

Abstract

This article examines women's rights to sexual and reproductive health as recognized by the ICPD and expressed in the Women's Convention and other international human rights documents. Rights relating to reproductive and sexual health include the rights to life, liberty, and the security of the person; to health care and information; and to nondiscrimination in the allocation of resources to health services and in their availability and accessibility. Of central importance are the rights to autonomy and privacy in making sexual and reproductive decisions, as well as the responsibility of health care providers to ensure informed consent and confidentiality in relation to health services. The article presents country examples from States parties' periodic reports under the Women's Convention that reflect systemic violations of the above rights in varied forms.

Cet article analyse les droits de la femme à la santé sexuelle et génésique tels qu'ils sont reconnus par la ICPD et exprimés dans la Convention de la femme et autres documents internationaux sur les droits de la personne. Les droits touchant à la santé sexuelle et génésique comprennent les droits à la vie, à la liberté et à la sécurité de la personne, aux soins et à l'information ainsi qu'à la non-discrimination dans l'allocation de ressources aux services de santé ainsi qu' à leur disponibilité et accessibilité. Les droits à l'autonomie et à la préservation de la vie privée dans les décisions touchant à la sexualité et à la reproduction, de même que la responsabilité des prestataires de soins pour assurer le consentement éclairé et la confidentialité en relation avec les services de santé, sont d'une importance primordiale. L'article présente des exemples régionaux tirés de rapports périodiques des États impliqués dans la Convention de la femme, lesquels reflètent la violation systématique des droits ci-dessus cités sous des formes diverses.

Este artículo examina los derechos de las mujeres a la salud sexual y reproductiva de acuerdo con lo reconocido por la Conferencia Internacional sobre la Población y el Desarrollo y con lo expresado en la Convención sobre la eliminación de todas las formas de discriminación contra la mujer (Convención de la Mujer) y otros documentos sobre los derechos humanos. Los derechos que impactan a la salud sexual y reproductiva incluyen los derechos a la vida, la libertad y la seguridad de la persona; a recibir atención e información médicas; y a la no-discriminación en la distribución de recursos a los servicios de atención médica y en su disponibilidad y asequibilidad. De importancia esencial son los derechos a la autonomía y a la privacidad en la toma de decisiones de naturaleza sexual y reproductiva, al igual que la responsabilidad de los proveedores de atención médica de asegurar el consentimiento informado y la confidencialidad con respecto a los servicios de atención médica. El artículo provee ejemplos nacionales extraídos de los informes periódicos presentados por los estados partes bajo la Convención de la Mujer que muestran la existencia de infracciones repetidas y frecuentes de los antemencionados derechos en diversas maneras.

RIGHTS TO SEXUAL AND
REPRODUCTIVE HEALTH:
The ICPD and the Convention on the
Elimination of All Forms of
Discrimination Against Women

Carmel Shalev

The International Conference on Population and Development (ICPD) held in Cairo in 1994 marked the acceptance of a new paradigm in addressing human reproduction and health. For the first time, the international community focused on the needs of individuals, the empowerment of women, and the emergence of an evolving discourse about the connection between human rights and health that linked new conceptions of health to the struggle for social justice and respect for human dignity.¹

The attention to human rights at the ICPD marked a departure from previous approaches, which had treated

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women instrumentally, as tools through which to implement population programs and policies. The reproductive health and rights approach adopted at the ICPD was premised on the view that women are intrinsically valuable; as such, it expressed genuine concern about their health and well-being.² Whereas the old approach had viewed women's reproductive capacity as an object of population control, the new approach focused on women's empowerment to exercise personal autonomy in relation to their sexual and reproductive health within their social, economic, and political contexts.³ This approach further recognized that women's health in general, and their sexual and reproductive health in particular, is determined not only by access to health services but by women's status in society and pervasive gender discrimination.⁴ The ICPD Programme of Action thus posited the human rights of women—especially their rights to personal reproductive autonomy and to collective gender equality—as a primary principle in the development of reproductive health and population programs.

Materials and Methods

The rights recognized in the ICPD Programme of Action are based in various international human rights treaties. This article elaborates the nature and scope of these rights as they relate to women's sexual and reproductive health by examining these legal texts. Of major importance is the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention), which contains many provisions formulating rights that have direct and indirect bearing upon women's sexual and reproductive health.

The meaning of these texts is illustrated through concrete instances of systemic violations of women's sexual and reproductive health rights that are indicative of contemporary patterns in different parts of the world. The examples are taken from reports considered by the Committee on the Elimination of Discrimination Against Women (CEDAW Committee) at its 18th session in January 1998.

The issues presented in these materials and discussed here include equality in the allocation of resources, the right

to life, reproductive choice in relation to abortion and family planning, informed consent, and equality before the law. The situation of women in vulnerable situations is given separate consideration. The analysis is brought under two broad headings: personal autonomy, as derived from the right to liberty and including the right to life and to reproductive choice and informed consent; and gender equality as a component of social distributive justice in the allocation of resources.

It is important to note that this article is not intended in any way to single out the countries under discussion. In every society there exist multiple forms of violations of human rights. The presentation of the examples in this article illustrates merely some of this diversity; it does not even exhaust the situation in the countries under consideration. The use of reports submitted to the CEDAW Committee shows how the reporting mechanism of the human rights treaties can serve to develop standards of human rights jurisprudence in international law and to increase awareness of the meaning of the rights guaranteed under the international instruments.

The ICPD Programme of Action

The Programme of Action adopted at the ICPD is a consensus document, the end product of a process of negotiation and compromise involving over 180 states. Of the 16 chapters in the Programme of Action, the most relevant to this discussion are Chapter II and Chapter VII. Chapter II, entitled "Principles," addresses gender equality and empowerment of women, placing the eradication of sex discrimination as a priority objective of the international community in relation to population and development policies and programs.⁵ Chapter VII, entitled "Reproductive Rights and Reproductive Health," articulates the principle of autonomy.

