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Toward Government Accountability for Women's Reproductive Rights

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TOWARD GOVERNMENT ACCOUNTABILITY FOR WOMEN'S REPRODUCTIVE RIGHTS

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INTRODUCTION: WOMEN'S REALITIES

A woman from the Fiji Islands once said, "I have six children and I am about to have my seventh one. I do not know how to explain to my husband that I do not wish to have any more. My mind would go racing as soon as I hear him climb into bed, all tired, he would start having sex with me. I don't know how long I can go on producing children, for I feel like a baby machine when you press a button and something pops out."

Meanwhile, a woman from China stated,

> A Chinese birth control team set up their tent next to our monastery. All women had to report to the tent for abortions and sterilizations or there would be grave consequences. For the women who went peacefully to the tent and did not resist, medical care was given. The women who refused were taken by force, and operated on and no medical care was given. Women nine months pregnant had their babies taken out.

These voices illustrate the diverse needs of women and the different types of reproductive rights violations that women worldwide confront on a daily basis. Many women want, and need, the right to control their reproductive lives.[1] This article focuses on one key reproductive rights

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[1] Adrienne Germain et al., *Setting a New Agenda: Sexual and Reproductive Health Rights*, *in* POPULATION POLICIES RECONSIDERED: HEALTH, EMPOWERMENT, AND STUDIES 27 (Gita Sen et al. eds., 1994). Most population programs view women as a means to fertility control. *Id.* at 37. These programs concentrate on providing contraceptive services to married, fertile women of child-bearing age, often ignoring young girls, single women, and older sterile women.

Even when family planning services are combined with maternal and child health programs, services often fail to address important health problems such as AIDS, other sexually transmitted diseases ("STDs"), and preventable cancers. *Id.* Despite considerable international debate, the political will to bring about more equitable development, especially in terms of gender, has been seriously lacking. *Id.* at 28; *see also* Claudia Garcia-Moreno & Amparo Claro, *Challenges from the Women's Health Movement: Women's Rights Versus Population Control*, *in* POPULATION POLICIES RECONSIDERED: HEALTH, EMPOWERMENT, AND STUDIES 47 (Gita Sen et al. eds., 1994)

issue: the right to reproductive health care.

I. THE RIGHT TO REPRODUCTIVE HEALTH CARE IN HUMAN RIGHTS

The right to reproductive health care raises concerns related to all human rights—economic, civil, social, and political. Yet, the human rights community has yet to address challenges relating to women's health, particularly reproductive health. Reproductive rights have been marginalized in both the practice and jurisprudence of human rights. It is important to note, however, that such rights have been recognized in many international human rights instruments.[2]

One of the cornerstone human rights documents is the Universal Declaration of Human Rights.[3] Article 25 of this instrument states that

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[hereinafter *Challenges*] (stating that women's health movement strongly criticizes emphasis on narrow programs designed to reduce fertility without addressing women's health or empowerment).

Conversely, Brazil has implemented the Comprehensive Program for Women's Healthcare ("PAISM") which, in addition to maternal care and family planning, includes breast and cervical cancer screening, diagnosis and treatment of STDs, and infertility services. The program provides services to adolescents and post-menopausal women. *Challenges*, *supra*, at 51; *see also* RUTH DIXON-MUELLER, POPULATION POLICY & WOMEN'S RIGHTS; TRANSFORMING REPRODUCTIVE CHOICE (1993) (analyzing complex relationship between women's rights and population policy and advocating that woman's right to control her own reproductive capacity should be essential part of any government population control policy).

[2] *See generally* Rebecca Cook, *International Protection of Women's Reproductive Rights*, 24 N.Y.U. J. INT'L L. & POL. 645 (1992) (discussing women's reproductive rights protected by international human rights instruments); Berta E. Hernández, *To Bear or Not to Bear: Reproductive Freedom as an International Human Right*, 17 BROOK. J. INT'L L. 309 (1991); U.S. RATIFICATION OF THE HUMAN RIGHTS TREATIES: WITH OR WITHOUT RESERVATIONS? (Richard B. Lillich ed., 1981) (discussing United States' failure to ratify almost all human rights treaties).

