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Table of Abbreviations

American Convention	American Convention on Human Rights
Banjul Charter	African Charter on Human and Peoples' Rights
Beijing Conference	1995 UN Fourth World Conference on Women
Beijing Platform for Action	Beijing Declaration and Platform for Action
CEDAW	Committee on the Elimination of Discrimination Against Women
Children's Rights Convention	Convention on the Rights of the Child
Civil and Political Rights Covenant	International Covenant on Civil and Political Rights
CRC	Committee on the Rights of the Child
CRLP	Center for Reproductive Law & Policy
EC	Emergency Contraception
Economic, Social and Cultural Rights Covenant	International Covenant on Economic, Social and Cultural Rights
European Convention	European Convention for the Protection of Human Rights and Fundamental Freedoms
FC/FGM	Female Circumcision/Female Genital Mutilation
ICPD	1994 UN International Conference on Population and Development
ICPD Programme of Action	International Conference on Population and Development Programme of Action
NGOs	Non-governmental Organizations
Rome Treaty	Rome Statute of the International Criminal Court
Special Rapporteur on Violence	United Nations Special Rapporteur on Violence Against Women
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
Universal Declaration	Universal Declaration of Human Rights
WHO	World Health Organization
Women's Convention	Convention on the Elimination of All Forms of Discrimination Against Women

Introduction

"[R]eproductive rights embrace certain human rights that are already recognized in national laws, international laws and international human rights documents and other consensus documents. These rights 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. It also includes the right to make decisions regarding reproduction free of discrimination, coercion and violence, as expressed in human rights documents."

Beijing Platform for Action, para. 95.¹

I. Moving Forward

In 1995, government delegates from 189 countries gathered in Beijing at the United Nations Fourth World Conference on Women (Beijing Conference) to discuss the status of women worldwide and adopt a program for future action. Five years after this historic meeting, the international community has gathered once again to assess the progress made and the challenges that lie ahead. This review process would be incomplete without a close look at the state of women's reproductive rights² in the year 2000. Only where women have the reproductive health care they need and autonomy in reproductive decision-making may they fully participate in all spheres of society.

Building on the momentum of the International Conference on Population and Development (ICPD) in 1994, the first global conference to take a broad view of women's sexual and reproductive rights, the Beijing Conference confirmed the centrality of reproductive rights in advancing the status of women. The last five years have seen expanded governmental action to improve women's reproductive health and promote their rights. Much work lies ahead, however, to ensure women's full enjoyment of their sexual and reproductive rights. With the new millennium upon us, we should take this opportunity to consider how recent positive developments can be replicated elsewhere to shape a future in which reproductive rights are recognized worldwide as basic human rights.

This publication is intended to provide an overview of the state of women's reproductive rights. While not attempting to be comprehensive, it looks at eight critical areas that impact these rights, with a focus on legal and policy developments since 1995. It also examines some of the obstacles to women's full enjoyment of reproductive rights. Laws and policies are examined in the following areas:

- population, reproductive health, and family planning;
- contraception, including emergency contraception;
- abortion;
- HIV/AIDS and other sexually transmitted infections;
- harmful traditional practices affecting reproductive health, including female circumcision/female genital mutilation (FC/FGM);
- rape and other sexual violence;
- marriage and family law; and
- reproductive rights of adolescents.

Before approaching these topics, however, it is important to look more broadly at reproductive rights and the manner in which they have been defined in legal documents and other influential instruments. This introduction will briefly discuss what is meant by “reproductive rights” and describe the history of their increasing recognition within the international community. It will also address the manner in which laws and policies can be employed to advance reproductive rights, as well as the limitations of these forms of governmental action.

A. What are reproductive rights?

Reproductive rights are firmly rooted in the most basic human rights principles. The interests that are protected by these rights are diverse. Broadly speaking, however, reproductive rights encompass two principles: the right to reproductive health care and the right to reproductive self-determination.

