COMMENT

Advancing Reproductive Rights Beyond Cairo and Beijing

By Rebecca J. Cook and Mahmoud F. Fathalla

The International Federation of Gynecology and Obstetrics' 1994 World Report on Women's Health concluded that improvements in women's health need more than better science and health care—they require state action to correct injustices to women.[1] Women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights. The use of human rights to advance reproductive health and self-determination has gained momentum through recent United Nations (UN) conferences, particularly the 1994 International Conference on Population and Development, held in Cairo, and the 1995 Fourth World Conference on Women, held in Beijing.

The Programme of Action adopted by 184 UN member states in Cairo recognizes the importance of human rights in protecting and promoting reproductive health.[2] The Cairo Programme strongly endorses a new strategy for addressing population issues, focused on meeting the needs of individual women and men rather than on achieving demographic targets. A key to this approach is empowering women and protecting their human rights, particularly those relevant to reproductive health. Building on the World Health Organization's definition of health, the Cairo Programme explains that reproductive health is:

> a state of complete physical, mental and social well-being and…not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant [para. 7.2].

The Declaration and Platform for Action adopted by 187 UN member states in Beijing[3] reaffirm the Cairo Programme's definition of reproductive health [para. 94], but advance women's wider interests:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences [para. 96].

The Cairo Programme and the Beijing Platform are points of advancement in identifying particular steps that countries have agreed to take to achieve reproductive rights within specified time periods. The Beijing Platform explains that "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents" [paras. 95 and 223]. However, both documents lack mechanisms for holding governments legally accountable; such mechanisms generally exist in national laws and constitutions and in regional and international human rights treaties, though, which establish general legal obligations that can be applied to the quest for reproductive health and self-determination (see Table 1, p. 116). National and international human rights law has yet to be adequately applied to reproductive health matters.

In this article, we explain how national constitutions and international human rights law can be applied to hold governments accountable for neglecting or violating these rights, how the Cairo Programme and the Beijing Platform can be used to add specific detail to reproductive rights and how programs have been developed to protect and promote reproductive rights beyond Cairo and Beijing.

Holding States Accountable

Most states commit themselves to promote and protect the human rights of women through national constitutions and by membership in regional and international human rights conventions. For example, as of July 1, 1996, 153 states have ratified the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention) and are thus obligated "...to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men" [Women's Convention, Article 3].[4]

Ratifying countries are to report regularly on what they have done "...to ensure the full development and advancement of women." They report to the Committee on the Elimination of Discrimination Against Women (CEDAW), which was established under the Women's Convention

Rebecca J. Cook is professor of law on the faculty of law, on the faculty of medicine and with the Centre for Boethics, University of Toronto, Canada. Mahmoud F. Fathalla is president of the International Federation of Gynecology and Obstetrics, London, is senior advisor for biomedical and reproductive health research, The Rockefeller Foundation, New York, and is professor of obstetrics and gynecology at Assiut University, Assiut, Egypt.

Table 1. Provisions of international human rights documents concerning rights related to reproductive health and self-determination

International document	Right										
	Life & survival	Liberty & security	Highest standard of health	Benefits of scientific progress	Receive & impart information	Education	Marry & found a family	Private & family life	Sexual non-discrim.	Age non-discrim.	Nondiscrim. on grounds of disability
Universal Declaration of Human Rights	3	1, 3	25	27(2)	19	26	16	12	1, 2, 6	1, 2, 6	1, 2, 6
International Covenant on Civil and Political Rights	6	9	na	na	19	na	23	17	2(1), 3	2(1)	2(1)
International Covenant on Economic, Social and Cultural Rights	na	na	12	15(1)(b), 15(3)	na	13, 14	10	10	2(2), 3	2(2)	2(2)
International Convention on the Elimination of All Forms of Racial Discrimination	na	5(b)	5(e)(iv)	na	na	5(e)(v), 7	5(d)(iv)	na	na	na	na
Convention on the Elimination of All Forms of Discrimination Against Women	na	na	11(1)(f), 12, 14(2)(b)	na	10(e), 14(b) & 16(e)	10, 14(d)	16	16	1–5	na	na
Convention on the Rights of the Child	6	37(b)–(d)	24	na	12, 13, 17	28, 29	8, 9	16	2(1)	2(2)	2(2)
European Convention on Human Rights, Its Five Protocols and Its Social Charter	2	5	Charter: 13	na	10	Protocol 1:2, Charter: 13	12	8	14	14	14
American Convention on Human Rights and Its Protocol	4	7	26; Protocol: 9, 10	26	13	26	17	11	1, 24	1, 24	1, 24
African Charter on Human and Peoples' Rights	4	6	16	22	9	17	18	4, 5	2, 3, 18(3), 28 (duty)	2, 3, 18(3), 28	2, 3, 18(4), 28
Cairo Programme of Action	Principle 1, 8.21, 8.25	4.10, 4.22, 5.5, 7.12, 7.40	7.2, 7.3, 7.5, 7.6, 7.16, 7.23, 7.27–7.33, 8.28–8.35	2.10 & 12.10–12.26	7.3, 7.20, 7.23	4.18, 7.47, 11.8	4.21	7.3, 7.12, 7.17–7.20	4.16, 4.25	7.41, 7.45, 7.46	7.34–7.40, 8.34
Beijing Declaration & Platform for Action	97, 106(i)–106(l)	97, 106(g), (h), (k), 107(e), (q), 124(l), 135, 269, 277(d), 283 (d)	92, 94, 95, 98, 103, 106(c), (e), (g), 108	104, 106(g), (h), 108 (o), (p)	95, 103, 106(m), 107(e), 108(i), 223	74, 80, 81, 83(k), (l), 267, 277(a)	93, 274(e), 275(l)	103, 107(e), 108(m), 267	97, 277(l)	83(k), (l), 106–108, 281	99, 108

