in domestic humanitarian conditions. As such, conditions for women in Iran are comparably freer than conditions for women in Saudi Arabia.

CONCLUSION

Conditions of gender equality vary throughout the Middle East and are affected by a number of factors. This essay has demonstrated how the specific political-institutional differences between Iran and Saudi Arabia have contributed to Iran's comparatively more liberal conditions for women's rights. The Iranian political system is fragmented, allowing women to pressure their government for reform through supporting reformist factions. In Saudi Arabia, the Monarchy and the Ulema are closely tied and deeply dependent on each other, and therefore it is more difficult for Saudi women to pressure the government to reform. Iranian women are able to pressure their governments through participation in the political sphere, best illustrated by the role they played in the reformist victory in the 1997 and 2000 elections and the Women's Bloc of the Sixth Majlis. While Saudi women are allowed to vote and participate in politics, they are voting for and participating in an institution which, compared to the Iranian parliament, does not have much power. It is true that the NGO sector of Saudi society has made considerable advancements in the area of women's participation in the public sphere, yet the most effective pressure on the Saudi elite come from the United States. Because the Saudi government is not held accountable to its population, but rather to foreign actors, the changes it makes are superficially reformist and have no meaningful effect on actual conditions for women in Saudi Arabia. In Iran, pressure to reform comes from groups within the country who are unsatisfied with perfunctory government action. For these reasons, women in Iran have comparably more rights than women in Saudi Arabia.

Addressing Overpopulation:

International Aid Agencies' Violation of Human Rights in the Voluntary Surgical Contraception Campaign of Peru

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INTRODUCTION

During the 1990s, the United Nations held the International Conference on Population and Development (ICPD) in Cairo. One of the concerns put forward was the high rate of fertility in certain countries, which might impede their ability to supply citizens with "an adequate standard of living for themselves and their families, including adequate food, clothing, housing, water and sanitation."[1] Linked to the solution of this impending overpopulation crisis was the notion of gender equality, in which both men and women would jointly take part in the family planning process. Alberto Fujimori, the President of Peru, appropriated this notion when he introduced a new family planning program concentrated on providing contraceptives to all citizens. One of the methods proposed by the government was sterilization by tubal ligation, specifically promoted through the Voluntary Surgical Contraception (AQV – Anticoncepción quirúrgica voluntaria) campaign. The Peruvian government's approach to family planning was innately detrimental to goals of gender equality for the disenfranchised groups it aimed to help. In this paper, I will demonstrate that

[1] United Nations International Conference on Population and Development, Cairo, Egypt, 5-13 September 1994. *Programme of Action,* http://www.iisd.ca/Cairo/program/p02003.html

international aid agencies such as the United States Agency for International Development and the United Nations Population Fund gave legitimacy and necessary funding to the proposed sterilization process. I will then reveal the violations of patient's rights faced by the rural, poor and indigenous women who were affected by this policy. The AQV took away their right to fair consultation before an operation, freedom of choice, and access to concrete measures to ensure their safety during and after the procedure.

HISTORICAL AND POLITICAL BACKGROUND TO THE ANTICONCEPCIÓN QUIRÚRGICA VOLUNTARIA CAMPAIGN

The preparations to establish the AQV campaign began during Alberto Fujimori's first term as president between 1990 and 1995. By proclaiming the 1990s the "Decade of Family Planning," he sought to put the campaign at the forefront of his political agenda. In 1992, the National Program on the Reproductive Health of the Family (PNASRF—Programa Nacional de Atención a la Salud Reproductiva de la Familia) replaced an older program that had been established in 1988. According to Rousseau, two of the five national development objectives stated in the documents that govern PNASRF were:

> [...] the creation of a new competitive and sustainable national economy; and [...] the reduction of poverty levels and progressive improvement of the quality of life for Peruvians. [Furthermore, t] he program explicitly sought to attain 'a population growth rate conducive to reaching desired development levels through a reduction of fertility, achieved in harmony with people's free decision to determine the size of their families and the intervals between pregnancies.' [2]