1. The right to reproductive health care

Reproductive health is a fundamental aspect of women’s well-being. Without regular access to safe, high-quality services, women become vulnerable to a host of health complications, which may include death or injury during childbirth, unwanted pregnancy, and sexually transmitted infections (STIs). The right to reproductive health care thus gives rise to a governmental duty both to ensure the availability of reproductive health services and to remove existing legal barriers to reproductive health care. Comprehensive reproductive health care should include measures to promote safe motherhood, care for those with HIV/AIDS and other STIs, abortion, infertility treatments, and a full range of quality contraception (including emergency contraception).

The right to reproductive health care is rooted in the provisions of international human rights instruments protecting life and health. The right to life is protected in most of the principal human rights instruments, including the Universal Declaration of Human Rights (Universal Declaration) and the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant).³ The right to life has traditionally been read to protect individuals from arbitrary execution by the state. More recently, the Human Rights Committee, the body that oversees compliance with the Civil and Political Rights Covenant, has interpreted this right to require governments to adopt “positive measures” aimed at preserving life, such as steps to “reduce infant mortality and to increase life expectancy. . . .”⁴

The right to health is recognized in Article 12 of the International Covenant on Economic, Social and Cultural Rights (Economic and Social Rights Covenant), which requires states to “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁵ The World Health Organization (WHO) has defined health as “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity.”⁶ Echoing the WHO definition of health, the ICPD Programme of Action defines “reproductive health” as total well-being “in all matters relating to the reproductive system and its functions and processes.”⁷ While the right to health does not guarantee perfect health for all people, it does encompass a governmental duty to ensure health care. The Economic and Social Rights Covenant requires states to create “conditions which would ensure to all medical services and medical attention in the event of sickness.”⁸

An obligation to provide reproductive health services, in particular, has support in principles of non-discrimination. States are bound to ensure the rights to life and health without discrimination on the basis of sex.⁹ To ensure equal enjoyment of the rights to life and health, states must take into account the particular health needs of both women and men. Because reproductive health care is fundamental to women's well-being, states must take affirmative measures to ensure that reproductive health care is available and accessible to all women. This principle is explicitly recognized in the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention), which provides that States Parties must take "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."¹⁰ The Committee on the Elimination of Discrimination Against Women (CEDAW), the United Nations (UN) body that monitors compliance with the Women's Convention, has addressed governmental obligations pertaining to reproductive health care. In its General Recommendation on Women and Health (Recommendation on Health), it declares that States Parties should "ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services."¹¹

Governments are also bound to remove legal barriers to reproductive health care. In its Recommendation on Health, CEDAW has stated: ". . . barriers to women's access to appropriate health care include laws that criminalize medical procedures only needed by women and that punish women who undergo these procedures."¹² Among such legal barriers to reproductive health are laws that prohibit abortion, restrict advertising of contraception, require a spouse's consent to obtain contraception, and criminalize voluntary sterilization.

2. The right to reproductive self-determination

The right to reproductive self-determination has support in the right to plan one's family, the right to freedom from interference in reproductive decision-making, and the right to be free from all forms of violence and coercion that affect a woman's sexual or reproductive life.

The right to plan one's family has been defined in international instruments as the right to determine "freely and responsibly" the number and spacing of one's children and to have the information and means that are necessary to do so. As will be discussed below, this principle has been affirmed in numerous consensus documents adopted at UN conferences throughout the last three decades and was given legal force in the Women's Convention. The right to plan one's family gives rise to a governmental duty to ensure that men and women have equal access to a full range of contraceptive choices and reproductive health services and that they have information about sexual and reproductive health.

