarily sufficient to ensure the institutionalization of gender perspectives.

Quality of Care: Opening the First Programmatic Window

The resistance that advocates of a gender perspective faced as they tried to incorporate these ideas in the field of family planning can be exemplified by the fact that the first measure taken to codify gender as an arena of technical expertise was the technical coding of the quality of care approach. Within the international population world, the comprehensive women's health approach gained official recognition in the late 1980s and early 1990s when Judith Bruce (1989) developed the quality of care framework. Earlier on, Bruce (1984) had introduced the concept of user perspective as a way to focus on women's needs. Rather than use the category gender, the quality of care framework addressed clients' rights to a "constellation" of services, which included, among others, rights to respectful treatment, unbiased information, and access to the widest range of available contraceptive methods with the client's informed consent.

Using Bruce's quality of care model, a group of nongovernmental organizations (NGOs), including the Population Council and IPPF/WHR, began to develop and apply indicators to evaluate the relationship between women, now defined as clients, and medical and paramedical personnel, now characterized as providers of family planning services.

This collaboration was part of a USAID-sponsored task force on Standardization of Family Planning Program Performance Indicators, which focused on four performance measures. The quality of care subcommittee, chaired by Judith Helzner, used a participatory process to allow specialists from a variety of agencies to push the discussion forward. When this task force published its report (USAID 1990), quality of care had progressed from an ambiguous, subjective notion to a more technically sound component of family planning evaluation that combined critical aspects of service delivery, few of which related to providers' technical competence, but most centered on the client's perspective.

From a gender perspective, the quality of care framework was important because it provided a window to address the uneven power relations under which women accessed contraception, especially at the grassroots level (Finkle and Crane 1990). It also provided an opening for gender concerns traditionally considered too emotional or subjective, including desired family size and interpersonal relations between clients and providers. Ruth Dixon-Muller expanded on the quality of care concept, arguing for the need to transform power relations in the family, the community, and society; to implement programs designed by women for women; and to make contraception part of a holistic approach to women's health needs

(Dixon-Muller 1989). While in-house advocates were aware of the framework's feminist implications, it was not expressed in these terms, at least within IPPF/WHR. Instead it was presented as part of broader trends, including the need to monitor medical practice, due to increasing legal liability; the "search for excellence" within the business sector; and competition among family planning agencies for service delivery in Latin America (Helzner 1993).

Quality of care analysis revealed some of the shortcomings of conventional family planning programs while also translating feminist concerns into programmatic and operational concepts. By focusing on clients, it provided a way to increase gender awareness without provoking a clash among the male providers and overall goals of the FPAs. Furthermore, prioritizing this approach proved to be strategic because its supporters (including women outside of IPPF/WHR) realized that its adoption would require more than just providing technical guidelines. Staff at IPPF made efforts to reach out and collaborate with international feminists, took steps toward developing new criteria to evaluate contraceptive research and addressed the provision of services from the perspective of women's needs rather than service delivery quotas or provider preferences.

Two other quality of care initiatives coded as areas of technical expertise—gender perspectives and family planning, and sexual health—increasingly placed women's empowerment at the center of family planning activities. Both met with a degree of resistance, but the fact that they focused on programs and clients meant that they remained essentially unchallenged. Far more difficult to implement were initiatives to bring about greater gender equality in institutional and personnel policies. However, in 1989 the board of the WHR adopted the principle of gender parity in board and committee membership, indicating that the regional office itself would apply the same goals of gender equality that they were advocating in the region. In 1995 the Members' Assembly voted to adopt a policy of gender equity to apply worldwide, according to which boards of directors and volunteer bodies at all levels should achieve a composition of at least 50 percent women.