[3] *Universal Declaration of Human Rights*, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., pt. 1, at 71, U.N. Doc. A/810 (1948) [hereinafter *Universal Declaration*]. Once the United Nations Charter was completed in 1945, it was recommended that a Commission of Human Rights be established to prepare an international Bill of Rights. A.H. ROBERTSON, HUMAN RIGHTS IN THE WORLD; AN INTRODUCTION TO THE STUDY OF THE INTERNATIONAL PROTECTION OF HUMAN RIGHTS 25 (3d ed. 1989) [hereinafter *Human Rights*]. The Commission decided to divide the Bill of Rights into three parts and appointed a drafting committee. The drafting committee was comprised of representatives from Australia, Chile, China, France, Lebanon, the United Kingdom, the United States, and the Soviet Union and was chaired by Eleanor Roosevelt. *Id.* In 1948, the General Assembly of the United Nations decided to consider only the draft Universal Declaration. Despite attempts by the USSR to delay consideration, the Universal Declaration was amended and approved by the General Assembly. *Id.* at 26. The Universal Declaration was adopted on December 10, 1948 by a 48-0 vote with only Czechoslovakia, Saudi Arabia, the USSR, Byelorussian SSR, Union of South Africa, and Yugoslavia abstaining. BASIC DOCUMENTS ON HUMAN RIGHTS 21 (Ian Brownlie ed., 1992) [hereinafter *Basic Documents*].

The Universal Declaration is regarded as an authoritative guide to interpreting the UN conventions intended to supersede the declaration. *Id.*

every person has the right to a minimum standard of living necessary for health and well-being.[4] This right is reiterated in the International Covenant on Economic, Social and Cultural Rights[5] and in the Women's Convention.[6] The latter addresses women's access to health care services,

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Most major international human rights treaties have not received Senate approval, despite presidental approval and the United States' active role in drafting them. Bruno V. Bitker, *The United States and International Codification of Human Rights: A Case of Split Personality*, *in* THE DYNAMICS OF HUMAN RIGHTS IN U.S. FOREIGN POLICY 77, 88 (Natalie K. Hevener ed., 1981). Despite this failure, most Americans consider the United States to be the leading protector of human rights. *Id.*

[4] *Universal Declaration*, *supra* note 3, at art. 25 states:

> 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
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> 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

Id.

[5] International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 993 U.N.T.S. 3 (1966). "The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family." *Id.* at art. 11. "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." *Id.* at art. 12(1). Article 3 reads: "The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant." *Id.* at art. 3. As of December 31, 1992, 188 countries were parties to this Covenant. UNITED NATIONS, MULTILATERAL TREATIES DEPOSITED WITH THE SECRETARY-GENERAL: STATUS AS OF 31 DECEMBER 1992 (1992); *Basic Documents*, *supra* note 3, at 113; *cf.* A. GLENN MOWER JR., THE UNITED STATES, THE UNITED NATIONS, AND HUMAN RIGHTS: THE ELEANOR ROOSEVELT AND JIMMY CARTER ERAS (1979) (discussing pressure on the United States to ratify human rights treaties).

[6] Convention on the Elimination of All Forms of Discrimination Against Women, *adopted* Dec. 18, 1979, 19 I.L.M. 33 (1980) [hereinafter Women's Convention]. "The States Parties to the International Covenants on Human Rights have the obligation to ensure the equal rights of men and women to enjoy all economic, social, cultural, civil and political rights." *Id.* at pmbl.

The Committee on the Elimination of Discrimination Against Women was created by the Women's Convention. Women's Convention, *supra*, at art. 17(1); Sandra Coliver, *United Nations Machineries on Women's Rights: How Might They Better Help Women Whose Rights Have Been Violated?*, *in* NEW DIRECTIONS IN HUMAN RIGHTS 25 (Ellen L. Lutz et al. eds., 1989). The Committee meets annually in Vienna and consists of 23 experts elected by the parties to the Women's Convention. The members serve staggered, four-year terms. In electing members, geographical distributions of representation and different legal systems are considered. *Id.* In 1987, all members of the Committee were women. Coliver, *supra*, at 34-35.

Some commentators have criticized the Women's Convention for not providing for the submission of complaints by either states or individuals. Roberta Jacobsen, *The Commission on the Elimination of Discrimination Against Women*, *in* THE UNITED NATIONS AND HUMAN RIGHTS: A CRITICAL APPRAISAL 444, 448 (Philip Alston ed., 1992) (quoting Theodor Meron, *Enhancing the Effectiveness of the Prohibition of Discrimination Against Women*, 84 AM. J. INT'L L. 213 (1990)). Signatory countries, however, are required to submit reports every four years to the

including those related to family planning, and their right to appropriate services relating to pregnancy confinement and postnatal care.[7] In addition, the Women's Convention is noteworthy for recognizing another key reproductive right—the right of both men and women to decide freely and responsibly on the number and spacing of their children.[8]

International human rights instruments thus call for placing an affirmative obligation upon national governments to provide health services. What, however, is the reality?