The right to freedom from interference in reproductive decision-making relates to broader principles of bodily autonomy, often referred to as the right to physical integrity. This principle has roots in the right to respect for human dignity, the rights to liberty and security of the person, and the right to privacy.¹³ It is explicitly protected in Article 4 of the African Charter of Human and People's Rights (Banjul Charter) and Article 5(1) of the American Convention on Human Rights (American Convention).¹⁴ The right to physical integrity protects women from unwanted invasion or intrusion of their bodies and other non-consensual restrictions on women's physical autonomy. Denying a woman the option of avoiding pregnancy or childbirth, for example, interferes with her right to decide on a matter with tremendous implications for her body and personal liberty.

Reproductive self-determination also implies the right to be free from all forms of violence and coercion that affect a woman's sexual or reproductive life. The ICPD Programme of Action states that women are entitled to "make decisions concerning reproduction free of discrimination, coercion and violence."¹⁵ As noted by the UN General Assembly, in its Declaration on the Elimination of Violence Against Women, "violence against women" encompasses gender-based violence that results in sexual harm.¹⁶ Violence is often directed specifically at a woman's sexual or reproductive capacity. Rape and other forms of sexual violence, FC/FGM, and forced or coercive sterilization are examples of the types of violence that infringe upon reproductive self-determination.

II. History of Reproductive Rights in the International Arena

Clearly, reproductive rights are grounded in some of the longest-recognized human rights, but the explicit international recognition of women's right to make choices in matters of reproduction can be traced to the late 1960s. In 1968, the participants of the First International Conference on Human Rights, held in Teheran, recognized that "[p]arents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information to do so."¹⁷ This right was reaffirmed several times over the following two decades, and by 1984 at the International Conference on Population (ICP) in Mexico City, the right had been reformulated to proclaim that "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"¹⁸

As noted above, a variant of this right is recognized in the Women's Convention, which was adopted in 1979, during the United Nations Decade for Women (1976-1985). Article 16(1)(e) provides 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."¹⁹ Ratified by 165 countries,²⁰ the Women's Convention provides the strongest legal support for the right to reproductive health and choice. In addition to guaranteeing equality in the freedom to determine family size, the Women's Convention guarantees non-discrimination in access to health care, including information and advice on family planning.²¹

In 1992, the United Nations Conference on Environment and Development held in Rio de Janeiro reiterated, in its Agenda²¹, the right to decide on the number and spacing of one's children.²² It further affirmed that governments should provide health facilities, including "affordable, accessible services, as appropriate for the responsible planning of family size."²³ In 1993, at the World Conference on Human Rights held in Vienna, governments recognized "on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels."²⁴

A major turning point was reached in 1994 at the ICPD held in Cairo. The ICPD Programme of Action noted for the first time that "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."²⁵ Not only does it reiterate the right to determine the number and spacing of children, it further posits that reproductive rights include the "right to attain the highest standard of sexual and reproductive health" and the right "to make decisions concerning reproduction free of discrimination, coercion and

violence, as expressed in human rights documents”²⁶ The ICPD Programme of Action is unprecedented in its broad understanding of “reproductive health.” Paragraph 7.2 provides:

*Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*²⁷

This paragraph goes on to define “reproductive health care” as the “constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.”²⁸ It specifically notes that reproductive health care should promote sexual health in order to enhance “life and personal relations.”²⁹ Consistent with its broad view of reproductive health, the ICPD Programme of Action directs states to address gender inequities that impede reproductive health, including “discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives.”³⁰

In 1995, the Beijing Conference produced two documents — known as the Beijing Declaration and the Beijing Platform for Action — that reaffirm the principles adopted in Cairo. The Beijing Platform replicates the key language from the ICPD Programme of Action discussed above, but it goes further by recognizing women’s right to control their own sexuality and sexual relations and to decide upon these matters on an equal basis with men.³¹