Reproductive health is defined in the Programme for Action as "a state of complete physical, mental and social well-being . . . in all matters related to the reproductive system," which "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."⁶

The ICPD Programme of Action defines the term “reproductive rights” as embracing “certain human rights that are already recognized in . . . international human rights documents and other consensus documents.” The most notable such consensus documents are the Universal Declaration of Human Rights and the Declaration and Programme of Action of the World Conference on Human Rights, Vienna, June 1993.⁷ The human rights already recognized in international human rights documents include “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” guaranteed by Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁸ Other health-related human rights fall within the scope of certain fundamental freedoms protected under the International Covenant on Civil and Political Rights (ICCPR). These include the right to life, the right to liberty and security of the person, and the right to privacy, to mention just a few.⁹ In addition, the Women’s Convention is particularly pertinent to the enjoyment of sexual and reproductive rights.

Reproductive rights, according to the ICPD Programme of Action:

rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.¹⁰

The language is adapted from Article 16.1.e of the Women’s Convention, which states that States parties shall ensure on a basis of equality of men and women:

the same rights to decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights.

Reproductive rights, according to the final ICPD document, also include the right “to make decisions concerning repro-

duction free of discrimination, coercion and violence, as expressed in human rights documents.”¹¹ This aspect of reproductive rights can also be understood to be derived from the Women’s Convention.

Before proceeding to examine the Convention more closely, it is worth noting that a subsequent consensus document of the international community—the Platform for Action of the Fourth World Conference on Women (FWCW), held in Beijing in 1995—reiterated the new paradigm of the ICPD. One of the critical areas of concern identified at the Beijing Conference referred to inequalities and inadequacies in access to health care and related services, adopting a life-cycle approach to women’s health from infancy to old age.¹² The Beijing Declaration stated that “the explicit recognition and reaffirmation of the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”¹³ Paragraph 97 of the Platform for Action adopted at Beijing was a notable addition to the ICPD in further explicating women’s human rights with respect to their sexuality.¹⁴

The Women’s Convention

Both the ICPD and the FWCW documents acknowledge the intrinsic relation of gender equality to women’s health, including sexual and reproductive health. These are consensus documents, expressing *political will*. International human rights documents—treaties or conventions—are, on the other hand, sources of international *law*, and as such are considered to be legally binding. The Women’s Convention is the core human rights treaty that addresses discrimination against women, and it is sometimes referred to as the international bill of women’s rights. In general, States parties to the Women’s Convention undertake to pursue a policy of eliminating discrimination in all its forms (Article 2) and to guarantee women the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men (Article 3).¹⁵ The Convention covers all areas of women’s lives in both the public and private spheres, including discrimination in relation to the right to health and health services.¹⁶

The CEDAW Committee was established under Article 17 of the Convention. It is composed of 23 expert members elected by States parties from among their nationals and serving in their personal capacity. The Committee's main function is to monitor implementation of the Convention by considering periodic reports submitted by States parties on the measures they have adopted to give effect to the provisions of the Convention and on the progress made in this respect.¹⁷ The Committee may also make general recommendations based on the examination of reports and information received from the States parties.¹⁸ Some of these general recommendations address formal matters, such as the reporting obligations of States parties, while others are explications of substantive matters that constitute authoritative interpretations of the rights guaranteed under the Convention.

Health-Related Rights under the Women's Convention

As already mentioned, Article 16.1.e of the Convention guarantees the right to decide on the number and spacing of children, but that is only one of the articles that address women's rights in relation to health. Article 12 is central. It formulates States parties' obligation "to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."¹⁹ It further stipulates that States parties must undertake to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."²⁰

It should be noted that, among the six human rights treaties in the United Nations system, the Women's Convention and the Convention on the Rights of the Child (CRC) are the only ones to mention family planning.²¹ In addition to the aforementioned articles, the right of access to specific educational information and advice on family planning is guaranteed under Article 10.h of the Women's Convention. Article 14.b specifies the right of women in

rural areas to have access to adequate health care facilities, including information, counseling, and services in family planning. In Article 11.1.f, the Convention also refers to the right of women to the protection of health and to safety in working conditions, including “the safeguarding of the function of reproduction.”

Many other provisions of the Convention have an implicit or indirect bearing on women’s rights in relation to health, some of which have been explicated in the General Recommendations of the CEDAW Committee in relation to female genital mutilation, sexual violence, HIV/AIDS, and reproduction.²² Most recently, a General Recommendation on women and health has elaborated the Committee’s understanding of Article 12 of the Women’s Convention, addressing the obligations of States parties to eliminate discrimination and to respect, protect, and fulfill rights relating to women’s health throughout the life span.²³

Before examining concrete instances of violations of health-related rights, the meaning of two concepts key to women’s reproductive health must be clarified: autonomy and discrimination.

Autonomy

Autonomy in the context of reproductive rights means the right of a woman to make decisions concerning her fertility and sexuality free of coercion and violence. Much turns on our understanding of coercion and violence and of the key notion of choice. In health care contexts, informed consent and confidentiality are instrumental to ensuring free decision-making by the client. These rights impose certain correlative duties upon health care providers and deliverers of services. Providers are bound to disclose information on proposed treatments and their alternatives so as to obtain the informed consent of the client, and they must respect her right to refuse treatment. Likewise, they are bound to maintain secrecy so as to allow her to make private decisions without the interference of others whom she has not chosen to consult, and who might not have her best interests at heart. Autonomy also means that a woman seeking health care in relation to her fertility and sexuality

is entitled to be treated as an individual in her own right—as the sole client of the health care provider, fully competent to make decisions concerning her own health. This is a matter, among other things, of the woman’s right to equality before the law as well as her legal capacity.