Note: Numbers show the relevant provisions of the international documents that relate to each named right.

to monitor its implementation. Countries that have ratified other human rights conventions (see Table 1) also accept reporting obligations. Mechanisms existing under some conventions (such as the European Convention on Human Rights and the International Covenant on Civil and Political Rights) enable individuals from consenting countries to bring complaints against them for violations of their rights.

Violations of reproductive rights can be categorized into three groups:

- Category 1 violations result from direct action on the part of a state (such as coercive sterilization); such actions are contrary to freedom from unwarranted state intrusion into reproductive health interests.
- Category 2 violations relate to a state's failure to meet the minimum core obligations of human rights, such as neglecting to reduce maternal mortality rates. These violations result when state action or inaction is contrary to the freedom to receive essential health services and the means of protecting one's reproductive health. For such violations to be demonstrated, standards showing that states are meeting their minimum core obligation of reproductive health protection and promotion have to have been formulated.

•Category 3 violations consist of patterns of discrimination, such as persistent and gross discrepancies in access to health services, that cumulatively disadvantage the reproductive health of groups, such as adolescents. These violations breach freedom from discrimination or the freedom to a positive allocation of resources as redress for past discrimination.

Meticulous documentation can show that human rights abuses represent systematic state policies rather than merely individual aberrations. Evidence in court cases can show that a government has failed to eliminate and remedy reproductive rights abuses, and such evidence can be used to analyze conscious patterns over time. Complaints before national, regional and international legal tribunals and incidents publicized by nongovernmental human rights organizations can also be used to direct attention beyond the facts to the underlying conditions of abuse of reproductive rights for which states are legally answerable.

If reproductive rights are to be effectively protected, committees created by conventions to monitor their observance need to develop systematic standards of performance for the states that have ratified them. Monitoring state compliance requires a clear conception of the specific components of each right and the concomitant obligations of states; the delineation of performance standards for each component, including the identification of violations; the collection of relevant data, appropriately disaggregated by sex and other significant variables; the development of information management systems to analyze these data and fascilitate the examination of trends over time and comparison of the reproductive rights of groups within a country; and the analysis of collected data.[5]

Treaty-monitoring committees develop performance standards through their general recommendations, which guide states in preparing reports. For example, at its 1995 meeting, CEDAW agreed to use the Cairo Programme in developing performance standards[6] to determine whether states are in compliance with their obligations to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning ... pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" [Women's Convention, Article 12].

Applying Human Rights

Reproductive rights may be protected through specific legal rights. Which rights are invoked and how they are shown to have been violated depend on the particular facts of an alleged violation and on the underlying causes of reproductive ill-health. The rights addressed here are not exhaustive, but only suggest some of the approaches that may be developed to advance reproductive interests. Table 1 shows the relevant provisions of the respective international instruments that relate to each right. Moreover, we indicate only certain ways in which specific rights may be applied to reproductive interests and how the Cairo Programme and Beijing Platform can be used to add meaning to them. As human rights laws are applied more vigorously to reproductive interests, a variety of ways of applying them will emerge to serve reproductive interests.

Life and Survival

The Cairo Programme reaffirms that "everyone has the right to life" [Principle 1]. A strong case can be made to apply this right to the lives of the estimated 500,000 women each year who die of pregnancy-related causes, in order to hold governments accountable for their failure to achieve significant reductions in national rates of maternal mortality.[7] Governments have agreed through the Cairo Programme [para. 8.21] and the Beijing Platform [para. 106(i)] to reduce maternal mortality by one-half of their 1990 levels by the year 2000, and to cut levels by a further one-half between 2000 and 2015.