Fujimori also chose the same year to conduct a self-coup, where he dissolved Congress, dismissed the judiciary, and suspended the Constitution, in order to draft a new one, which later was approved by referendum in 1993. The new constitution enshrined the right for a family to decide both the number and timing of its children, mentioned women as explicit participants in the notion of parenthood, and recognized the right to health protection. Abroad, however, "Fujimori's self-coup in 1992 was viewed poorly by international observers."[3] The 1995 election, in which he won a second term as President and in which his party "won a strong majority in Congress, [was accused] of rampant election fraud."[4] As President of Peru and the leading actor in the 1992 coup, Fujimori therefore needed to legitimize his place in politics at the international level.

Fujimori utilised speeches and family planning measures to support his claim to democratic leadership. On July 28th 1995, during the inauguration speech for his second term, he expressed his support for the goals of the United Nations International Conference on Population and Development and spoke of his commitment to family planning, especially in relation to the economic crisis that Peru was facing. He "used a pro-poor discourse to justify state intervention in redressing unequal access to contraceptives and family planning information."[5] The first measure taken to confirm his support for family planning was to decriminalize certain modern contraceptives. In August 1995, the Peruvian Congress approved the use of sterilization as a method of contraception.

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[2] Stéphanie Rousseau, "The Politics of Reproductive Health in Peru: Gender and Social Policy in the Global south." *International Studies in Gender, State and Society* 14, no. 1 (2007): 105.

[3] Caralyn M. Elliot, *Global Empowerment of Women: Response to Globalization and Politicized Religions.* (New York: Routeledge, 2008), 329.

[4] Rousseau, 2007, 106.

[5] *Ibid.*, 107.

In September of the same year, Fujimori spoke to an international audience about Peru's new family planning initiatives. At the United Nations International Conference on Women in Beijing, he brought forward the notion of women as important players in family planning. It was particularly notable that he was the only male head of state to speak at the conference. He emphasized that Peru would "carry out a vast national campaign to actively make public all these family planning methods."[6] He also mentioned that, "family planning methods are now legally available within the reach of women, men, and families of all social classes –so they can use them, I underline this, free[ly] and responsibl[y] or not use them, if they opt for a different solution according to their personal or family beliefs."[7] By presenting women as key actors and emphasizing that this family planning approach would lead to a better future, he achieved international recognition by linking his own government to the prevalent feminist discourse iterated by the United Nations.

Around the same time, the PNASRF established the AQV campaign. The goals of the program were to decrease the fertility rate in order to reduce poverty and improve Peru's economy.[8] The campaign "absolutely required the support of international cooperation agencies in order to be implemented"[9] due to the costs of the program they where implementing. In 1995, the Ministry of Health (MINSA - Ministero de la Salud), had "decided it would provide [family planning] services free of charge."[10] In Peru's tiered health system, MINSA takes care of 75 percent of the Peruvian population, yet it only received 26 percent of the total of public and private funding allocated to healthcare.[11] Its clientele includes the poor, rural and indigenous peoples of Peru. By addressing family planning and emphasizing a human-centric approach to supplying modern contraception methods, the government hoped to attract international financial support for the measures it was implementing.

FUNDING FROM US AID AND THE UN

Due to the success of the discourse iterated by the Peruvian government, the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) were both important contributors to PNASRF and its AQV campaign. Senn states that "[t]he United Nations report[s] that Peru receive[d] US$157 million for population control activities in 1994-1998."[12] Peru also became the country with the tenth highest funding allocated to it directly from the UNFPA for contraception in 1996 with a contribution of US$3.5 million. The following year this amount increased to US$4.9 million.[13] The direct financial support implicated the UNFPA and by proxy, the United Nations, in the consequences of the policy.