As mentioned earlier, the right of women to control their fertility and sexuality free of coercion is guaranteed implicitly by the Women’s Convention. The right to autonomy in making health decisions in general, and sexual and reproductive decisions in particular, derives from the fundamental human right to liberty. Autonomy is liberty in the pure sense: in the words of Isaiah Berlin, “It is not merely freedom ‘from’ but freedom ‘to’ . . . in the sense that one is entitled to recognition of one’s capacity, as a human being, to exercise choice in the shaping of one’s life.”²⁴ The word “autonomy” itself is not mentioned expressly in the Convention, but it is certainly implicit in the fundamental freedoms it guarantees to women on a basis of equality with men.²⁵ Autonomy is intimately and intrinsically connected with many fundamental human rights, such as liberty, dignity, privacy, security of the person, and bodily integrity. These rights form the basis for asserting individual decision-making in relation to health services and health care, in particular with respect to informed consent and confidentiality.²⁶ Moreover, Article 15 of the Convention guarantees women’s right to equality before the law and to full legal capacity, which encompasses the right of women to make free and informed decisions about health care, medical treatment, and research.

Equality, Discrimination, and Difference

The concept of discrimination also deserves some explanation. Equality implies nondiscrimination, and therefore discrimination is a violation of the right to equality. Article 1 of the Women’s Convention defines the term “discrimination against women” as:

any distinction, exclusion or restriction made on the basis of sex which has the *effect* or purpose of impairing or nullifying the recognition, enjoyment or exercise by women irrespective of their marital status, on a basis of

equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field (emphasis added).²⁷

Two comments are appropriate here. First, the Women's Convention adopts an "effect" approach, whereby discrimination is condemned even if it is not purposeful. This is of particular significance in the area of health, where discrimination may be manifested in differences in the health status of women and men that may be the result of certain attitudes and patterns of behavior that are considered "natural," given the biological differences between women and men. These patterns persist by the mere inertia of habit if no intervention is undertaken to remove discriminatory barriers, or if we fail to pay attention to the factors that comprise the "real" differences—some biological or physiological, some social—between women and men in relation to their health. It should be mentioned in this context that the CEDAW Committee has noted that discrimination under the Convention is not restricted to action by or on behalf of governments.²⁸ States may also be responsible for acts of discrimination perpetrated in the private sphere by nongovernmental actors, including health care providers.

The second comment is that the definition of discrimination under the Women's Convention applies to all women, irrespective of their marital status. This is of significance in two respects. First, it expresses an underlying recognition of the ways in which the institution of marriage constructs women's social status. In the health area, for example, women are sometimes denied care and services because they are not married. Second, it expresses an underlying theme of feminist theory on gender equality: that equality relates not to a woman's personal relations with men, but rather to discrimination against women as a group in a society that is structured collectively by gendered patterns of power (one of which is the traditional marital relation).

The area of health is particularly interesting in terms of equality theory because of the "real" differences between women and men that have already been noted. Many of women's health needs are different from men's, and these

differences are derived from both biological differences and societal factors. This is particularly true as regards women's reproductive and sexual health, not only because of the obvious biological differences, but also because discrimination against women is closely associated with prejudices and stereotypes based on patriarchal notions of women's sexual and reproductive roles and functions.

Social Construction of Difference

While the Women's Convention acknowledges the maternal function of women as one among many life possibilities, social and cultural patterns of conduct often glorify motherhood in a manner that circumscribes women's right to autonomy in exercising life choices. Cultural and religious attitudes may lead to a valuation of women according to their ability to produce children. Women's health may consequently be jeopardized by repeated pregnancies spaced too closely together, often as the result of efforts to produce male children. Women who have not borne children may be cast out of marriages on the assumption that they, rather than their male partners, are infertile. Women may be denied access to health care that is unrelated to their reproductive functions, and their health needs may be considered secondary to those of their children or, in the case of pregnant women, to those of their fetuses.

Stereotypes of women's sexuality underlie codes of chastity that circumscribe women's freedom of movement and their participation in public life. Discriminatory attitudes about women's sexuality are related to certain practices that are harmful to women's health and deny them the right to a satisfying sex life. These practices include unnecessary interventions such as female genital mutilation, forced virginity examinations, and hymen repair. Women's sexuality is frequently subordinated to the satisfaction of male needs, exposing them to risks of sexual abuse and violence. As a consequence of unequal power relations based on gender, women and girls are often unable to refuse sex or negotiate safe sex, therefore increasing their risk of contracting sexually transmitted diseases, including HIV/AIDS.

Biological Difference

While the social phenomena mentioned above are clearly mediated by gender discrimination, health-related discrimination can also be attributed in part to biological differences between women and men. Contemporary feminist legal theory propounds that the principle of gender equality must take into account such difference, rather than requiring women to meet standards set by a male model.²⁹ Equality requires that we treat the same interests without discrimination, and also that we treat different interests in ways that respect those differences. Failure to take into account the particular health needs of women so as to ensure their access to appropriate health information and services constitutes discrimination. Equality requires not only guaranteeing women the same formal rights as men and combating purposeful discrimination, but also ensuring the effective enjoyment of equal outcome in health status and well being. Women's rights to health and health care on a basis of equality with men encompass health needs both comparable to men's and specific to women. Failure to allocate resources or to ensure the provision of services for women's particular health needs is discriminatory.

From the General to the Particular: Illustrations of Rights to Reproductive and Sexual Health

Guided by the legal context presented above, we may now proceed to examine violations of women's rights in relation to reproductive and sexual health. The Convention imposes a duty under international law to respect, protect, and fulfill the human rights articulated thereunder. In an ideal world these legal norms would be observed, but often the reality is that they are not. Violations of these standards take different forms at different times and in different places. The following examples of some contemporary patterns of rights violations are taken from the reports of States parties submitted in fulfillment of their obligations under the Convention and considered by the CEDAW Committee at its 18th session in January 1998. At this session, the Committee considered official reports submitted by govern-

ments of eight States parties: Azerbaijan, Bulgaria, the Czech Republic, Croatia, the Dominican Republic, Indonesia, Mexico, and Zimbabwe. In accordance with its usual practice and that of other human rights treaty bodies, the Committee also took note of unofficial, or “shadow,” reports provided independently by international and national nongovernmental organizations.³⁰

Nondiscrimination in Allocation of Resources

The issue of distributive justice in the allocation of resources for health is of major concern throughout the world, especially given both the rising costs of medical technology and the budget cuts often associated with programs of structural adjustment. Too often women’s health needs are the first to be adversely affected. The bias against the allocation of resources to provide health services for women’s needs, as may be seen in those countries characterized as having “economies in transition,” may be understood as a form of gender-based discrimination.