The root causes of maternal mortality are complex, ranging from a lack of contraception or of trained birth attendants to women's unequal status in society, which results in poor schooling and early marriage.[8] In order to use human rights effectively to hold a government accountable for neglecting the high rate of maternal mortality in a community, the causes of maternal mortality in that community must be understood. If the causes are multifaceted (which is often the case), then the right to life may be invoked in addition to the rights discussed below. If, for instance, the predominant cause is a lack of trained birth attendants, the right to the highest attainable standard of health might be more appropriately invoked to require governments to provide services. This is so in developing countries, where WHO data indicate that only about 55% of women are attended at delivery by a health worker who has received at least the minimum of necessary training.[9]

A lack of effective means of birth spacing and fertility control endangers women's survival and health. All pregnancies and births carry some health risks, but these are higher when pregnancies are too early, too late, too closely spaced or unwanted. Without obstetric care, women who give birth before age 18 are three times as likely to die in childbirth as are women aged 20–29 under similar circumstances; among women aged 35 and older, the risk of maternal mortality is five times as high as among 20–29-year-olds.[10] Comprehensive reproductive health care, including contraceptive services[11] and requested terminations of ill-timed or high-risk pregnancies, would build toward safe motherhood. Further, evidence shows that if births could be spaced so that they came when women wanted them, overall child mortality in many countries might be reduced by more than 20%.[12]

Sexual abstinence is an obvious way to prevent unwanted pregnancy. However, sex is a natural part of life; furthermore, many women lack the power to determine when they will have intercourse. Thus, contraception is a necessary alternative.

Contraception is not proof against failure, however. For women who wish to terminate a pregnancy after contraceptive failure, safe abortion and contraceptive after-care are necessary to reduce their risk of death.[13] Global estimates of maternal deaths arising from unsafe abortion number as many as 200,000 per year.[14] The Cairo Programme (for the first time at a UN Population Conference) calls on governments to recognize unsafe abortion as a leading cause of maternal mortality and as a "major public health concern" [para. 8.25]. The call for safe abortion was underscored in the Beijing Platform [paras. 97, 106(j) and 106(k)].

The Cairo Programme recognizes that increasing women's ability to survive pregnancy is an issue of their being "equal in dignity and rights" [Principle 1]. If women are to be equal, governments have at least the same obligation to prevent maternal death as to prevent death from disease. In fact, given that maternity, the sole means of natural human propagation, is not a disease, equity requires more protection against the risk of maternal mortality than against death from disease.

Disparities between rich and poor countries are greater for rates of maternal mortality than for any other public health indicator. Almost 99% of maternal deaths occur in developing countries, and the lifetime risk of maternal death is as high as one in 20 for women in parts of Africa

(compared with one in 4,000 for women in North America).[15] The magnitude of this differential is a challenge to the universality of human rights, even though the Cairo Programme and the Beijing Platform emphasize that "the human rights of women ... are an inalienable, integral and indivisible part of universal human rights" [Cairo, Principle 4; and Beijing, para. 10].

Liberty and Security of Person

States apply the right to liberty and security to reproductive self-determination in a variety of ways. Through the Beijing Platform, governments recognize women's liberty interest by agreeing, for instance, to consider "reviewing laws containing punitive measures against women who have undergone illegal abortions" [para. 106(k)]. Courts have addressed abortion by finding restrictive criminal abortion provisions unconstitutional for violating women's right to liberty and security. For example, the Supreme Court of Canada declared a restrictive criminal abortion provision to violate women's right to security of the person.[16] Several Constitutional Courts, including those of Austria,[17] France,[18] Italy[19] and the Netherlands,[20] have also found that liberal abortion laws are consistent with women's right to liberty.

"The right to enjoy the benefits of scientific progress has yet to be effectively applied to requiring governments to give a high priority to reproductive health research."

Government regulation of population size may violate the liberty and security of the person if it results in compelled sterilization and abortion[21]—or, at the other extreme, in criminal sanctions against contraception, voluntary sterilization and abortion.[22] The potential for abuse of rights is often greater among women from minority and low-income communities, indicating that great care must be applied in delivering family planning services in such communities. In the United States, for example, some attempts have been made to exert subtle means of control over the reproduction of poor and minority women, such as when courts have offered low-income female offenders release on probation if they will use long-acting contraceptive implants.[23]

In other places, barriers to the removal of hormonal implants that were originally inserted without coercion or inducement have been reported. One study in Bangladesh, for example, reported that 15% of women with contraceptive implants had had to make at least three requests for removal.[24] The Cairo Programme affirms that "the principle of informed free choice is essential to the long-term success of family planning programmes [and that] any form of coercion has no part to play" [para. 7.12], a principle reaffirmed in the Beijing Platform [paras. 106(g) and (h), and 107(e)].