USAID adopted a different approach and chose to allocate its funding to non-government organizations (NGOs) involved in the AQV

[6] Alberto Fujimori. Address to the 4th World Conference on Women, United Nations Fourth World Conference on Women, Beijing, China, September 15, 1995 http://www.un.org/esa/gopher-data/conf/fwcw/conf/gov/950915131946.txt
[7] *Ibid.*
[8] Rousseau, 2007, 105.
[9] *Ibid.*, 106.

[10] Roberto Lopez-Linares (United States Agency of International Development),*Contraceptive Procurement in Peru: Diversifying Suppliers*, (2008), 3 http://www.healthpolicyinitiative.com/Publications/Documents/620_1_Contraceptive_Procurement_Peru_Diversifying_Suppliers_FINAL_acc.pdf
[11] Rousseau, 2007, 99-100.
[12] Guillermo Senn, "Under the "First-World" Scalpel: The Sterilization of Quechua Women between 1995-1998" (M.A. diss., University of Ottawa, 2004). 114
[13] United Nations Population Fund, *Donor Support for Contraceptives and Condoms for STI/HIV Prevention.* (Geneva: UNFPA, 2002), 9 http://www.unfpa.org/upload/lib_pub_file/192_filename_contraceptives_01.pdf

campaign. They contributed in excess of US$40 million, including US$5 million to ReproSalud, an NGO whose role was to promote to ethnic minorities the government-approved methods of family planning, specifically sterilization.[14] A further "[US]$18 million was provided to [the NGO] CARE for training doctors to perform sterilization and supplying sterilization equipment used in the coercive campaigns".[15] USAID's choice of NGOs confirms their awareness of the nature of the campaign and the method of modern contraception that they support. The formal review of the campaign attests that, through the AQV campaign, 314 605 women received tubal libations and 24 563 men had vasectomies between 1990 and 1999.[16] The funding and involvement of USAID and the UNFPA were instrumental in the campaign achieving these results.

VIOLATION OF PATIENTS' RIGHTS

The manner in which the AQV campaign was conducted robbed the targeted patients of their rights. An entire list of Patients' Rights are recognised in both Peru and in the United States, from which the majority of the funding came. In 1985, The World Medical Association, of which both the Colegio de Médicos of Peru and the American Medical Association (AMA) are members, enshrined the rights of a patient.[17] The AMA further acknowledged these rights by creating their own set of rights in 1990.[18] These rights include the right to information, the right to self-determination and the right to medical care of good quality. These renowned institutes promote public health and protect both patient and physician rights. They are also recognized as important lobby groups by the government. Therefore, the state should also consider the particular health policies that they adopt, as nearly all doctors fall under this association.

Right to Information

The first right violated by the AQV campaign was the patients' access to information. A patient has the right to receive information on the treatment chosen and also to be aware of any alternative treatments that are available. Insufficient information was given to patients about the sterilization program. In the report released by the Peruvian Ministry of Health's Special Commission on AQV, out of 2 096 clinical reported cases of sterilization in Peru, 59.3 percent of the cases were identified as lacking the full informed consent of the women.[19] There were two ways in which women were left misinformed about tubal ligation surgery. First, women were not aware that the process led to permanent sterilization. A worker at one of the MINSA areas in northern Peru was quoted as saying, "[i]n most cases [women] are not told that the ligations are usually definite

> "59.3 PERCENT OF THE CASES WERE IDENTIFIED AS LACKING THE FULL INFORMED CONSENT OF THE WOMEN"

[14] Steven. W. Mosher, "USAID Supported Fujimori Sterilization Campaign; Seeks to Cover-Up Involvement" *PRI Review* 13, no. 5 (2003) http://www.pop.org/content/usaid-supported-fujimori-sterilization-1658

[15] *Ibid.*

[16] Subcommittee Investigation of Persons and Institutions Involved in Voluntary Surgical Contraception, "Final Report Concerning Voluntary Surgical Contraception During the Years 1990-2000" *PRI Review* 12, no. 4 (2002) http://www.pop.org/content/final-report-concerning-voluntary-surgical-1424