In Croatia, for example, when economic constraints led to budget cuts in the comprehensive public health system, contraception was the first type of medication to be cut off from state funding, and abortion was the first medical procedure to be removed from the list of free health services.³¹ Similarly, in Bulgaria—where the government reported that the number of abortions was considerably higher than that of births—the economic crisis of the transition period led to problems in the free-of-charge health care system and, specifically, inefficiencies in family planning education.³²

Likewise, budget cuts in Azerbaijan resulted in a decrease in the number of maternal health centers. In addition, although maternity care was officially provided at no charge through the state-funded health system, an informal fee-for-service practice had developed that made hospital delivery unaffordable to many women, resulting in a rise in the number of home births.³³ Azerbaijan also reported that maternal mortality rates had increased five-fold between 1990 and 1995.³⁴

The Right to Life

Indeed, discrimination against women is a significant factor in the high numbers of complications and deaths related to pregnancy and childbirth. Failure to provide maternal health services often reflects the low priority attached to women's particular needs in the allocation of resources. Maternal mortality and morbidity can largely be avoided through the provision of reproductive health services, including contraception, safe abortion, and essential and emergency obstetric care. The most obvious human right violated by avoidable death in pregnancy or childbirth is women's fundamental right to life itself.³⁵ It is arguable that the core minimum content of governmental obligations under international human rights instruments is to provide access to affordable quality health services that would prevent maternal mortality.

In Indonesia, the high maternal mortality rate suggested that the government was in violation of its core responsibility to provide safe maternal health services. The government attributed the high maternal mortality rate to deliveries in the home by traditional birth attendants, which amount to almost 64% of the total. Its report explained that many women prefer home births "due to convenience, low cost and flexible payment arrangements, the aftercare offered and the comfortable atmosphere prevailing in home deliveries."³⁶ But it is arguable that "customer preference" should not relieve a government of its obligation not only to respect but also to protect and fulfill women's right to life. As noted by the Committee, "It is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services, and they should allocate to these services the maximum extent of available resources."³⁷

While the high rate of maternal mortality in Azerbaijan seemed to be caused by violations relating to affordable services, a similar problem in the Dominican Republic appeared to be caused by a lack of quality care. Due to the unreliability of health statistics in general and the lack of

sex-disaggregated data in particular, the actual rate of maternal mortality was not known until recently. It is nonetheless clear that in recent years there had been an increase in maternal deaths despite the prevalence of prenatal care and hospital births.³⁸ According to nongovernmental sources, the rising levels of maternal mortality were due to the low priority accorded to women's reproductive health.³⁹

Reproductive Choice: Abortion

Unsafe abortion is also a major cause of maternal mortality and morbidity. States parties' reports to the Committee often lack official data on abortion because the procedure is illegal in many countries. The information presented, however, consistently demonstrates a correlation between unsafe abortion and high rates of maternal mortality and morbidity in the form of hemorrhaging and pregnancy complications.

Zimbabwe, for example, reported that hemorrhage and infection after abortion are major causes of death, though actual figures are not ascertainable because abortion is illegal.⁴⁰ Similarly, the Dominican Republic reported that "clandestine abortions" are the third leading cause of maternal death (after toxemia and hemorrhages during childbirth) but also noted "heavy underreporting."⁴¹

There are grounds for the view that laws criminalizing health services that only women need—whether such laws are aimed at the persons who provide such services or at the women who receive them—are discriminatory as such. The criminalization of abortion is particularly heinous, because it not only impairs women's right to reproductive choice—to make free and responsible decisions concerning matters that are key to control of their lives—but also exposes them to the serious health risks of unsafe abortion, violating their rights to bodily integrity and, in the most extreme cases, to life itself.⁴²

In many countries there are exceptions to a criminal norm, allowing for legal abortion in limited circumstances, such as in cases of danger to the life of the mother, serious fetal malformations, or pregnancy resulting from rape. In

Indonesia, however, where rape does not constitute grounds for legal abortion, the state effectively compounds the sexual violence targeted at women by forcing women who have been raped to carry the pregnancies that may result.⁴³

Reproductive Choice: Family Planning

Reproductive choice means the right of women to choose whether or not to reproduce, including the right to decide whether to carry or terminate an unwanted pregnancy and the right to choose their preferred method of family planning and contraception. One violation of this right was revealed by a nongovernmental report on widespread pregnancy-based discrimination against women employed in Mexico's export-processing (*maquiladora*) sector. A fact-finding mission investigating allegations of the practice found that all women applying for work in this sector were routinely required to undergo pregnancy tests and that employed women were often forced to resign when their pregnancies became known. In some factories, women were obliged to show sanitary napkins to company nurses as a condition of ongoing employment. The report concluded that such practices penalize women for exercising reproductive choice and inherently compromise women's ability to decide freely on the number and spacing of their children, and that therefore the human rights obligations of the Mexican government include ensuring that such employment practices cease.⁴⁴

The right to family planning education, information, and services is central to reproductive choice and to women's sexual and reproductive health, especially given the risk of maternal mortality and the illegality of abortion in many countries.

Family planning services are particularly important where abortion is illegal. In the Dominican Republic, abortion is illegal and birth control education is provided only by nongovernmental organizations.⁴⁵ Arguably, where the state does not allow for safe legal abortion, its core obligation is at least to provide those family planning services that guarantee women their right to exercise reproductive choice.