Quality of Care and Concern for Women: Widening the Program Window

During the early 1990s, grants from the Jessie Smith Noyes Foundation and the MacArthur Foundation helped IPPF/WHR in-house advocates initiate a strategic transition, focusing on going beyond existing paradigms that sought to bring women into the development process, to one which looked at gender roles and expectations that

derive from power relationships between men and women, known as gender and development. By looking at both economic and gender inequalities, the gender and development approach also allowed closer attention to the interplay of social factors such as race, class, and culture and allowed in-house advocates to test the ground around gender demands (Stein 1997; Williams et al. 1994).

This work was directly geared toward sexual and reproductive health through the use of the quality of care framework, which focused on the improvement of client-oriented service provision. To continue building expertise, Magaly Marques, a Brazilian feminist, joined IPPF/WHR as a program officer (thanks to a MacArthur Foundation grant) signaling the organization's willingness to work more closely with Latin American feminists in all of these areas.

Between 1994 and 1997 the IPPF/WHR received a MacArthur Foundation grant to institutionalize a gender perspective by promoting women's ability to make decisions about reproductive and sexual health moved toward the conceptualization of service delivery into a human rights framework. This new approach, called gender perspectives and family planning, focused specifically on overcoming power inequalities derived from gender relations, and the next phase, titled sexual health, emphasized family planning within the framework of a range of sexual and reproductive rights for women. In renewing its support, MacArthur signaled that the IPPF program had the potential to be a pioneer in the field of reproductive and especially sexual health, informing NGO efforts and subsequent grant making in those areas.

In short, the shift from quality of care, with its focus on female clients, to gender and sexual health, with its focus on individual rights and women's empowerment, was profound, and its incorporation in IPPF programs was attributable in part to the triumph of feminist language inclusion and principles in major UN conferences in the 1990s. They also formed part of an entire paradigm shift—from service provision, to concern for gender relations and power inequalities as well as sexual and reproductive rights. Furthermore, the IPPF headquarters in London endorsed these approaches, and the regional office advocated for their implementation, making it difficult for individual FPAs to directly oppose them as affiliated members. This makes it relevant to emphasize the role that the coding of gender as an arena of technical expertise played in the field of family planning as it moved toward the institutionalization of the field of sexual and reproductive health.

However, because the lack of overt opposition is not the same as active endorsement, it was necessary to introduce various forms of gender awareness to bring about change at the country level, includ-

ing fostering links between IPPF/WHR staff members and representatives of Latin American feminist NGOs. This strategy to develop what Kathleen Staudt (1985) has called "nurturing constituencies" strives to coalesce groups of outside supporters who provide leverage for those working inside and are essential to any process of organizational change. As stated at the beginning of the article, this represented a stepping stone for the inclusion of gender perspectives.

Because gender equity requires institutional change, in-house advocates' first step was to seek out firm commitments by the affiliates' leadership, such as the executive director and/or the chair of the volunteer board. For example, in 1992, Marques and Helzner arranged a gender training seminar for women members of country level boards of directors who were to attend the worldwide Members' Assembly meeting that year. As a result of the training, women were far more active, organizing a women's caucus at the Members' Assembly and taking active leadership roles back home in their FPAs, many for the first time. Nonetheless, the translation of these newly gained ideas into programs at the country level remained more problematic.

Different tools were used to advance the institutionalization of gender. The first of these tools was providing gender training to the staff of the FPAs. Such training served to portray gender as a legitimate area of programmatic interest. Gender training was justified as a means to move beyond the narrow frontiers of competent medical care, to delve into the heart of the issue: the social relations that sustain gender arrangements (Rodríguez et al. 1998). Gender training sessions took place amid the tense or, in many cases, nonexistent relations between the FPAs and Latin American feminist groups. Training sessions relied on exercises developed by feminists in both the North and the South, drawing especially on the so-called Harvard school of gender analysis (Overholt et al. 1985) and the practical and strategic needs approach developed by Caroline Moser at the Department of Planning Unit of the University of London. Gender-practical needs emerge out of the position that men and women occupy in the present division of labor. Gender-strategic needs are those that directly lead to a change in the status of men and women, facilitating women's more egalitarian relationships with men (Moser 1993). They introduced such concepts as the construction of gender roles in society and differential access to power and resources, which in this case included access to information and services for better decision-making about their own health.[5] The focus was primarily on health needs and how improving women's status at all levels enables women to take responsibility for their own reproductive health. By involving Latin American feminists they were able to extend the cri-

tique of service provision beyond the individual to include the responsibility of public institutions (such as the state) in providing services.