The right to liberty and security of the person has not yet been effectively applied to hold governments accountable over their failure to enforce existing laws against female genital mutilation. This practice, also known as "female circumcision," is supposed to attenuate sexual desire, thus "saving" young girls from temptation and preserving chastity and marital fidelity.[25] Female genital mutilation occurs in one form or another in about 40 countries, mostly in East and West Africa and in areas of the Arabian Peninsula. However, as emigration from these regions has increased, the practice is now reported occasionally in Europe and North America. The prevalence of female genital mutilation ranges by country from 5% to almost 98%;[26] worldwide, about 6,000 girls are circumcised every day.

Governments agreed to enforce the prohibition of female genital mutilation under the Cairo Programme [paras. 4.22, 5.5 and 7.40] and the Beijing Platform [paras. 124(i) and 283(d)]. The Cairo Programme urges governments "to prohibit [female genital mutilation] wherever it exists and to give vigorous support to efforts among nongovernmental and community organizations and religious organizations to eliminate such practices" [para. 4.22]. The Beijing Platform underscores the importance of education, particularly of parents, to aid understanding of the health consequences of the practice [para. 277(d)].

Related to the right to liberty and security is the right to freedom from torture and from inhuman and degrading treatment. The Beijing Platform recognizes that women are tortured, sexually and otherwise, because of their low status in society and their sexual vulnerability [para. 135] and calls on governments to prevent it [para. 107(q)]. Globally, the physical consequences of rape and sexual violence account for about 5% of disease burden among women.[27]

The Beijing Platform condemns "torture, involuntary disappearance, sexual slavery, rape, sexual abuse and forced pregnancy*" [para. 135]. The Cairo Programme urges governments "to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation" [para. 4.10]. The Inter-American Commission on Human Rights' Report on the Situation of Human Rights in Haiti under the Raoul Cedras Administration determined that the rape and abuse of Haitian women were violations of their right to be free from torture and inhuman and degrading treatment and of their right to liberty and security of the person.[28]

Highest Attainable Standard of Health

The Cairo Programme and the Beijing Platform identify components of the right to the highest attainable standard of reproductive health from a women's perspective. Both stress the importance of affordable, accessible and acceptable services throughout the life cycle [Cairo, paras. 7.5 and 7.23; Beijing, paras. 92 and 106(e)]; "acceptable" services include gender-sensitive standards for the delivery of quality services [Cairo, para. 7.23; and Beijing, paras. 95, 103, 106(c) and 106(g)]. Concerning the scope of reproductive health services, the Cairo Programme and the Beijing Platform state:

> Reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases [Cairo, para. 7.2; Beijing, para. 94].

The Cairo Programme sets targets whereby states agree to:

> make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015 [para. 7.6]; [and] take

*Forced pregnancy occurs when abortion following rape is legally denied, practically obstructed or unacceptable to women themselves on religious or cultural grounds.

steps to meet family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law [para. 7.16].

The unmet need for family planning services is immense. In developing countries, an estimated 350 million of the 747 million married women of reproductive age are not using contraceptives. Of these, 100 million would prefer to space their next birth or not have more children. Worldwide, women would prefer to delay or avoid about 25% of all pregnancies that occur.[29]

In addition, through the Cairo Programme and the Beijing Platform, governments have committed themselves to act on the prevention of sexually transmitted diseases (STDs)—including the human immunodeficiency virus (HIV) and AIDS—and to provide services to treat and counsel those who are infected [Cairo, paras. 7.27–7.33 and 8.28–8.35; and Beijing, paras. 98 and 108].

Treaty-monitoring bodies will build on commitments made in consequence of the Cairo and Beijing texts to develop performance standards to determine whether states have met their minimum core obligations to respect individuals' right to the highest attainable standard of reproductive health throughout the life cycle.[30]

The Benefits of Scientific Progress

The Cairo Programme and Beijing Platform require governments to promote women's health research to ensure that women enjoy the benefits of scientific progress [Cairo, paras. 12.10–12.26; and Beijing, paras. 104 and 108(o) and (p)]. For example, the Beijing Platform calls on governments to "support and initiate research which addresses women's needs and situations, including research on HIV infection and other sexually transmitted diseases in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female attitudes and practices" [para. 108(p)]. It similarly requires "action-oriented research on affordable methods, controlled by women, to prevent HIV and other sexually transmitted diseases, on strategies empowering women to protect themselves from sexually transmitted diseases, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research" [para. 108(o)].