Even in countries where abortion is legal, prevention of pregnancy is preferable to termination in terms of women's health. In many instances, however, the legal option of abortion is not supported by adequate family planning measures. In the Czech Republic, for example, the government noted the high incidence of induced abortions as a major public health problem, mirroring the inadequate use of contraception. However, the costs of contraception are only partly covered by the general health insurance scheme (which in itself may reflect discrimination in the allocation of resources, given that these are services only women need). The Czech report also pointed out that health care personnel sometimes lack sufficient knowledge about contraception.⁴⁶

In other instances, there is a gap between the *de jure* (legal) protection of reproductive choice and the *de facto* (actual) situation. In such cases, governments may be held accountable for unauthorized violations by health care personnel. In Zimbabwe, for example, where abortion is legal only in limited circumstances, the government subsidizes the costs of contraceptives, and there are no legal restrictions on the provision of family planning services to minors. Yet the governmental report stated candidly that "it is not unusual for health personnel to turn away sexually active school girls requesting contraception on the grounds that the girls are still too young to indulge in sexual intercourse or that they are not married and therefore have no need for contraceptives."⁴⁷ Perhaps in part because of such attitudes on the part of health providers, teenage pregnancy appears to be a major problem.⁴⁸ In this context, it is also worth noting that the cumulative data on the incidence of HIV/AIDS in Zimbabwe show that infection among females accounts for 84% of the cases in the 15–19 age group.⁴⁹ Clearly, sexual and reproductive health education, information, and services are essential for adolescent girls in this country. Mexico also described the negative health and social effects on adolescent girls caused by the high rate of teenage pregnancy. It noted inadequate sex education and information as one of the causes, despite an official policy to provide information and high-quality services for pregnant adolescent girls.⁵⁰

Informed Consent

The report from Mexico demonstrated another instance of the gap between the *de jure* and the *de facto* implementation of the Convention. While the Federal Constitution recognizes the right to reproductive choice, and family planning services are provided by law as basic health services, one study has shown that only two contraceptive methods are offered: the IUD and surgical sterilization. Furthermore, while the law provides that consent to sterilization must be given freely and voluntarily in writing, another study found that one-fourth of sterilized women claim not to have been informed of its irreversible nature or of alternative contraceptive methods, while two-fifths claim not to have signed a consent form. In addition, there was at least one case in which the ovaries of a woman suffering from an undiagnosed urinary tract infection were removed without her knowledge.⁵¹ Interestingly, in her oral presentation to the CEDAW Committee, the representative of the Government of Mexico stated that most of the complaints submitted to a newly established Medical Arbitration Board during the first year of its operation concerned gynecological care. This fact suggests disproportionate violations by medical practitioners of patient rights in the area of reproductive health.

In extreme cases, violations of women's right to autonomy and informed consent in relation to reproductive health care amount to outright coercion. According to nongovernmental sources, Indonesia provides an unfortunate example. There, the government adopted a rigorous family planning program resulting in a significant decline in birth rates, which was presented in the State party's report as one of the most successful in the world.⁵² Nongovernmental sources, however, reported that women have not been allowed choice as to contraceptive method, nor have they been given information on the side effects of the methods provided by the government.⁵³ Moreover, there have been recurring reports of coercive practices employed by local officials attempting to meet target quotas set by the government, often involving military and police officials rounding up women in villages and forcing them to accept

contraception. According to one study, IUDs were inserted at gonpoint in women who had refused them.⁵⁴

Equality Before the Law

Indonesia also requires spousal authorization for certain reproductive health procedures. There, a woman cannot choose to be sterilized without her spouse's consent. In addition, though abortion may be undergone if the mother's life is in danger, the agreement of "the husband or the members of the family" is required in addition to that of the pregnant woman. Such laws violate women's right to full legal capacity and equality before the law in relation to informed consent and to confidentiality in health care.

Another example of violation of women's right to equality before the law relates to procedures for legal abortion. Even where there do exist grounds for lawful abortion in limited circumstances, there may not be adequate legal procedures to ensure women's enjoyment of their legal rights. In Zimbabwe, for example, there was one case of a pregnancy resulting from rape in which the request for permission to undergo abortion dragged on in court for so long that the permission was finally granted one month after the woman had given birth.⁵⁵ In Mexico, abortion is outside of the federal system, in the jurisdiction of states. As a rule it is treated as a criminal offense, with varying exceptions, but there are no legal procedures for establishing whether a particular case falls within the exceptions. Moreover, even though in some states a woman who seeks an abortion may be liable for punishment, it appears that often prosecution may be avoided by the payment of a bribe.⁵⁶

Women in Vulnerable Situations

In recent years, as a result of increased interest in economic and social rights and the concomitant concept of social justice, human rights work has increasingly focused on vulnerable groups. Whereas the earlier emphasis on civil and political rights drew mainly from the concept of liberty and focused on individuals as such, this approach includes attention to violations of rights of individuals as members of vulnerable groups within a given society. This suggests

that health practices and policies should increasingly be examined in light of the needs of the most disadvantaged groups in society. These should include, among others, rural and marginal urban groups, women in situations of armed conflict, and women engaged in sex work.

Here, again, country and nongovernmental sources suggest important patterns. Mexico indicated the unmet need for contraception among rural women and the urban poor in its report.⁵⁷ In Zimbabwe, according to a nongovernmental source, 20% of the population in rural areas is without access to family planning or maternal health services despite the government's political will to provide them.⁵⁸

Women in situations of armed conflict are particularly vulnerable to sexual violence and torture and the possible health consequences of mental harm and reproductive health problems, such as sexually transmitted infections and unwanted pregnancy. For example, as a result of sexual abuse, women may be isolated, stigmatized, and rejected by their families and communities. As indicated by a nongovernmental report on women in East Timor, women often feel such violations to be shameful and are therefore reluctant to report them, thus suffering not only physical but also mental consequences from their abuse.⁵⁹

Women who are internally displaced as a result of armed conflict may have limited access to reproductive health services. A study of women in five settlements for internally displaced persons in Azerbaijan, conducted by a United Nations High Commissioner for Refugees reproductive health field worker, found that, although women overwhelmingly consider family planning to be a primary health concern, there had been bureaucratic hurdles to supplying contraception.⁶⁰ Similarly, in Croatia, refugee women were not legally entitled to the range of services provided under the comprehensive publicly funded health care scheme.⁶¹