In this context, it seems relevant to analyze additional critical elements in the strategies followed by in-house advocates to advance egalitarian ideals and gender concerns as well as to embrace a comprehensive sexual and reproductive health program. This relevant factor is the careful building of alliances between feminist in-house advocates and feminists in the region.

Building Bridges at the Regional Level

Difficulties in building links to local women's groups at the country level indicated the persistence of mutual misconceptions and mistrust on both sides. Perceiving this, in-house advocates concluded that efforts to overcome these problems might be more effective at the regional level. Building on IPPF's traditional strengths as an international network, in-house advocates arranged two regional workshops that brought together FPA staff and members of local women's groups, one in the Dominican Republic in 1994 and the other in Nicaragua in 1997. A total of fourteen countries participated in these workshops. The objective was to provide an opportunity, outside the day-to-day workplace, where feminists and FPA representatives from each participating country could establish collegial relationships, allowing them to overcome their mutual distrust while moving on to the articulation of common goals (Rodríguez et al. 1998).

In arranging the meetings, IPPF/WHR worked closely with the Red de la Salud de la Mujer Latinoamericana y del Caribe (Latin-American and Caribbean Women's Health Network), the central coordinating body for the organizations working within the women's health movement in the region. Their collaboration with IPPF/WHR developed in late 1993 when the network made the decision to enter into dialogue with FPAs to build an effective feminist presence at the ICPD in Cairo the following year. Starting at that point, selected representatives of Latin American feminist groups were encouraged to take one-month internships in the regional office of IPPF/WHR, with a combined objective of providing an outside assessment of IPPF/WHR operations and facilitating a transfer of technical knowledge from IPPF/WHR staff to feminist groups to build their institutional capacity. Working from the New York office, the interns assisted in selecting the feminist representatives and arranging their participation at the regional meetings.

The appropriate selection of the participants, facilitated by the network, contributed to the success of the meetings. Participants claimed

that they had broken down many of the mutual stereotypes, allowing them to build working partnerships. Although the results varied considerably among the participating countries, the meetings did help focus attention on issues that the Latin American women's health community had been trying to make visible for years, notably gender violence and the need for a gender perspective in dealing with HIV/AIDS prevention.

Building Alliances, Nurturing Constituencies

The importance of the women's health movement as a supportive constituency for reproductive health organizations cannot be underestimated. The confluence of efforts created a space that permitted that social debate around these aspects began to manifest, albeit in uneven terms, according to the specific degree of openness or conservatism that prevailed in each country. Additionally, thanks to the collective efforts of feminists in the region, outright attacks on gender issues targeted at reproductive health organizations were averted or policy changes introduced. For example, after two years of intense lobbying, abortion laws were decriminalized in Mexico. In other instances, interest of donors in the region increased and programs in sexual and reproductive health multiplied in the region (Ortiz-Ortega 2000). Thus, although the church and related opposition groups remained powerful forces, at the level of the individual client, this could not prevent the opening of programs in sexual and reproductive health. As NGOs, the FPAs occasionally face direct attacks, but more often they work to preempt opposition via information, education, and communication techniques to counter incorrect propaganda on the part of the Catholic Church and its allies.