II. THE REALITY OF THE RIGHT TO REPRODUCTIVE HEALTH

The reality is that, worldwide, governments are generally the largest providers of health care services for all their citizens, including women.[9]

Committee, which report the actions they have taken to put the Convention into effect. Women's Convention, *supra*, at art. 18. They are also required to report the obstacles they have faced and the measures they have adopted to overcome them. Coliver, *supra*, at 35. The Committee may then make informal suggestions addressing specific countries or general situations. *Id.* Unfortunately, the Committee is unable to read all the reports it receives with its limited resources *Id.*

As of 1987, the United States, Israel, and the Netherlands were among the few western democracies that had not ratified the Women's Convention. STATUS OF INTERNATIONAL DOCUMENTS, U.N. Doc. ST/ESA/102, U.N. Sales No. E87.XI.2 (1987).

[7] Women's Convention, *supra* note 6, at art. 12. Article 12 states:

> 1. States Parties shall 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.
> 2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall 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.

Id.

[8] Women's Convention, *supra* note 6, at art. 16(1)(e). Article 16(1)(e) states:

> States Parties shall take all appropriate measures to . . . ensure, on a basis of equality of men and women . . . [t]he 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 rights.

Id. But cf. Theodor Meron, *Enhancing the Effectiveness of the Prohibition of Discrimination Against Women*, 84 AM. J. INT'L L. 213 (1990) (discussing effectiveness of Women's Convention).

[9] *See* The WORLD BANK, WORLD DEVELOPMENT REPORT 1993: INVESTING IN HEALTH (1993). World health spending totaled approximately $1700 billion in 1990. Of this amount, governments' portion accounted for more than $1000 billion, or nearly 60 percent. Of the $170 billion spent on health care in Africa, Asia, and Latin America, government accounted for half. *Id.* at 52; *see also* THE STATESMAN'S YEAR-BOOK: STATISTICAL AND HISTORICAL ANNUAL OF THE STATES OF THE WORLD FOR THE YEAR 1994-95 (Brian Hunter ed., 131st ed. 1994) [hereinafter YEAR-BOOK].

Albania provides free medical services, but requires payment for medicines. YEAR-BOOK, *supra*, at 76. Argentina provides free medical attention at public hospitals, while trade unions

This may come as a surprise to many Americans who utilize a privatized health system.[10] With respect to women's health, however, most governments are involved in providing a narrow range of services referred to as "family planning."[11] Family-planning services usually focus on the delivery of contraceptives. In rare instances, however, such programs deal with additional reproductive health services such as prenatal and postnatal care.[12] Moreover, family planning, in its narrowest sense, lies at the

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provide maternity services for members and their dependents. *Id.* at 101. Australia expended an estimated $14,829,000 in health care in 1992-93. Since 1984, they have provided Medicare, an automatic entitlement program covering medical services, including eye care. The program provides for discounted and maximum fees, free access to public hospital accommodations, and in-patient and out-patient treatment by doctors appointed by the hospitals. *Id.* at 119-20. Botswana's central and local governments run health care facilities, while medical missions, mining companies, and voluntary organizations also provide health care. *Id.* at 222.

The Canadian Constitution delegates the responsibility of health care services to its provinces and territories; yet there is national health insurance. *Id.* at 284. Cuba provides free polyclinics and there are a few private practitioners. YEAR-BOOK, *supra*, at 461. In India, health programs are primarily the responsibility of the states. Family planning, however, is centrally sponsored and only locally implemented. *Id.* at 714. Italy centrally funds its health services and pays a portion of prescription costs. *Id.* at 815. Jamaica provides public health services in primary health centers. *Id.* at 819. Kenya provides free medical services to children and adults on an out-patient basis. *Id.* at 839. Kiribati provides free medical care to its citizens. *Id.* at 842. North Korea provides free medical services to citizens. YEAR-BOOK, *supra*, at 853. Kuwait provides free medical care to residents. *Id* at 857. Great Britain provides national insurance to citizens funded by various taxes; people can choose to pay a higher tax and opt-up their coverage. Maternity benefits are also provided. *Id.* at 1373-76.

[10] United States health care is not entirely privately provided. YEAR-BOOK, *supra* note 9, at 1443. The federal government provides health insurance for those 65 and over and for certain disabled persons under Medicare. The program also provides voluntary medical insurance. The Social Security Program also provides for maternal and child health care. The federal government also provides Block Grants to the states which have their own health programs and services. *Id.* at 1443-44. For example, in 1989, the federal government provided, through Block Grants, $135 million for family planning programs, $414.8 million for community health centers, $487 million for alcohol, drug abuse and mental health programs, and $155 million for alcohol and drug treatment and rehabilitation. *Id.*

[11] Ivonne Prieto, Note, *International Child Health and Women's Reproductive Rights*, 14 N.Y.L. SCH. J. INT'L & COMP. L. 143, 179 (1993) (stating family planning accounts for less than one-half of one percent of national budgets in nearly all countries); *see* THE POPULATION PROBLEM 24 (Stanley Johnson ed., 1973). The bulk of the effort in Southern nations has been the extension of family planning programs, i.e., organized contraception. *Id.* at 24; *see* Gayle D. Ness, *The Impact of International Population Assistance*, *in* AID AND DEVELOPMENT 185-200 (1989) (states that two-thirds to three-fourths of all international population assistance in low-income countries is used to support family planning programs); Germain et al., *supra* note 1 (explaining that many national programs have failed to invest in factors which encourage people's use of programs and stating that coordination between population, finance, planning, and development agencies is necessary).