Female sex workers are marginalized in all societies and are at extremely high risk of suffering rape and other forms of violence. This is a problem of increasing concern given the economics of sex work and the international trafficking in women and girls.⁶² At the same time, these women suffer additional discriminatory treatment by public health

programs that target and blame them, rather than their clients, without adequately addressing their health needs. In Indonesia, for example, the Department of Social Affairs disseminates information on the danger of HIV/AIDS “in the vicinity of the location of prostitutes” while apparently failing to offer appropriate services to these women.⁶³ There have also been reports that women detained as suspected sex workers under sporadic urban “cleansing” programs are at risk of being forced to undergo vaginal examinations during interrogation.⁶⁴

It should be noted that health professionals are often in a position to identify the health consequences of sexual violence and to respond effectively to the health needs of survivors. Although Bulgaria, for example, failed to include any information on sexual or gender-based violence in its report, a nongovernmental source provided first-hand evidence from health care professionals that violence was a serious problem for Bulgarian women.⁶⁵

Conclusion

All the above examples can be summarized as violations of the major human rights concepts of liberty (incorporating autonomy), social justice, and equality. In broad terms, the principle of liberty is key to notions of civil and political rights, while the principle of justice is key to notions of economic and social rights. The principle of equality can be understood as an overarching theme. Questions of distributive justice arise in relation to the often tragic economic choices that must be made with regard to the fair allocation of scarce resources and the setting of priorities. Here we often find discrimination against women in the low priority given to their sexual and reproductive health needs.⁶⁶ But many of the issues raised by this article also relate to matters that are not essentially economic: the attitudes of policy makers and of health care providers in relation to their clients, and the fundamental notion of respect for human dignity and the right to reproductive autonomy.

The discourse of human rights cannot provide ready-made answers to the problems and dilemmas that arise in

any given context. Human rights are not absolute values in the sense that they trump all other considerations. Indeed, in some instances the rights of one person may be in conflict with the rights of another. But rights are absolute in the sense that they must be taken into consideration and balanced against other interests. In making and implementing law and policy, and in the delivery of services, violations of human rights may be justified only as measures of last resort, after all other possible means to achieve desired goals have been exhausted. Where several measures present themselves as comparably effective, the preference should be for the alternative that is the least detrimental to the enjoyment of human rights. Struggles over women's rights to sexual and reproductive health have been central to generating advances in women's human rights. Advocates of women's human rights have drawn attention to the ways in which the status of women is fundamentally linked with their reduction, through social and political processes, to aspects of their physical selves.⁶⁷ When reproductive health is understood to involve more than just the biological workings of a woman's womb, we arrive at "women-centered" approaches to sexual and reproductive health. This sort of approach means trusting women as autonomous beings who are able to exercise control over their sexual and reproductive lives and to make decisions on these matters on the basis of access to adequate information. Yet a woman's right to reproductive autonomy is often impaired by her status in society. Enjoyment of this right depends on her ability to act as an independent adult of full legal capacity, to participate in civil society, and to be free from discrimination in its various forms. In the absence of reproductive choice, all other human rights—civil and political; economic, social, and cultural—have only limited power to advance the well-being of women.⁶⁸

References

1. On the needs of individuals and on the empowerment of women, see N. Sadik, Foreword, Programme of Action of the International Conference on Population and Development, Report of the International Conference on Population and Development, 5–13 September 1994, UN Doc. A/CONF.171/13. On social justice and respect for human dignity,

see L. P. Freedman, "Human Rights and the Politics of Risk and Blame: Lessons from the International Reproductive Health Movement," *Journal of the American Medical Women's Association* 1997, 52: 167.

2. Freedman (see note 1), pp. 167–68.

3. See A. E. Yamin, "Transformative Combinations: Women's Health and Human Rights," *Journal of the American Medical Women's Association* 1997, 52: 172.

4. Reproductive rights were articulated as a subject of international concern for the first time at the international human rights conference held in Teheran in 1968. The Final Act of the Teheran Conference included a provision stating: "Parents have a basic human right to decide *freely and responsibly* on the number and spacing of their children and a right to adequate education and information in this respect (emphasis added)." The term "freely and responsibly" is key to the notion of reproductive autonomy. The meaning of this phrase was influenced by two different international movements: the population movement, on the one hand, which was motivated by concern about unchecked population growth, and the women's rights movement, on the other hand, which was motivated by the idea that every woman must have the right of bodily integrity and control. See L. P. Freedman and S. L. Isaacs, "Human Rights and Reproductive Choice," *Studies in Family Planning* 1993, 24: 20. The ICPD incorporates the latter approach.

5. The essence of Chapter II is captured in its Principle 4, as follows:

Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community.

The last two sentences in this passage are a verbatim quote from the Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, June 1993, UN Doc. A/CONF.157/24 (Part I) at 20 (1993), para. 18.

6. ICPD Programme of Action (see note 1), para. 7.2. The text continues to state:

Implicit in this last condition are the rights of men and women 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.

7. The right to health is mentioned first in the Universal Declaration of Human Rights, G.A. Res. 217A (III), UN GAOR, Res. 71, UN Doc. A/810 (1948), which says in Article 25.1 that "everyone has the right to a stan-

dard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness." See also Paragraph 31 of the Vienna Declaration and Programme of Action.

8. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966). Article 12 of the ICESCR expanded on the vague articulation of the right to health in the Universal Declaration of Human Rights by listing specific steps to be taken to achieve the full realization of this right, including steps necessary for the healthy development of the child, the improvement of industrial hygiene, the control of epidemics, and "the creation of conditions which would assure to all medical services and medical attention in the event of sickness." A similar provision is found in Article 24 of the Convention on the Rights of the Child, G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989). But there the language is stronger. It states that the child also has the right "to facilities for the treatment of illness and rehabilitation of health" and that "States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." Among the measures States parties undertake to pursue full implementation of this right, one finds mention of primary health care, malnutrition, clean drinking-water, prenatal and postnatal care, environmental sanitation, and health and family planning education. The article makes special mention of the need to abolish traditional practices prejudicial to the health of children and of the need for international cooperation "to achieve progressively the full realization of the right recognized in the present article." Note, also, the Convention on the Elimination of All Forms of Racial Discrimination, UN G.A. Res. 2106A(XX) (1965), which expressly mentions in Article 5.e.iv "the right to public health [and] medical care."