In short, in the past decade, the word *gender* gained acceptance within government and international decision-making bodies (Hinojosa and Jimenez 1996). Thus, by the mid-1990s, feminists working within the organization had initiated activities within each of the four fronts mentioned at the start of this article, involving three areas of institutional activity: introducing women-focused programs, adopting gender-equity policies, and hiring and promoting women to leadership positions (see Table 1). However, there was not an even advance on all of these fronts. Additionally, change did not result from outside pressure so much as in-house feminist advocacy. As this work has shown, advocates took significant steps under increasing donor and headquarter pressure to generate greater gender consciousness as the family planning field in general underwent major changes. In this context the building of alliances with feminists was important. Yet there have been difficulties in creating enduring alliances, partic-

Table 1. Practical Steps toward Opening Windows to Gender by IPPF/WHR (1987–2002)

Category of activity	Specific examples
Staffing changes	Hiring of in-house feminists as advocates (advocacy administrators)
Formal and informal policy change from the top	Regional board of directors sets policy ensuring that at least half of decision-makers will be women at regional level
	Advisory panels are established at international and regional levels with the mandate of reviewing policies; a worldwide Gender Equity Policy is adopted
	Secretary general of IPPF worldwide speaks out in favor of feminist ideas ("jawboning" on behalf of the cause)
Programmatic changes (made possible largely by restricted funding sources from interested donor agencies)	*Quality of care* moved from serving as an early opening to emphasize women clients' realities in clinical service delivery settings, without threatening the power structures of decision making levels, to a technical area with clear gender critiques of broad areas
	Gender sensitization training sessions were initially quite general in content; later, new funding allowed specific efforts on integrating screening for gender-based violence into services, gender perspectives on men's roles in reproductive health, etc.
	Sexual health and rights approaches receive priority through: meetings on sexuality, promotion of the IPPF Charter on Sexual and Reproductive Rights and the video spots illustrating the rights, etc.
Constituency changes	Creating linkages with feminist groups: through meetings held for that express purpose by IPPF/WHR through collaboration at other meetings, e.g., on UN conferences by hiring leading individual feminists as consultants, and/or offering internships at IPPF/WHR for two-way exchange on specific products, such as the manual to evaluate quality of care from a gender perspective

ularly with the women's health movement. One cause is resistance to feminism within FPAs. Also, feminists in this movement, like feminists across the globe, must constantly evaluate whether and how to collaborate with mainstream institutions in an effort to improve the lives and status of women. Those who oppose cooperation with mainstream organizations argue that such cooperation encourages internal competition for resources and a neutralization of feminist ideology and politics. Those who support cooperation insist that feminists can successfully negotiate with major institutions, gain breadth without losing their autonomy, and infiltrate mainstream organizations to negotiate a greater social impact (Gobbi 1997).

Within the international women's health movement, this position of mainstream involvement has gained strength as the movement itself has gained strength. Starting in the 1970s, feminists from both the North and the South pioneered a vision of family planning that revolved around women's sexual and reproductive rights. Although their focus was not primarily on governments and international agencies, by the end of the 1980s their success in articulating their insights and concerns resulted in major international agencies requesting their cooperation in introducing new approaches to the issue of family planning. Some feminist groups, such as the International Women's Health Coalition, took the lead among more established population agencies. IPPF/WHR was one of the first to advocate for the incorporation of feminist ideas at the level of service provision. As a result, feminists became a powerful constituency in many countries.

Nonetheless, many feminists remain skeptical that the commitment to gradual change through concrete steps promoted by in-house advocates will suffice to initiate the major transformations needed to make sexual and reproductive health accessible to women. This is especially true at a time when the hope and euphoria following the Cairo ICPD consensus has given way to frustrations over the slow pace of tangible progress and fears that governments and other agencies have only changed their rhetoric. Five years after Cairo, for example, FPAs throughout Latin America and the Caribbean found themselves forced to increase fees for service as donors move away from the region. Moreover, as feminist groups themselves seek funding from outside agencies and foundations they face accusations of transforming feminism into a co-opted profession, one that has subordinated its political goals to professional interests.