This right is to the benefits of scientific progress. As a result, the Cairo and Beijing texts recognize that any compromise of women's liberty and security through the inappropriate use or the abuse of medical research or technology frustrates scientific progress [Cairo, para. 2.10; Beijing, paras. 106(g) and (h)].

The right to enjoy the benefits of scientific progress has yet to be effectively applied to requiring governments to give a high priority to reproductive health research. This right could be applied, for instance, where women are denied access to antiprogestins for nonsurgical abortion or to emergency contraception, and where women are denied oral contraceptives (as is the case in Japan[31]). Both women and men are entitled to this human right. Thus, the Cairo Programme specifically notes that men too should enjoy the right to the benefits of scientific progress, by calling on governments to give high priority to developing new male contraceptives to serve as alternatives to such methods as condoms, withdrawal and vasectomy [para. 12.14].

Receiving and Imparting Information

The texts from Cairo and Beijing call on governments to remove legal, medical, clinical and regulatory barriers to reproductive health information [Cairo, paras. 7.3 and 7.20; Beijing, paras. 95, 103, 106(m), 107(e), 108(i) and 223] and to improve its quality [Cairo, para. 7.23; Beijing, para. 103]. The significance of information to reproductive health is reinforced by the Women's Convention, which requires that women have "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning" [Women's Convention, Article 10(h)].

Nonetheless, in a number of countries it remains a criminal offense, sometimes described as a crime against morality, to spread information about contraceptive methods or to publicize where women can get pregnancy termination services.[32] The European Court of Human Rights recently held Ireland in violation of individuals' right to receive and impart information because the government tried to prevent the circulation of information about abortion services legally available in Britain.[33]

Education

The right to education is particularly important for the promotion and protection of health. Research has consistently shown that women's education strongly influences improved reproductive health, including infant survival and healthy growth of children.[34] Despite broad progress toward literacy, a huge gap still exists worldwide between men and women. According to UN estimates, illiterate girls and women in the world in 1985 numbered 597 million, an increase from 543 million in 1970. Illiteracy in men increased from 348 million to 352 million in the same period,[35] showing that women are still disproportionately disadvantaged. The Cairo Programme and the Beijing Platform call for instituting universal primary education by the year 2015 and for closing the gender gap in levels of secondary, vocational and higher education [Cairo, para. 4.18; Beijing, paras. 80–81].

The Cairo and Beijing documents encourage an educational setting designed to eliminate all barriers that impede the schooling of married or pregnant young women and young mothers [Cairo, para. 11.8; Beijing, para. 277(a)]. Such a barrier was removed in 1995, for instance, when the Botswana Court of Appeal ruled as unconstitutional a college regulation that discriminated against female students by requiring that they inform the college director of their pregnancy, and thus become liable to suspension or expulsion.[36]

These documents also urge governments to address adolescent sexuality through educational programs in sexual and reproductive health made available to and understandable by the young and through the provision of contraceptive counseling and services, including services related to STDs [Cairo, para. 7.47; Beijing, paras. 74, 83(k), 83(l) and 267]. The inclusion of reproductive health information in school curricula can be controversial, because sexual biology and behavior may be explained in ways that parents oppose, at a time they consider premature, or with the effect of causing children to ask questions at home with which parents are uncomfortable. The European Court of Human Rights has respected sensitivity to parents' views, but has upheld a compulsory sex education course in a state's schools because "the curriculum is conveyed in an objective, critical and pluralistic manner [and does not] pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions."[37]

Family and Private Life

In some regions, infertility due to reproductive tract infection jeopardizes the right to form a family and the right to the highest attainable standard of health. In some parts of Africa, this is the cause of up to 50% of infertility.[38] Because such in-

fections are generally identifiable, curable and preventable, governments appear to have a positive obligation to provide relevant information, education and services to protect the formation of families.

At times, rights may be in conflict. Laws concerning the minimum age at marriage prevent early family formation, but they might well be justified as a way of promoting maternal survival and the formation of families later in the reproductive life span. Both the Cairo and Beijing texts require that governments and nongovernmental organizations generate social support for compliance with laws on the minimum age of marriage, in particular by providing women with educational and employment alternatives to entering marriage prematurely [Cairo, para. 4.21; Beijing, paras. 93, 274(e) and 275(b)].