[17] World Medical Association, 34th World Medical Assembly, Lisbon, Portugal, September/October 1981. *WMA Declaration of Lisbon on the Rights of a Patient.* http://www.wma.net/en/30publications/10policies/l4/

[18] Council on Ethical and Judicial Affairs, American Medical Association House of Delegates, June 26 1990, *Fundamental elements of the Patient-Physician Relationship,* http://jama.ama-assn.org/content/264/24/3133.full.pdf+html?sid=6ab8e587-0556-418c-a60b-98c22638b11c

[19] Juan Succar Rahme, Maita Garcia Trovato, Esperanza Reyes Solari, Hilaria Supa Huaman, Ministero de Salud, "Comisión Especial Sobre Actividades de Anticoncepción Quirúrgica Voluntaria (AQV)" (Lima, 2002) http://www.mamfundacional.org/ef/Informe-Final.pdf 88

and irreversible."[20] Women therefore cannot choose their birth control opinion critically.

Furthermore, the written consent forms did not provide a legitimate alternative source of information for patients. There were two logistical problems with the written consent that had to be signed by the patient before the operation took place. The first problem concerned language. According to the 1993 Peruvian census, 14.4 percent of people surveyed in Peru spoke Quechua, a largely oral language, as a mother tongue.[21] The Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer (CLADEM) also notes that there is a part of the population that speaks only an indigenous language who were not included in the census. [22] This indicates that some Quechua-speaking people would have been unable to read the consent form. The Peruvian Constitution of 1993 recognized Quechua and other indigenous languages as official languages in the provinces in which the population of speakers is largely concentrated. Despite recognizing indigenous peoples and their rights, during the AQV, the Peruvian government only provided consent forms in Spanish. [23] The information was provided was unhelpful to patients if they could not understand the language it was written it and therefore they were still unaware of the implications of the surgery. Consequently, the use of the form disenfranchised Quechua women and other indigenous people as it was written in a language that they did not understand.
Secondly, rates of illiteracy were high among the people in the regions that were targeted. While the 1993 census revealed that 71 percent of the population lived in urban regions,[24] a survey of the sterilization campaign found that only 19 percent were from urban regions, while 53 percent came from rural regions and 28 percent from marginal urban zones.[25] The surgical campaign purposefully concentrated its efforts on the rural areas of the country rather than basing it on population distribution. The people living in rural regions were at a disadvantage when they needed to consent to the surgery because of the likelihood of being illiterate. In 1993, 29.8 percent of people living in rural regions were illiterate.[26] The rate for women was also disproportionately higher: 42.9 percent as opposed to 17.0 percent for men in rural areas.[27] Since tubal ligation was concentrated in rural areas where illiteracy rates are high, it is likely that many women did not fully understand the consent form. By capitalising on the monolingualism and illiteracy of the groups it was targeting, the Peruvian government did not take into account patients' right to information in order to achieve higher rates of sterilization.

Additionally, not all patients were provided with adequate information about other available methods of contraception. The Family Planning Policy created by the Peruvian government was based on the free distribution of five different types of birth control[28], including condoms, oral birth control pills, injectables, intrauterine devices,[29] in addition to sterilization. However,

[20] Brita Schmidt, "Forced Sterilization in Peru", *Political Environments* 6, Fall 1998.
[21] As quoted by Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer (CLADEM), "Diagnóstico sobre la Situación de los derechos sexuales y los derechos reproductivos: 1995-2002. Perú. Campaña por la Convención de los Derechos Sexuales y los Derechos Reproductivos" (Lima, 2003), 9.
[22] CLADEM, 2003, 9.
[23] Senn, 2004, 30.
[24] Ministerio de Salud. Plan Nacional de Salud (año 1993) in CLADEM, 2003, 8.
[25] Juan Succar Rahme et al., 20002, 88.
[26] INEI – PROMUDEH, Género: Equidad y Disparidades, 1999. in Fundo de Población de las Naciones Unidas, "Perú en Cifras: Educación: Tasa de analfabetismo por sexo" http://www.unfpa.org.pe/infosd/educacion/educacion_05.htm
[27] *Ibid.*
[28] Stéphanie Rousseau, "Women's Citizenship and Neopopulism: Peru under the Fujimori Regime" *Latin American Politics and Society* 48, no.1, (2006): 129.
[29] Lopez-Linares (USAID), 2008, 5.