9. International Covenant on Civil and Political Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 52, UN Doc. A/6316 (1966). It is worth mentioning in this respect that Article 7 of the ICCPR prohibits torture and states that "in particular, no one shall be subjected without his free consent to medical or scientific experimentation." For further articulation of these and other civil and political rights in the context of sexual and reproductive health, see the IPPF Charter on Sexual and Reproductive Rights (International Planned Parenthood Federation, 1996).

10. ICPD Programme of Action (see note 1), para. 7.3. Note further Principle 8, which states:

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly

the number and spacing of their children and to have the information, education and means to do so.

11. ICPD Programme of Action (see note 1), para. 7.3.

12. The life-cycle approach includes sexual and reproductive health while addressing a larger range of issues—including, *inter alia*, nutrition, sanitation, violence against women, mental health, and environmental health—and noting that “a major barrier for women to the achievement of the highest attainable standard of health is inequality, both between men and women and among women in different geographical regions, social classes and indigenous and ethnic groups.” Platform for Action of the Fourth World Conference on Women, UN Doc. A/CONF.177/20 (October 17, 1995), para. 89.

13. FWCW Platform for Action (see note 12), para. 17.

14. Paragraph 97 of the FWCW Platform for Action (see note 12) states:

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.

15. As of May 1, 1999, 163 states had either ratified or acceded to the Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180 UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979).

16. In addition to general provisions, the Women’s Convention specifies rights in relation to such diverse issues as the rights to vote, stand for election, hold public office, and acquire nationality; equality in education and employment; finance; sports; and family life. It also contains specific provisions on various topics such as trafficking and rural women. For an elaboration of women’s right to health in international jurisprudence, see D. J. Sullivan, “The Nature and Scope of Human Rights Obligations Concerning Women’s Right to Health,” *Health and Human Rights* 1995, 1(4): 368–98.

17. Article 18 of the Women’s Convention (see note 15) stipulates that each State party undertakes to submit an initial report within one year after the entry into force and thereafter at least every four years and whenever the Committee so requests.

18. Women’s Convention (see note 15), art. 21.

19. Women’s Convention (see note 15), art. 12, para. 1.

20. Women’s Convention (see note 15), art. 12, para. 2.

21. The CRC (see note 8) also mentions family planning in Article 24.2.f. The other treaties are the ICCPR (see note 9); the ICESCR (see note 8); the Race Convention (see note 8); and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/45, UN GAOR, 39th Sess., Supp. No. 51, at 197, UN Doc. A/39/51 (1985).

22. General Recommendation No. 14 (9th sess., 1990), on female circum-

cision, notes the serious health consequences for women and children of female circumcision and other similar traditional practices. It also places a special responsibility on health personnel and traditional birth attendants to explain the harmful effects of such practices.

General Recommendation No. 19 (11th sess., 1992), on violence against women, refers *inter alia* to the health aspects of sexual violence and notes that the treatment of women as sexual objects contributes to gender-based violence in general. In addition, General Recommendation No. 12 (8th sess., 1989), on violence against women, recommends that States parties include in their reports information about legislation in force to protect women against violence, as well as statistical data on the incidence of violence.

General Recommendation No. 15 (9th sess., 1990), on avoidance of discrimination against women in national strategies for the prevention and control of HIV/AIDS, recommends that programs to combat HIV/AIDS should give special attention to factors relating to the reproductive role of women and their subordinate position in some societies, which make them especially vulnerable to HIV infection.

General Recommendation No. 21 (13th sess., 1994), on equality in marriage and family relations, refers *inter alia* to coercive reproductive health measures and to the adverse health effects of early marriage.

Note further General Recommendation No. 18 (10th sess., 1991) on women with disabilities, which expresses concern about disabled women as a vulnerable group and calls for special measures that would ensure their equal access to health services in general.

23. General Recommendation No. 24 (20th sess., 1999).

24. I. Berlin, "Two Concepts of Liberty," in *Four Essays on Liberty* (Oxford: Oxford University Press, 1969), p. 118.

25. Women's Convention (see note 15), art. 1 and 3. Article 1 defines discrimination as the impairment of women's ability to exercise their human rights and fundamental freedoms on a basis of equality of men and women. Article 3 is an operative provision that enjoins States parties to take all measures to ensure the 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." Thus Article 3 incorporates in the Convention all the human rights and fundamental freedoms guaranteed under the other human rights treaties.

26. See further *Medical Ethics and Human Rights: The Guiding Principles* (London: Commonwealth Medical Association, 1994).

27. Women's Convention (see note 15), art. 1.

28. General Recommendation No. 19 (see note 22), para. 9.

29. See, for example, A. Scales, "The Emergence of Feminist Jurisprudence: An Essay," *Yale Law Journal* 1986, 95: 1373-1403, and C. MacKinnon, "Difference and Domination: On Sex Discrimination," in *Feminism Unmodified: Discourses on Life and Law* (Cambridge, MA: Harvard University Press, 1987), pp. 32-45.

30. It is clear that the effectiveness of a monitoring system based on State party reports is enhanced when the monitoring body receives additional

information from external independent sources. In the most serious cases of human rights violations, the reporting government is unlikely to be wholly forthcoming on the matter. However candid the State party may be, it will tend to present its report in the most favorable manner. Matters that are of serious concern to human rights advocates within the country may go unmentioned or may be camouflaged by innocuous language. Given the broad scope of the Women's Convention, even in the best of circumstances where relevant information is actually presented in a comprehensive report, its significance may be lost among the wealth of facts, figures, and legal analyses.

31. B.a.B.e. Women's Human Rights Group, NGO Report on the Status of Women in the Republic of Croatia (1997).

32. Second and Third Reports of the Republic of Bulgaria, UN Doc. CEDAW/C/BGR/2-3 (November 3, 1994), paras. 113, 116, 120-121.

33. Human Rights Center of Azerbaijan, Comments on Government Report (trans. International League for Human Rights); International Women's Rights Action Watch (IWRAP), Independent Report on Azerbaijan, submitted to the Committee on Economic, Social and Cultural Rights (Minneapolis: Hubert Humphrey Institute of Public Affairs, University of Minnesota, 1997), pp. 3, 11.