To ensure women's autonomous and confidential choice in reproductive matters, the Cairo Programme and the Beijing Platform invoke the right to private life against public officials' intrusions [Cairo, paras. 7.3, 7.12 and 7.17–7.20; Beijing, paras. 103, 107(e), 108(m) and 267]. Claims by women to autonomous choices against their partners' attempted vetoes have been consistently upheld by courts in countries of all regions of the world[39] and by the European Commission of Human Rights.[40] Moreover, national laws allowing resort to abortion on privacy grounds, including U.S. law,[41] have been approved under international human rights instruments.[42]

Nondiscrimination

•*Sex.* The Women's Convention identifies the need to confront the social causes of women's inequality by addressing "all forms" of discrimination that women suffer, including discrimination on grounds both of biological characteristics and of social, cultural and psychological constructs. The need to eliminate all forms of discrimination against women is a unifying and pervasive theme in the Cairo and Beijing texts. A particular contribution of these texts to sexual equality is that they urge states "to eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection" [Cairo, para. 4.16; Beijing, para. 277(c)] and "to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles" [Cairo, para. 4.25; Beijing, para. 97].

•*Age.* Discrimination on the grounds of young age is comprehensively addressed through the Convention on the Rights of the Child, whereby states agree "to ensure that no child is deprived of his or her right of access to...health care services" [Article 24(1)]. However, the Cairo Programme recognizes that the "reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services" [para. 7.41]. In many countries, high rates of adolescent unmarried pregnancy are epidemic, and in others appear endemic.[43]

The Cairo and Beijing texts call for the removal of regulatory and social barriers to reproductive health information and care for adolescents [Cairo, para. 7.45; Beijing, paras. 106–108 and 281]. These documents urge countries to ensure that the programs and attitudes of health care providers do not restrict adolescents' access to appropriate services [Cairo, para. 7.45; Beijing, paras. 106–108], and that to reduce the number of adolescent pregnancies, they protect and promote the rights of adolescents to reproductive health education, information and care [Cairo, para. 7.46; Beijing, paras. 83(k) and (l), 107(g) and 281].

Adolescents suffer unjust discrimination when they are not free to seek reproductive health counseling and services with the same confidentiality as adults. Courts have rejected laws and interpretations of laws that, on the grounds of age, deny competent adolescents reproductive health services without parental consent. When minors are intellectually mature or emancipated, many courts will recognize their equal rights with adults to health care and to confidentiality.[44] A sign of maturity in minors is their understanding of the need to protect their reproductive health, and their requesting contraceptive services when they are or are about to be sexually active.

•*Disability.* Human rights conventions prohibit discrimination not only on specified grounds, such as sex and age, but also on general grounds. The general prohibition includes discrimination on grounds of disability (such as HIV infection). The Cairo and Beijing texts require governments to eliminate discrimination against persons infected with HIV and their families; strengthen services to detect HIV infection, making sure that they ensure confidentiality; and devise special programs to provide care and the necessary emotional support to men and women affected by AIDS and to counsel their families and near relations [Cairo, para. 8.34; Beijing, para. 108].

The Cairo and Beijing texts also recognize that HIV infection in women often reflects women's "preconditioning disability" that, as women, they lack social and legal power to control whether, when and with what protections they have sexual relations [Cairo, paras. 7.34–7.40; Beijing, para. 99].

Moving Beyond Cairo and Beijing

The Cairo and Beijing texts suggest a variety of strategies for effectively protecting and promoting reproductive rights at every government level, from local government to international agencies. The Beijing Platform recognizes that legal literacy and legal service programs are required to ensure that women understand their human rights, how to use them and how to gain access to courts to enforce their rights [paras. 232–233]. Moreover, the Beijing text recommends support of those who try to uphold human rights, sometimes against great odds [para 232].

Important efforts toward this end include hearings held at the Cairo and Beijing nongovernmental forums, where women testified about violations of their reproductive rights.[45] At the national level, for instance, Profamilia, the largest provider of reproductive health services in Colombia, has integrated legal programs into its organization.[46] Women who come for reproductive health services thereby have access to advocates who can educate them about their rights and counsel them if these have been violated. Legal services advocates can recommend individual and collective remedies for such violations, as well as preventive actions that governments can take in anticipation of rights violations.

The Cairo and Beijing texts also indicate a variety of mechanisms with which to determine whether states are in compliance or violation. The Beijing Platform recommends creating independent ombudspersons, rights advocates or defenders with the power to investigate alleged violations of reproductive rights, issue periodic reports, advise governmental and other agencies and make recommendations for reforms [para. 232(e)].