[12] Family planning services were invented by the British. Their essential philosophy embraces the notion that a couple should be able to have the number of children that they choose. One or both partners, therefore, should be able to practice some form of birth control to make this

center of "population programs."[13] These programs, and their policies, were the focus of discussions at the 1994 International Conference on Population and Development.[14] This conference estimated that "the

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possible. THE POPULATION PROBLEM, *supra* note 11, at 24. Family planners tend to advocate what they call the "cafeteria approach"; anything will do as long as it works. *Id. But cf.* WORLD POPULATION GROWTH AND RESPONSE 1965-1975: A DECADE OF GLOBAL ACTION 5 (1976) (stating that some commentators refer to family planning as including other health services); H.R. 2447, 103rd Cong., 1st Sess. (1993), *available in* LEXIS, Legis Library, BTX103 File (defining family planning services under § 499B to include, public education, development efforts, health services and empowerment of individuals).

Family planning services have been implemented as a result of the widespread belief that continued population growth at current rates would be disastrous for low-income nations. *See, e.g.*, THE POPULATION PROBLEM, *supra* note 11, at 21; Ness, *supra* note 11, at 185; R.T. Revenholt, *Taking Contraceptives to the World's Poor*, *in* FREE INQUIRY, Spring 1994, at 7.

The plea for UN help came from governments like India and Pakistan which recognized the immensity of their "population problems." THE POPULATION PROBLEM, *supra* note 11, at 28. Not all lower-income countries and population experts agree that a problem exists. *See, e.g.*, Jan Narveson, *A Dissenting Viewpoint: The Overpopulation Scare*, *in* FREE INQUIRY, Spring 1994, at 33-34 (stating that it is necessary to distinguish between "starvation due to the inhumanity, cruelty, imbecility, and sheer incompetence of governments, and starvation due to the lack of sufficient resources to sustain life").

Despite Vatican opposition, in 1966 there was a breakthrough in the General Assembly, and a broad resolution was passed authorizing the assistance of population control and family planning. THE POPULATION PROBLEM, *supra* note 11, at 28-29. Such services have contributed somewhat to lower fertility, but not enough to ensure that all those who wish to regulate their fertility can do so safely and effectively. Germain, *supra* note 1.

Governments that provide family planning services include: Nigeria, Columbia, Venezuela, Costa Rica, Ecuador, El Salvador, Honduras, Panama, Nicaragua, Dahomey Hong Kong, Chile, and Botswana. THE POPULATION PROBLEM, *supra* note 11, at 23; *see also Cheeky Manila Condom Bar's Permit Held Up*, Reuter News Service-Far East, Sept. 30, 1994, *available in* LEXIS, NewsLibrary, WIRES File (stating that Philippine Government has "population programs" providing access to artificial contraception).

[13] Population programs include formulating national family planning policy, removing restrictions on the importation and distribution of contraceptives, changing marital age requirements, opening clinics, paying and training staff, and purchasing clinic equipment. Ness, *supra* note 11, at 185-90. Not all population aid falls explicitly within these categories. For example, programs characterized as education aid help to raise the required female school attendance age limit which, in turn, raises the marital age limit, supports the use of contraceptives within marriage, and reduces fertility. *Id.* at 198-99.

Current debate spans a wide spectrum of positions, from those who believe population growth in low-income countries is the largest global threat, to those who regard the size of a population as being an insignificant phenomenon. Germain et al., *supra* note 1. Between these two extreme positions are family planning "revisionists" who would improve current programs, those who would transform current programs into reproductive and sexual health programs, and those who would broaden programs to encompass improving the status of women, education, children's health, and material resources access. *Id.* at 27.