in reality, patients were not always provided with access to these other methods of contraception. In fact, "temporary methods of birth control [...] were intentionally withheld in order to promote sterilization."[30] A woman who wished to choose when and how many children she would have, as enshrined by the 1993 Constitution, had to consent to sterilization as the only option presented to her. This only allowed her to choose how many children she would have and not when she could have them. By providing limited information on the outcome of tubal ligation and withholding other methods of birth control, the government forced patients to choose sterilization.

Right to Self-Determination

A second violation of patients' rights during the AQV campaign was the inability to choose to have the surgery without constraints. The government first took away their right to choose through a monetary incentive policy. Although MINSA has a policy that bans the exchange of goods or services for contraceptive care,[31] the AQV campaign was linked with the distribution of food, clothes, and medical aid. In poor areas, a package of food and clothing worth approximately US$36 was given to women who elected to have the tubal ligation operation.[32] In rural areas, 36 percent of the population was considered poor and 30.1 percent was considered extremely poor.[33] With a total of 66.1 percent of the population in need, the incentive of food and clothing was much more appealing despite the procedure required to obtain it. This procedure is even more alarming after recognising that this incentive has been linked to USAID food aid in rural regions.[34] Food and clothing, which should have been freely offered, were used as an incentive to force women into sterilization in order to provide for their family.

"IN POOR AREAS, A PACKAGE OF FOOD AND CLOTHING WORTH APPROXIMATELY US$36 WAS GIVEN TO WOMEN WHO ELECTED TO HAVE THE TUBAL LIGATION OPERATION."

A second incentive given to women in order to motivate them to have tubal ligation was the offer of free medical aid. Without agreeing to the surgery, the necessary help would not be provided. In a healthcare system where they needed to pay for natal care, "poor pregnant women are regularly offered free birth services in exchange for tubal ligation."[35] It became the mother's choice to obtain healthcare for her newborn by taking away her own right to reproduction. By merging two healthcare matters together, women are often unable to electively choose another option, as their current state of being forces them to accept healthcare they are offered.

While some women were incited to choose the surgery, other women had no choice at all. Some women who gave birth in a hospital setting through caesarean had tubal ligation surgery performed unbeknownst to them while they were unconscious. One woman spoke of going to the hospital to give birth to her child by caesarean and when she woke up, her doctors told her of the death of her son and the sterilization they performed without her consent.[36] Others also shared her experience.[37] This surgical intervention relies on the vulnerability of women who are pregnant and also on their trust in the

[30] Anna-Britt Coe, "From Anti-Natalist to Ultra-Conservative: Restricting Choice in Peru" *Reproductive Health Matters* 12 (24), 2004, 62

[31] Hearing Before the Subcommittee on International Operations and Human Rights of the Committee on International Relations, (U.S. House of Representatives), *The Peruvian Population Control Program*) 1998, 15.

[32] Senn, 2004, 30.

[33] CLADEM, 2003,10.

[34] Hearing on International Operations and Human Rights, *The Peruvian Population Control Program*, 7.

[35] Senn, 2004, 118.

[36] Hearing on International Operations and Human Rights, 55.

[37] Rousseau, 2007, 108.

health authorities to keep patients' interests in mind when conducting an operation. In such a case, the women are unable to even speak up against the action taken on their body before it occurs.