An alliance of the health and legal professions could encourage governments, for instance, to enact reproductive health laws that give force to the human rights that serve reproductive health and self-determination. A law could require that social, economic, political or other relevant policies, developed by either public or private agencies, be accompanied by reproductive rights impact assessments.[47] Since the Cairo Conference, Argentina is con-

sidering enactment of a reproductive health law[48] and Guyana has enacted components of one.[49] State policies that protect and promote reproductive health within a wider program of women's health have been enacted in Colombia[50] and Brazil.[51]

The Cairo and Beijing documents recommend that the health professions develop, disseminate and implement ethics codes to ensure practitioners' conformity with human rights, ethical and professional standards [Cairo, para. 7.17; Beijing, para. 106(g)]. Promising signs are the development of ethical guidance by medical associations such as the International Federation of Gynecology and Obstetrics[52] and the Commonwealth Medical Association.[53]

Overall, the Cairo and Beijing documents develop the content and meaning of reproductive rights. These rights will mean very little to the well-being of women and men, however, if national, regional and international human rights instruments are not used to ensure governments' compliance with their Cairo and Beijing commitments. Moreover, where violations exist, these instruments have to be used to hold governments accountable, legally and politically, for such violations if reproductive rights are to be advanced beyond Cairo and Beijing.

References

1. M. F. Fathalla, "Women's Health: An Overview," *International Journal of Gynecology & Obstetrics*, **46:**105–118, 1994.

2. United Nations (UN), *Report of the International Conference on Population and Development*, Document A/Conf.171/13, New York, 1994, paragraph 7.3.

3. ——, *Report of the Fourth World Conference on Women*, Document A/Conf.177/20, New York, 1995.

4. Convention on the Elimination of All Forms of Discrimination Against Women, G. A. Res. 34/180(xxxiv) 34 UN GAOR Supp. (No. 46) AT 193, Doc. A/39/45.

5. A. Chapman, "Monitoring Women's Right to Health Under the International Covenant on Economic, Social and Cultural Rights," *American University Law Review*, **44:**1157–1175, 1995, p. 1159.

6. UN, "Report of the Committee on the Elimination of Discrimination against Women (14th Session)," Document A/50/38, 31, New York, May 1995.

7. C. AbouZahr and E. Royston, *Maternal Mortality: A Global Factbook*, World Health Organization (WHO), Geneva, 1991, p.1.

8. M. F. Fathalla, "The Long Maternal Road to Maternal Death," *People*, Vol. 14, No. 3, 1987, pp. 8–9.

9. WHO, *Coverage of Maternity Care: A Tabulation of Available Information*, 3rd ed., WHO/FHE/MSM/93.7, Geneva, 1993, p. 12.

10. World Bank, *World Development Report 1993—Investing in Health*, Oxford University Press, New York, 1993, p. 84.

11. J. A. Ross and E. Frankenberg, *Findings from Two Decades of Family Planning Research*, The Population Council, New York, 1993, pp. 85–87.

12. World Bank, 1993, op. cit. (see reference 10), p. 83.

13. Ibid., p. 84.

14. Ibid., p. 84.

15. M. F. Fathalla, 1994, op. cit. (see reference 1).

16. *R.* v. *Morgentaler* (1988) 44 D. L. R. (4th) 385 (Sup. Ct. Canada).

17. Judgment of Oct. 11, 1974, Constitutional Court of Austria, [1974] *Erklanrungen des Verfassungsgerichtshofs* 221.

18. Judgment of Jan. 15, 1975, Conseil Constitutionnel, [1975] D. S. Jur. 529, *Journal Officiel*, Jan. 16, 1975.

19. Judgment No. 108/81 of 25 June 1981, Corte Costituzionale, 57 *Raccolta Ufficiale della Corte Costituzionale* 823, 1981.

20. *Juristenvereiniging Pro Vita* v. *De Staat der Nederlanden*, 8 Feb 1990, Court, The Hague, *Nederlandse Jurispurdentie* 43, 1990, 707, as summarized in *European Law Digest*, Vol. 19, No. 5, 1991, pp. 179–180.

21. R. Boland, S. Rao and G. Zeidenstein, "Honoring Human Rights in Population Policies: From Declaration to Action," in G. Sen, A. Germain and L. C. Chen, eds., *Population Policies Reconsidered: Health, Empowerment and Rights*, Harvard University Press, Boston, 1994, pp. 89–106.

22. C. Hord et al., "Reproductive Health in Roumania: Reversing the Ceausescu Legacy," *Studies in Family Planning*, **22:**231–240, 1991.

23. T. Lewin, "Implanted Birth Control Device Renews Debate Over Forced Contraception," *New York Times*, Jan. 10, 1991, p. A20.