[14] The conference was held in Cairo on September 5-13, 1994. *See* Michael Elliot et al., *Body Politics: Population Wars*, NEWSWEEK, Sept. 12, 1994, at 22-26 (depicting overview of draft program and stating that although conference is about population, real topic is women's rights).

implementation of programs in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases . . . will cost: $17.0 billion in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015."[15] The family-planning component of this total is expected to cost $10.2 billion in 2000.[16] Two-thirds of the cost of these programs will be provided by national governments;[17] the remainder will derive from external sources such as multilateral organizations and bilateral donor governments such as the United States, which is one of the largest international donors to family-planning and population programs.[18] There are, however, many problems associated with the delivery of family-planning services. First, every program, whether a population program or a family-planning program, is founded upon a narrow paradigm—the provision of contraceptive services. Susan Davis[19] eloquently noted the various inter-relationships among the many different issues with which one must contend. People do not exist in isolation, and, as a result, population issues must be placed within the broader context of human development. Moreover, people must be viewed nonclinically. Population programs deal with human beings, both men and women. As such, women's lives must be viewed holistically and women's bodies must not be regarded solely as reproductive vessels.

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[15] Report of the International Conference on Population and Development, at 98, ¶ 13.15, U.N. Doc. A/CONF.171/13 (1994).

[16] *Id.* ¶ 13.5(b).

[17] In 1990, "developing" countries spent almost $4 billion on population programs. *Soutien Financier De L'Union Europeenne A Des Programs en Faveur De La Population*, Rapid, Dec. 23, 1993, *available in* LEXIS, News Library, PAPERS File (containing breakdown of spending by each nation).

[18] For example, the United States proposed a population assistance budget of $569 million for 1995, a 13% increase from 1994. Hobart Rowen, *Giving Population Planning a Boost, Despite the Vatican's Opposition*, WASH. POST, June 19, 1994, at H2. Japan made a recent commitment of $3 billion over the next seven years. Carol Giacomo, *U.S. Sees Tragedy in Unchecked Population Growth*, Reuter News Service-United States, Feb. 22, 1994, *available in* LEXIS, News Library, PAPERS File; *see* Dominic Evans, *Rich Nations Urged to Give More to Family Planning*, Reuter News Service-World Service, *available in* LEXIS, News Library, PAPERS File (quoting President of Population Action International); WORLD POPULATION GROWTH AND RESPONSE 1965-1975: A DECADE OF GLOBAL ACTION 5 (1976) (describing how, in 1962, Sweden made birth control major part of expanding foreign aid program). *See generally* 137 CONG. REC. S6868 (1991) (statement of Senator Wirth) (discussing United States and international funding for population stabilization); Rebecca J. Cook, *United States Population Policy, Sex Discrimination and Principles of Equality Under International Law*, 20 N.Y.U. J. INT'L L. & POL. 93 (1987) (discussing international health care needs and United States policy).

[19] Susan Davis is the Executive Director of the Women's Environment and Development Organization. *See* Susan Davis, *WEDO and the Public Advocacy Agenda in Creating Sustainable Human Development*, 69 ST. JOHN'S L. REV. 179 (1995).

A second problem related to the reality of reproductive health care is that women's bodies have been regarded as a battleground. Population programs have been narrowly focused almost exclusively on contraceptive delivery and "victory" is often determined by measuring fertility rates. This obsession with fertility rates has had a profound effect upon women's general health status.[20] Family-planning programs have not dealt with the larger issues of women's health. Thus, a woman might have access to the pill, yet she may be suffering from anemia, STDs, or other reproductive health problems.

There are obviously many measures that governments can utilize to improve women's reproductive health. A fundamental shift would be for governments to commit themselves to the empowerment of women. Increased budgetary resources must be committed to improving the status of women. Governments should enact laws and policies that improve the economic independence, educational and training opportunities, and the social status of women. A key aspect of this holistic view of women's lives is the provision of health services which meet the health needs of women.

Governments are only beginning to regard women's lives and needs in a holistic manner. They are gradually becoming involved in the provision of a broader range of reproductive health services. Unfortunately, most of these attempts are still in their infancy.[21] The creation of the

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[20] *See* Rebecca J. Cook, *State Responsibility for Violations of Women's Human Rights*, 7 HARV. HUM. RTS. J. 125, 157 (1994). The African practice of female genital mutilation threatens women's lives and longevity and denies them their personal liberty and security. *Id.*; Catharine A. MacKinnon, *Crimes of War, Crimes of Peace*, 4 UCLA WOMEN'S L.J. 59, 74 n.42 (1993) (explaining how China uses forced abortions and sterilization as means of population control); *see* Note, *What's Culture Got to Do with It? Excising the Harmful Tradition of Female Circumcision*, 106 HARV. L. REV. 1944, 1950-51 (1993). Responses from adherents to the practice of female genital mutilation are at odds with the medical reality against the practice. *Id.* Medical reports "confirm that circumcision often causes infertility and is even more dangerous during pregnancy," when the procedure is usually performed. *Id.*