Yet feminism is never monolithic or static in either ideology or practice. According to Sen and Grown (1987), feminism represents the political expression of the concerns and interests of women from different regions, classes, nationalities, and ethnic backgrounds. As conservatives in countries throughout the region and the world have

regrouped after their losses at Cairo, many feminists within the women's health movement have realized the need to operate on both an inside and an outside track. If it is time for some to reinfuse the movement with the original passion, reasserting the demands for women's empowerment from a position that does not require compromise, it is time for others to broaden their movement by strengthening successful alliances and building new ones. Women working within mainstream agencies are aware that to make the concept of reproductive health meaningful for women, they will need continued pressure, support, and cooperation from outside feminists.

Conclusions

Opening windows has made a difference: The changing dynamic within the organization—as well as within the family planning field as a whole—has created an opportunity for the expansion of the traditional family planning paradigm. Yet bringing about gender equity within the institution itself has proved more difficult. Thus, although feminist demands have been transformed into areas of technical concern, and there is now greater openness about gender issues among program officers (especially women), the question remains to what extent such changes will bring about sustainable progress in women's sexual and reproductive health.

Overall, the effort to incorporate a gender perspective within IPPF/WHR has been more successful in terms of improving service delivery than in terms of changing institutional gender relations. At the country level, commitment by leadership, along with activities such as gender training and evaluation, have had an effect in terms of increasing awareness by service providers of women's gender-specific needs and thus have undoubtedly contributed to improving their lives. In terms of institutional change, success has been more limited. A major shift is needed to transform a family planning clinic into a reproductive health center (Helzner 2002). Though some changes have been noted, including greater awareness of women's broader health needs and some consciousness of the power relations in society that restrict their independence of choice and action, more are necessary, including the incorporation of such awareness into patient–provider relations and a perception of women as subjects of rights in all social relationships (Blanc 2001).

At the regional level, the conceptualization of the organization's mission away from contraception and toward women's empowerment has undoubtedly had an impact in restoring the organization's credibility, not only within the donor community but also within the women's health movement. At the same time, little has changed in

terms of the centralization of power and decision making. This suggests that relying on outside donors for gender and sexual health programs while allowing in-house advocates to act as free agents may have created obstacles to the formal institutionalization of a gender perspective by allowing the organization to postpone long-term commitments or changes in budget allocations (Rogow 1992). In-house advocates should push for gender-inclusive policies and programs and enforce their completion, rather than fulfill temporary programmatic needs and promote complacency without changing official policy.

The greatest obstacles lie in the persistence of political culture and bureaucratic norms within the organization. Departmental specialization, vertical control, and excessive focus on the generation of procedures foster the same atmosphere that plagues bureaucracies worldwide. Because these values reflect the corporate Western culture within which international private voluntary organizations operate, one challenge faced by in-house advocates—and others committed to social change—is to demonstrate that more collective leadership, acceptance of gender and cultural diversity, or simple forms of trust can overcome these problems.

Feminist demands are being translated into policies and programs via the work of in-house advocates who openly advocate in favor of women's rights. Already the results can be seen as the organization moves to expand its quality of care perspective to directly address gender violence, human relations, and hierarchical exchanges between providers and clients. Yet the presence of in-house advocates alone cannot reverse the power relations that permeate the organization. Indeed, it may be that for IPPF/WHR to fully embrace a sexual and reproductive health paradigm it would need to lobby in more explicit ways in favor of sexual and reproductive rights (including problematic issues such as sexual orientation and abortion) and tackle collectively the formal and informal ways in which traditional gender relations continue to permeate its bureaucratic culture. Both of these require the creation of a new climate with regard to women's autonomy and decision making, which can only be brought about with the strong support of the women's health movement and, in fact, the broader women's movement, nationally and internationally.