24. K. Hardee et al., "Contraceptive Implant Users and Their Access to Removal Services in Bangladesh," *International Family Planning Perspectives*, **20:**59–63, 1994.

25. M. F. Fathalla, 1994, op. cit. (see reference 1).

26. Ibid.

27. World Bank, 1993, op. cit. (see reference 10), p. 50.

28. OEA/Ser. L/V/II.88, Feb. 9, 1995, at 12-13, 39-47, 93-97.

29. M. Catley-Carlson, "The Challenges of Population: Reflections on the Eve of Cairo," *New World*, 1994, pp. 1–3.

30. A. Rahman and R. Pine, "An International Human Right to Reproductive Health Care: Toward Definition and Accountability," *Health and Human Rights*, **1:**400–427, 1995, p. 406.

31. M. Jitsukawa and C. Djerassi, "Birth Control in Japan: Realities and Prognosis," *Science*, **265:**1048–1051, 1994.

32. S. Coliver, ed., *The Right to Know: Human Rights and Access to Reproductive Health Information*, Article 19, London, 1995, and University of Pennsylvania Press, Philadelphia, Pa., USA, 1995.

33. *Open Door Counselling and Dublin Well Women Centre v. Ireland*, 15 Eur. H. R. Rep. 244 (1992).

34. J. N. Hobcraft, "Women's Education, Child Welfare and Child Survival: A Review of the Evidence," *Health Transition Review*, **3:**150–175, 1993.

35. UN, *The World's Women, 1970–1990*, New York, 1991, p. 15.

36. *Student Representative Council, Molepolole College of Education* v. *Attorney General of Botswana (for and on behalf of the Principal of Molepolole College of Education and Permanent Secretary of Ministry of Education)*, unreported, Civil Appeal No. 13 of 1994, Misca No. 396 of 1993; judgment delivered on Jan. 31, 1995; as reported in E. K. Quansah, "Is the Right to Get Pregnant a Fundamental Human Right in Botswana?" *Journal of African Law*, **39:**97–102, 1995.

37. *Kjeldsen* v. *Denmark*, 1 Eur. H. R. Rep. 711 (1976) at para 53.

38. J. Wasserheit, "The Significance and the Scope of Reproductive Tract Infections Among Third World Women," *International Journal of Gynecology and Obstetrics*, Supplement 3, 1989, pp. 145–168.

39. R. Boland, "Population Policies, Human Rights and Legal Change," *American University Law Review*, **44:**1257–1278, 1995, p. 1276; and R. J. Cook and D. Maine, "Spousal Veto over Family Planning Services," *American Journal of Public Health*, **77:**339–344, 1987.

40. *Paton* v. *United Kingdom*, 3 Eur. H. R. Rep. 408 (1980).

41. *Roe* v. *Wade* 410 U. S. 113 (1973).

42. *Case 2141*, Inter-Am. C. H. R. 25, OEA/ser. L./V./1154, doc. 9 rev. 1 (1981).

43. P. Senanayake and M. Ladjali, "Adolescent Health: Changing Needs," *International Journal of Gynecology and Obstetrics*, **46:**137–143, 1994.

44. *Gillick* v. *West Norfolk and Wisbech Area Health Authority and the DHSS* [1986], AC 112 (House of Lords, England).

45. Center for Women's Global Leadership, *From Vienna to Cairo: The Cairo Hearing on Reproductive Health and Human Rights*, Center for Women's Global Leadership, New Brunswick, N. J., USA, 1995.

46. M. I. Plata, "Reproductive Rights as Human Rights: The Colombian Case," in R. J. Cook, ed., *Human Rights of Women: National and International Perspectives*, University of Pennsylvania Press, Philadelphia, Pa., USA, 1994, pp. 515–531.

47. K. Tomasevski, *Human Rights in Population Policies*, Swedish International Development Agency, Lund, Sweden, 1994.

48. La Ley de Procreación Responsable (Law of Responsible Parenthood), 251-D-948, Buenos Aires, Argentina, July 1995.

49. Medical Termination of Pregnancy Act 1995, Guyana Act No. 7 of 1995.

50. M. I. Plata, 1994, op. cit. (see reference 46).

51. J. Pitanguy, "From Mexico to Beijing: A New Paradigm," *Health and Human Rights*, **1:**454–460, 1995, p. 458.

52. Committee for the Study of Ethical Aspects of Human Reproduction, *Recommendations on Ethical Issues in Obstetrics and Gynecology*, International Federation of Gynecology and Obstetrics, London, 1994.

53. Commonwealth Medical Association, *Medical Ethics and Human Rights: Guiding Principles*, London, 1994.