[21] *See* Pamela Goldberg & Nancy Kelly, *Recent Developments: International Human Rights and Violence Against Women*, 6 HARV. HUM. RTS. J. 195 (1993) (highlighting efforts of intergovernmental organizations, nongovernmental organizations and activists to help women through human rights doctrine and practice). The principal international document which addresses women's human rights is the Convention on the Elimination of All Forms of Discrimination Against Women, adopted by the United Nations in 1979. *Id.* The Convention prohibits discriminatory acts by states and requires affirmative steps to be taken in order to eliminate social, cultural, and political discrimination against women. *Id.* However, not every country has ratified it and many of the countries that did have limited their obligations under the Women's Convention. *Id.* In September 1995 the "Fourth World Conference on Women: Action for Equality, Development and Peace" is to be held in Beijing, China. *Id.* The purpose of the conference is to "review and appraise the advancement of women since 1985 in terms of the

political will to improve women's health by funding broad reproductive health services would be a milestone. Rather than simply seeking to control women's fertility, policies should enable women to manage their own fertility, to enjoy healthy and satisfying sexual lives, and to bear children as, and when, they desire.[22] More specifically, a reproductive health delivery program that focuses on all services related to pregnancy (prenatal and postnatal care as well as safe delivery), STD prevention, gynecological care, sexuality information, and health counseling, is desirable.[23]

The problems associated with reproductive health care have several human rights implications. Not only does a virtually exclusive focus on contraceptive services violate the right to reproductive health care set forth in various international instruments such as the Women's Convention and the International Convention on Economic, Social and Cultural Rights, but its consequences also violate more traditional civil and political human rights. Given the drive to control women's fertility, it is not surprising that many family-planning programs have been marred by coercion. Claims of outright coercion, including forced sterilizations, have been made in both India and China.[24] Such allegations have called international attention to the need to respect the human rights of family planning clients and to recognize violations of reproductive rights as international human rights problems.[25] Similarly, there are claims that clients' rights to informed

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objectives of the Nairobi . . . strategies and to mobilize women and men at the policy-making and grassroots levels." Goldberg & Kelly, *supra*, at 203-04. This conference will provide a forum for women's advocates to share concerns and develop strategies. *Id.* at 204. Many programs in the United States confront human rights abuses against women in this country and advocate asylum for victims in other countries. *Id.* at 206-07.

[22] *See* Germain et al., *supra* note 11, at 30.

[23] *Id.*

[24] *See* Barbara Crossette, *A Third-World Effort on Family Planning*, N.Y. TIMES, Sept. 7, 1994, at A8 (noting lack of family planning choices in India, where poor Indian women are forced to undergo sterilization in assembly-line fashion); Christian Van Schayk, *United States Should Heighten Involvement with China*, ST. PETERSBURG TIMES, Aug. 10, 1993, City Times at 2 (discussing United States' objections to China's policies). Objections have centered around China's lack of democracy and its population control policy. *Id.* Families are limited to one child and are ostracized if they do not comply. *Id.* Reports of forced sterilizations and abortions continue to surface, although Chinese guides insist the practices no longer take place. *Id.*; *see also* MacKinnon, *supra* note 20, at 74 n.42 ("They admit, however, that punishment is rare and have yet to provide documentation for any punishments.").

[25] *See Political Asylum for Persecuted*, ATLANTA J. & CONST., Apr. 2, 1994, at A14 (taking position that, due to human rights abuses in many countries, including forced sterilizations and abortions, United Nations and Clinton administration must recognize need for asylum for many refugees of such abuses). "[G]radually, around the world, the silence is lifting. Today a growing number of women and human rights groups are demanding that gender-based persecution be

consent are also being violated. The *Norplant®* [26] case is illustrative of this point. There has recently been a global trend toward promoting long-acting contraceptives, although many nations do not possess the necessary medical infrastructure for the safe delivery of such contraceptives. This issue has also arisen in the U.S., with respect to promoting *Norplant®* among Native American women without adequate testing to determine whether it would actually be useful for those women.[27] There are serious questions as to whether women have had the opportunity to choose these methods freely and responsibly.

It is difficult, if not impossible, to identify a particular country where a woman's human right to reproductive health care has been consistently respected.[28] This violation and denial of rights is a universal phenome-

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recognized as a violation of human rights and grounds for political asylum." *Id.* Goldberg & Kelly, *supra* note 21, gives an overview of the many national and international programs and policies that have been implemented in reaction to human rights abuses against women. Human rights groups have provided better documentation to accompany reports of gender-related abuses. *Id.* at 204-05. Local groups have become increasingly involved in directing attention to abuses against women in their home countries by devising strategies to monitor such abuses, protecting the victims of such abuses, and supporting United Nations programs to eliminate discrimination against women. *Id.* at 204. Increased advocacy placed on asylum cases has emphasized the need to ease standards for women who are victims of human rights abuses in other countries, seeking asylum in the United States. *Id.* at 205.