Kidnappings also occurred among women who, aware of the implications of the sterilization policy, had elected to forego the operation. There are recorded cases of these women being "captured" by health care authorities and then sterilized despite refusing to have the operation. [38] To forcefully kidnap and operate on a person is perhaps the most direct violation of their right to choose. The health care workers ignored their patients' right to explicitly choose an elective procedure, thereby assuming that the women themselves were unable to make decisions regarding their own reproduction. Family planning matters became the responsibility of the state as opposed to a personal choice. Despite the gender equalization discourse used to promote Peruvian family planning policies, the AQV campaign used methods which were detrimental to gender equality. It led to an entrenchment of the traditional notion of women as caregivers of the family and as unable to make decisions about things that concern them.

Right to Medical Care of Good Quality

The final violation made by Peruvian authorities within the sterilization process was foregoing the patients' right to a safe medical procedure. When a patient undergoes surgery, they have the right to undergo procedures that seek to prevent complications and treat them if they arise. The sterilizations in Peru, however, were conducted without precaution. First, the government set quotas for the amount of sterilizations that were to take place in a year. The goal for 1997 had been 130 000 sterilizations, while for 1998, a quota of 160,000 was set.[39] Instead of concentrating on safe operations, the government's stance sought to reduce the amount of births over the safe conduction of the operations. This approach was supported by USAID. Through a partnership with the NGO Association of Voluntary Sterilization (AVS), the AQV campaign received a contribution from the World Bank amounting to US$ 200 million in 1998.[40] The agreement between USAID-AVS specified that AVS "must offer technical assistance to governments" to help them "establish and expand sterilization activities."[41] The timing of the extra funding, as well as the discourse used to describe its goals, shows USAID's support for the campaign and its increased quotas. At the time, feminist lawyers, CLADEM, and the Peruvian Ombudsman's Office were all investigating cases of abuse by the campaign.[42] USAID showed continued support for the practice, which has been deemed at the very least questionable, by using its affiliations with other organizations to provide the AQV campaign with the necessary collateral to continue a high amount of sterilizations per year.

The target rates of sterilization were entrenched through different incentives passed down to MINSA workers. First, for every woman sterilized, a health worker received a bonus ranging from four dollars to 12 dollars.[43] Workers who did not comply with the quota faced the possibility of termination.[44] Workers were then much more likely to use any means possible to coax women into agreeing to tubal ligation, including using those previously mentioned, such as monetary

[38] Schmidt, 1998; Senn, 2004, 1.

[39] Abraham Lama. "Voluntary and Forced Sterilization in Peru" *Inter Press Service*, 31 May 1998. http://search.proquest.com.libproxy.mta.ca/pqrl/docview/446071468/13297FFE77B78027D19/1?accountid=12599

[40] Senn, 2004, 114.

[41] *Ibid.*

[42] Rousseau, 2007, 108.

[43] Schmidt, 1998.

[44] Senn, 2004, 30.

incentives or not providing patients with the information. Physicians also faced similar measures from MINSA. Those that performed the operations were also required to comply with a minimum quota of tubal ligations per month.[45] These physicians also perform many surgeries every day, sometimes over twenty.[46] When given directions from authorities telling them to prioritize the quantity of surgeries performed over the quality, the health workers and doctors implicitly put the patient at risk. The workers were less likely to provide the necessary information or act without any incentives to coax women to choose the operation and the physicians' ability to conduct surgery was diminished by the demands they faced.

After surgery, the patients did not receive the follow-up care necessary to ensure their safety. Due to the systematic approach that governed the sterilization procedure, patients did not receive adequate rest time after surgery. Some women were given very short recovery periods of less than four hours. [47] After a major surgery, which required general anaesthesia, women were at risk to develop major complications. These complications include bleeding, bladder infection, uterine perforation and infection. There were seventeen cases that led to the death of the woman who had her tubes tied.[48] Forcing them to leave health care facilities quickly minimized their ability to receive care from health care professionals in case of complication. Then, in order to achieve the high quota that MINSA had assigned to them, workers organized "sterilization festivals" in rural sectors, where they consult women, perform the operation and leave on the same day.[49] Access to healthcare in rural communities is limited due to the segmentation of the healthcare system[50], therefore, women's access to follow-up care was limited in case complications arose. Finally, while the sterilization operation is free according to MINSA guidelines, follow-up care is not.[51] With the large majority of surgeries being conducted on poor women, none of the necessary considerations were taken into account in order to As previously shown, poor women were the targets of these surgeries, yet no consideration was taken to provide affordable adequate care to women who were faced with complications following the surgery.