34. The figure was 44.6 per 100,000 births in 1995. Initial Report of Azerbaijan, UN Doc. CEDAW/C/AZE/1 (16 September 1996), para. 12.

35. R. Cook, "International Protection of Women's Reproductive Rights," *Journal of International Law and Politics* 1992, 24: 688. For the effect of gender discrimination on women's mortality throughout the life cycle, consider further L. P. Freedman and D. Maine, "Women's Mortality: A Legacy of Neglect," in M. Koblinsky, J. Timyan, and J. Gay (eds), *The Health of Women: A Global Perspective* (Boulder, CO: Westview, 1992), p. 147.

36. The figure was 425 per 100,000 births in 1995. Second and Third Periodic Reports of Indonesia, UN Doc. CEDAW/C/IDN/2-3 (February 12, 1997), pp. 49-51.

37. CEDAW General Recommendation No. 24 (see note 23), para. 27.

38. Second and Third Periodic Reports of the Dominican Republic, UN Doc. CEDAW/C/DOM/2-3 (May 12, 1993), paras. 157-58, 161. The Fourth Periodic Report of the Dominican Republic, UN Doc. CEDAW/C/Dom/4 (November 10, 1997) did include statistical data and estimated an increase in maternal mortality rates from 180 per 100,000 births in 1991 to 229 per 100,000 in 1996.

39. IWRAP to CEDAW Country Report on the Dominican Republic (Minneapolis: Hubert Humphrey Institute of Public Affairs, University of Minnesota, 1996), p. 15.

40. Initial Report of Zimbabwe, UN Doc. CEDAW/C/ZWE/1 (July 20, 1996), p. 50.

41. Fourth Periodic Report of the Dominican Republic (see note 38), para. 289.

42. CEDAW General Recommendation No. 24, para. 11, states: "It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women." Cf. para. 14:

“[B]arriers to women’s access to appropriate health care include laws that criminalize medical procedures only needed by women.”

43. Second and Third Periodic Reports of Indonesia (see note 36), p. 53; IWRAW to CEDAW Country Report, Supplement on Indonesia (Minneapolis: Hubert Humphrey Institute on Public Affairs, University of Minnesota, 1998), p. 10. Note that this might be considered cruel and inhumane treatment, prohibited under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

44. Human Rights Watch Women’s Rights Project, *No Guarantees: Sex Discrimination in Mexico’s Maquiladora Sector* (1996).

45. IWRAW to CEDAW Country Report on the Dominican Republic (see note 39), p. 15.

46. Initial Report of the Czech Republic, UN Doc. CEDAW/C/CZE/1, paras. 175, 178, 215–16.

47. Initial Report of Zimbabwe (see note 40), pp. 45, 50.

48. Women’s Health in Zimbabwe: A Report of a Workshop Held by the Zimbabwe Medical Association and the Commonwealth Medical Association, Harare, January 1996.

49. The exact figure was 644 out of 761 cases in the years 1987–1994. Initial Report of Zimbabwe (see note 40), p. 48. The Fourth Periodic Report of the Dominican Republic (see note 38) also reported a higher incidence of HIV/AIDS infection among females than among males in the 15–24 age group (para. 300).

50. Combined Third and Fourth Periodic Reports of Mexico, UN Doc. CEDAW/C/MEX/3–4 (May 21, 1997), paras. 298–306.

51. The studies mentioned above are cited in Center for Reproductive Law and Policy (CRLP) and Grupo de Informacion en Reproduccion Elegida, *Women’s Reproductive Rights in Mexico: A Shadow Report* (1997), pp. 6, 7–8, 11.

52. Second and Third Periodic Reports of Indonesia (see note 36), pp. 52, 53, 75.

53. IWRAW to CEDAW Country Report, Supplement on Indonesia (see note 43), p. 10.

54. Amnesty International, *Women in Indonesia and East Timor: Standing Against Repression* (London: Amnesty International, 1995), p. 15.

55. Center for Reproductive Law and Policy (CRLP) and Women in Law and Development in Africa, *Women’s Reproductive Rights in Zimbabwe: A Shadow Report* (1997), p. 8.

56. CRLP and Grupo de Informacion en Reproduccion Elegida (see note 51), pp. 9–10.

57. Combined Third and Fourth Periodic Reports of Mexico (see note 50), para. 196.

58. CRLP and Women in Law and Development in Africa (see note 55), p. 2.

59. Amnesty International (see note 54), pp. 2, 13.

60. IWRAW (see note 32), p. 15, referring to Situation Report on Azerbaijan, UNHCR, June 1997.

61. B.a.B.e. Women’s Human Rights Group (see note 31).

62. CEDAW General Recommendation No. 24 (see note 23), para. 18 states:

Women in prostitution are particularly vulnerable to [sexually transmitted] diseases. States parties should ensure, without prejudice or discrimination, the right to sexual health information, education and services for all women and girls, including those who have been trafficked, even if they are not legally resident in the country.

63. Second and Third Periodic Reports of Indonesia (see note 36), p. 54.

64. Amnesty International (see note 54), p. 12.

65. IRAW to CEDAW Country Report to CEDAW [summarizing the Minnesota Advocates for Human Rights report of a fact-finding mission to Bulgaria on domestic violence, March 1997].

66. Much of the literature on human rights has been concerned with violations within the classical focus on civil and political rights. In recent years there has been an evolving concern with economic and social rights and a concomitant attempt to define the "minimum core content" of government obligation to respect, protect, and fulfill the rights guaranteed by international human rights documents. For a proposal for a minimum package of reproductive health information and services that governments must provide, see A. Rahman and R. N. Pine, "An International Human Right to Reproductive Health Care: Toward Definition and Accountability," *Health and Human Rights* 1995, 1(4): 400-427.

67. J. Mann and S. Gruskin, "Women's Health and Human Rights: Genesis of the Health and Human Rights Movement," *Health and Human Rights* 1995, 1(4): 309-12.

68. Freedman and Isaacs (see note 4), pp. 18, 19.