[26] *See* Karin Winegar, *Norplant's Faded Promise; Three Years Ago a New Birth-Control Method Sounded Almost Too Good; Maybe It Was*, STAR TRIBUNE, Sept. 18, 1994, at 1A. *Norplant®* was seen as a safe and easy birth control method three years ago. *Id.* Today, lawsuits have been filed across the country by unhappy users who claim the contraceptive is unsafe and causes serious side effects. *Id. Norplant®* involves the implantation of six matchstick-sized silicone rods under the skin of the upper arm which release progestin, a synthetic steroid hormone. Insertion takes approximately fifteen to twenty minutes under local anesthesia and is designed to last five years. *Id.* It costs $450 to $700 in the United States and less than $25 in southern countries. *Norplant®* was developed to be sold in southern countries at a low cost. *Id.*

[27] *See* Winegar, *supra* note 26, at 1A. In 1992 in South Dakota, the Native American's Women's Health Education Resource Center produced a report, "The Impact of Norplant in the Native American Community" that charged The Indian Health Service with recklessly promoting the device to women whose health makes them unsuitable for the implant, without a system of informed consent, monitoring, or guidelines for removal. *Id.* The director of the Center claims to have heard from dozens of Native American women who were never fully informed about the side effects of *Norplant®*. *Id.*; *see* Sally Jacobs, *Norplant Draws Concerns Over Risks, Coercion*, BOSTON GLOBE, Dec. 21, 1992, National/Foreign, at 1.

[28] *See* Cook, *supra* note 20, at 157 (stating that outrages against women occur where women are valued for their chastity and manageability while denied access to effective means of birth spacing and fertility control); Goldberg & Kelly, *supra* note 21 (noting that abuses of women cut across cultural and economic lines, leaving international, national, and local programs to fight such abuses); Nancy Kelly, *Gender-Related Persecution: Assessing the Asylum Claims of Women*, 26 CORNELL INT'L L.J. 625 (1993) (advocating asylum for women subject to human rights abuses in countries such as China where women are forced to limit their family to one child and use sterilization as means of birth control); MacKinnon, *supra* note 20, at n.42 (discussing forced

non. Not only is women's right to informed consent[29] constantly being violated, but women's right to health and other human rights remains unfulfilled. Although numerous human rights treaties exist, they are not being implemented. Current family-planning programs are extremely limited and in need of reform. Not only do we need to expand the range of services available to women, but we must view women's health holistically. Programs associated with coercion or motivated by the promotion of, or disincentive to use, specific contraceptives do not promote choice or informed consent. The right to reproductive self-determination

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abortions and sterilizations in China); *see also Convention on the Elimination of All Forms of Discrimination Against Women: Hearing Before the Senate Foreign Relations Comm.*, 103d Cong., 2d Sess. 20-32 (1995) (statement of Robert F. Drinan, S.J., on behalf of the American Bar Association). Drinan's testimony encouraged ratification of the Women's Convention by the United States. He pointed out that at the Human Rights Conference in Vienna, Secretary of State Warren Christopher stated that the Administration was prepared to approve the Women's Convention, as well as other human rights treaties. *Id.* at 20. Though human rights abuses against women are an international problem, "gender-based discrimination remains an all too common experience for women in the United States." *Id.* at 22. Drinan called for ratification of the Women's Convention as necessary to end the discrimination that still exists against women in this country. *Id. But see* Crossette, *supra* note 24, at A8. Crossette discusses "Partners in Population and Development, A South-South Initiative," a partnership of ten "developing" countries such as Columbia and Indonesia, that claim to offer the widest possible range of options to women, but that do not allow abortions. *Id.* Experts say that birth control most often fails in countries where there are a lack of family planning choices. *Id.* An example cited is India, where many women are forced into sterilization. *Id.*