AFTER SURGERY, THE PATIENTS DID NOT RECEIVE THE FOLLOW-UP CARE NECESSARY TO ENSURE THEIR SAFETY.

CONCLUSION

The funding and continued support from international agencies made the systematic violation of women's rights by the Peruvian government's AQV campaign possible. The feminist discourse used in UN conferences provided the wording necessary to justify the aggressive promotion of a family planning program based on sterilization. Because of the international promotion of his policy, President Fujimori was able to secure the necessary funding through international aid agencies like USAID and UNFPA. With their financial aid, these organizations became responsible for a policy that violated its own promoted goal of achieving gender equality. The Voluntary Surgical Contraception campaign disenfranchised poor, rural, and indigenous women by violating their patients' rights. They received inadequate

[45] Schmidt, 1998.
[46] *Ibid.*
[47] *Ibid.*
[48] Rousseau, 2007, 104.
[49] Senn, 2004, 30.
[50] Rousseau. 2007, 100.
[51] Schmidt, 1998.

information, were not always able to consent to the surgery and furthermore, did not receive adequate healthcare during and after the procedure. Due to the efforts of external organizations to uncover the unlawful practices behind the AQV campaign, the government of Peru has acknowledged responsibility for actions undertaken in the name of family planning and has made significant changes to its to try to improve the availability and the quality of all modern methods of family planning. However, despite reports that implicate them as well, the UNFPA and USAID continue to affirm that their actions in no way supported the violation of rights that occurred. . While the Peruvian government was ultimately responsible for carrying out the AQV campaign, it would not have been possible without funding from these agencies. Therefore, program funding comes with the responsibility of ensuring that no harm will come to those who take part in the programs. Both organizations need to review their monitoring process of programs that are funding activities that could potentially be linked to a violation of basic human right. In 2011, the Peruvian government reopened the case and is conducting a review of the criminal activities undertaken during this period. In the same manner, USAID and the UNFPA should also conduct a thorough review of the funding of the procedures and the implications of their support for the program.

BOTH ORGANIZATIONS NEED TO REVIEW THEIR MONITORING PROCESS OF PROGRAMS THAT ARE FUNDING ACTIVITIES THAT COULD POTENTIALLY BE LINKED TO A VIOLATION OF BASIC HUMAN RIGHT

Environment and Gender in Africa's Christian Revolution

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Christianity is growing rapidly in Africa: over the last hundred years the number of Christians has increased from nine percent of the continent's population to 46 percent, or around 360 million people.[1] Contrary to popular assumption in the global north, much of this growth has occurred since the end of the colonial period. Africans have actively sought out older denominations that no longer represent the oppressor and are creating their own churches based on Africanized understandings of Scripture. This is an African Christian revolution, alongside which another revolution is taking place: the growing influence of the churches of the global south. The global character of Christianity is changing. The ways in which it dialogues with contemporary development issues, such as environmental sustainability and gender equality, will likely have a strong southern influence in the future. Africans are continuously building bridges between traditional beliefs and the new faith. I argue that this represents a revolutionary form of alternative development over which Africans may have greater ownership.

Both traditional denominations and new African churches play an important role in the countries of southern Africa with predominantly Christian populations. In the first section of this paper, I trace the history of Christianity on the continent. I focus on the developmental trajectory of the Roman Catholic Church (RCC) and then the rise of the African Independent

[1] Philip Jenkins, *The next Christendom* (Oxford; New York: Oxford University Press, 2007), 2-3.