For this reason, it is important that feminists work to overcome their skepticism and endure the charges of co-optation, recognizing that collaboration is a two-way street. Thus, helping population agencies achieve their respective family planning goals may, in fact, improve the lives of many women. Bettina Avila, a Brazilian feminist and health activist, criticized feminists for viewing alliances as a means of gathering support for their position, rather than lending support to the agenda of others (Avila 1997). The experience of

IPPF/WHR described in this article shows that the women's health movement in Latin America and the Caribbean has gone beyond that, but it also demonstrates the need to continually revitalize and renew these collaborations. In the words of Marge Berer (1997, 7), editor of the peer-reviewed journal *Reproductive Health Matters*: "What has kept this movement relevant and strong is the dedication to finding out and articulating women's needs until these are heard, formulating this knowledge into demands and working as activists to turn 'needs' and 'demands' into realities locally, nationally, globally. Who after all will empower us, if not we women ourselves?"

From the point of view of the literature of gender and bureaucracies, the complexity of the issues at stake proves the need to continue theorizing the experiences of private voluntary organizations. Needless to say, it remains necessary to generate gender-specific theoretical developments to test old and new paradigms that can serve to advance interpretations and lead us to imagine new scenarios for social change at an international scale. In the case of IPPF/WHR, the practical model conceived to work at the level of people, programs, and policies proved more successful as connections between the needs of grassroots women began to be tied to policy changes. As this article has shown, historically this has not been an easy task. Programs that only vaguely address the connections between women and development have had limited success, and directly promoting greater participation of women in decision making has often been perceived as too threatening to allow for change.

This proves that in practice even nineteenth-century liberal ideals, such as considering women as "rational, autonomous actors whose ultimate goal is to make organizations more efficient, effective and fair" (Calás and Smircich 1996, 223) continue to face tremendous resistance. This is the case even in fields where the mission of the organization is to serve the needs of grassroots women. The just organization—especially one located amid globalization and transnationalization—that allows men and women to exercise their capabilities and fulfill themselves through a merit system is still in the making.

Most likely, a social transformation based on alliances between feminists and in-house advocacy administrators would need to delve even deeper in the ways intersections of sexuality and power relations shape organizations at the macro and micro levels, including how power and sexuality interweave in work relations both at the local and international levels. From theoretical or practical perspectives, this cannot be seen as an easy task in the context of growing poststructuralist, postmodern, and postcolonial bodies of literature with their recurring questioning of how the power/knowledge relations constitute and are constituted through discourses and language.

However, by recognizing the heterogeneity within the apparently unitary category of gender, new avenues of political engagement might open up insofar as women are willing to make a patchwork of overlapping alliances that do not subscribe to one essential notion of womanhood. For these reasons, it seems important to pay attention to postmodern/poststructuralist or postcolonial feminisms. In particular, such approaches allow for more complex intersections of gender and other social categories that both deconstruct taken-for-granted analytical subject positions while opening the space for different political engagements that recognize asymmetrical power relations encompassing issues of inequality, injustice, and intolerance of various sorts.

NOTES

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1. "UNIFEM promotes women's empowerment and equality. It works to ensure the participation of women al all levels of development planning and practice, and acts as catalyst within the UN system, supporting efforts that link the needs and concerns of women to all critical issues on the national, regional and global agenda" (UNIFEM 1995).

2. IPPF (2001). Today, operating through local autonomous associations, IPPF has a total of 152 affiliates with 128 nationally representative voting members.

3. For an early examination of the internal transformation of population agencies see Helzner and Shepard (1990).

4. Similar initiatives were taken by Sweden, Great Britain, and New Zealand. A $3 million grant from the Victor Fund in 1965 allowed IPPF to expand its operations worldwide. Suitters (1973), 281–316.

5. For the model's theoretical underpinnings see Molyneux (1985). The IPPF/WHR, with the Overholt-Austin team, created its own case studies covering topics such as links with women's groups and assessing the content of educational materials from a gender perspective, for its regional training. Each country-specific gender training was custom-tailored to the programs and concerns of the particular association involved.

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