[29] Informed consent is a principle of law which requires that a physician disclose the full range of risks and all available alternatives to a patient regarding a particular course of treatment. Janet F. Ginzberg, Note, *Compulsory Contraception as a Condition of Probation: The Use and Abuse of Norplant*, 58 BROOK. L. REV. 979, 1003 (1992) (questioning compulsory contraception as violation of informed consent). In the United States, a person's right to control medical treatment is rooted in the Constitution; "the root premise [in the doctrine of informed consent] is the concept, fundamental in American jurisprudence, that [e]very human being of adult years and sound mind has a right to determine what shall be done with his [or her] own body . . . ." Paula Berg, *Toward First Amendment Theory of Doctor-Patient Discourse and the Right to Receive Unbiased Medical Advice*, 74 B.U. L. REV. 201, 221 n.111 (1994) (quoting Cantebury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972)). Informed consent statutes serve the purpose of informing patients about risks and options without advancing a particular viewpoint or allowing excessive government involvement in doctor-patient relationships. Berg, *supra*, at 264 n.303. The scope of information to which every patient is entitled includes "everything that the patient reasonably would consider relevant to her decision to undergo treatment." Stacey L. Arthur, *The Norplant Prescription: Birth Control, Woman Control or Crime Control?*, 40 UCLA L. REV. 1, 94 (1992). Informed consent is "critical to a woman's ability to select the method of birth control most appropriate for her." *Id.* It is suggested that physicians should be required to inform patients of the benefits, risks, alternatives and all major information regarding the contemplated method of contraception. *Id.* It is most important that a person have the ability to refuse or discontinue treatment at any time. *Id.* For a recent discussion on the necessity of the informed consent requirement in health care, see Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899 (1994).

has been attacked by the far-right wing, including the unholy alliances formed at the International Conference on Population and Development. This right is fundamental to women's control over their lives.[30] Women must continue to strive to achieve such rights.

CONCLUSION: TOWARDS ACCOUNTABILITY FOR REPRODUCTIVE HEALTH

When considering accountability, the central inquiry is: How can governments be forced to deal with these very concrete problems that millions of women around the world face? Obviously, these are enormous problems—and not just within the reproductive-rights framework, but in all human rights areas. The first issue that must be considered relates to the human rights standard by which to hold governments and other players accountable for their actions. This important determination necessitates inquiries regarding the definition of the right to health care, assessments of women's enjoyment of this human right, and the progress made in this field.

One method by which to assess whether women's right of access to reproductive health care is being met is to analyze socio-economic indicators. Socio-economic indicators are often equated with statistics such as maternal mortality rates (which vary widely in the world from forty-five per one hundred thousand in the United States to ten times that in other countries).[31] Other traditional indicators include literacy rates, life expectancy rates, and women's educational status.[32] Many other economic indicators can be employed to determine whether progress is being made

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[30] Cairo Conference on Population & Development. *See, e.g.*, *Women Tell Conference Abortion Is Their Right; Activists Testifying at Cairo Meeting, Demanding "Reproductive Choice,"* S.F. EXAMINER, Sept. 6, 1994, at A1.

[31] *See Selected Indicators of Life Expectancy, Child-bearing and Mortality*, 1990-91 U.N. STAT. Y.B. 162-69.

[32] *See Illiterate Population by Sex*, 1990-91 U.N. STAT. Y.B. 81-138, 139-45, 146-61, U.N. Sales No. E/F.93.XVII.1; Cass R. Sunstein, *Well-Being and the State*, 107 HARV. L. REV. 1303 (1994). Existing measures of well-being in the United States include: unemployment rate, poverty level, consumer price index, average weekly earnings, income distribution, costs and benefits of government regulation, and subjection to violent crime. *Id.* at 1311-19. The problem is that there is no effort to come up with a composite figure or to provide indications of changes over time. *Id.* at 1319. The United Nations is the best international effort to measure well-being, compiling the Human Development Report which provides statistical comparisons for 173 countries on life expectancy rates, adult literacy rates, years of education attained, and a myriad of other statistics. *Id.* at 1319-23. It should be a priority for domestic and international agencies to compile accurate information on quality of life and to disseminate such information. *Id.* at 1323-24. Only in this way can we focus public and private attention on problems and develop policies and programs which strive toward reform. *Id.* at 1324-25.

with respect to the right to reproductive health care. Such indicators may be difficult to obtain given that most nations do not disaggregate such information by gender, age, or race.

Accountability for abuses in the specific context of service delivery can be furthered by implementing human rights standards. It is essential that the focus of services be on quality of care, including counseling that will enable women to exercise choice. Hence, for example, providers should be concerned with enabling women to make choices rather than with contraceptive prevalence rates, how many contraceptive acceptors they have gained, or how many women are taking *Norplant®* or other long-acting methods of contraception.

One of the major stumbling blocks to the achievement of women's rights is the lack of political will. Advocates of human and reproductive rights have the difficult task of forcing governments to respect women. Governments must understand that women are not merely a means to an end, whether that end be economic growth, the reduction of fertility, or the creation of an ideal nation. Governments must realize that the empowerment of women is an ultimate goal. It would indeed be a better world if women were equal partners with men. The movement for women's reproductive rights seeks not to reduce women to wombs or to reproductive machines. Rather, it seeks universal recognition of women as human beings endowed with basic rights.