Since 1995, the international community has expanded its recognition of reproductive rights under international law and reaffirmed its commitment to the declarations made at international conferences. The Rome Statute of the International Criminal Court (Rome Treaty), a treaty adopted in July 1998 to create a permanent International Criminal Court (ICC)³² to investigate and punish genocide, crimes against humanity, and war crimes, reflects the international community’s growing recognition that reproductive rights are indeed protected human rights.³³ The treaty recognizes that rape and other forms of sexual violence are among the most serious crimes under international humanitarian law.³⁴ The ICC will become operational after 60 states ratify the Rome Treaty.³⁵ As of April 2000, the treaty has been ratified by eight countries.³⁶

In July 1999, a year after the adoption of the Rome Treaty, the international community gathered again to negotiate a document with important implications for reproductive rights. This meeting was a five-year review of the 1994 ICPD and the Programme of Action agreed upon at that conference. While the review process was fraught with conflict, the document adopted³⁷ is an important affirmation of the principles agreed to in 1994. It also contains crucial strategies for advancing reproductive rights.³⁸ The promotion of reproductive rights remains firmly on the international agenda.

III. The Role of Laws and Policies in Advancing Reproductive Rights

The successes in gaining international recognition of women's reproductive rights have been accompanied by a major challenge: how can women give these declarations meaning in their own lives? They can begin by working toward the adoption of laws and policies reflecting the principles of these international agreements. Laws and policies create the framework through which governments affect the behavior of people. Where law is uniformly respected and enforced, it can directly influence people's actions and enhance government accountability. Law can also have a moral force and shape people's understanding of equity and justice.

It is important to bear in mind, however, that the degree to which laws and policies influence people's lives depends upon whether these measures are implemented and enforced. For example, laws intended to ensure informed consent and quality of care in reproductive health facilities have little weight where there is no government commitment to training health care workers to respect reproductive rights. Similarly, laws ensuring free access to reproductive health care services, such as abortion, can only be implemented where there is an investment in facilities that are equipped and authorized to perform these procedures. Nonetheless, formal laws and policies are crucial indicators of government commitment to promoting women's reproductive rights. The following chapters examine the global commitment to improving women's reproductive lives by reviewing legislative and policy initiatives in key areas.

Chapter 1

POPULATION, REPRODUCTIVE HEALTH, AND FAMILY PLANNING POLICIES

“ . . . Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.”

Beijing Platform for Action, para. 92.³⁹

“Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take 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 the number and spacing of their children and to have the information, education and means to do so.”

ICPD Programme of Action, Principle 8.⁴⁰

I. Introduction

Reproductive health and rights are often addressed in a country's health policy, its population policy, or both. In addition to stating the government's broad objectives on health or population, these policies often provide the framework for the delivery of reproductive health care. This chapter examines the link between reproductive rights and health and population policies. It then examines some characteristics of population and reproductive health laws and policies, and provides examples of developments since 1995. The chapter concludes with recommendations emphasizing the need for population and reproductive health laws and policies that comprehensively address women's reproductive and sexual health needs and encompass a rights-based approach to the provision of all health services.

II. Linking Population with Reproductive Health and Rights

At the ICPD in 1994, countries agreed that the advancement and protection of women's human rights should be central to governmental efforts to address population and development issues.⁴¹ The resultant ICPD Programme of Action focused unprecedented attention on gender equality, equity, and women's empowerment. It expressed the progressive view that “[t]he empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself.”⁴²

Thus, the ICPD Programme of Action took the ground-breaking step of explicitly affirming that women's reproductive rights “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 on “the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents.”⁴³ The provision went further in declaring that “[t]he promotion of the responsible exercise of these rights for all people should be the fundamental basis for gov-

ernment- and community-supported policies and programmes in the area of reproductive health, including family planning."⁴⁴ The ICPD Programme of Action also affirmed that coercive practices in the provision of family planning services constitute a violation of reproductive rights and should be eliminated.⁴⁵

In light of the ICPD consensus and their obligations under numerous other international human rights instruments, governments have a duty to implement a comprehensive national strategy to promote women's right to health, including their reproductive health. Article 12 of the Women's Convention requires that States Parties eliminate discrimination against women in the field of health care in order to promote equal access to health care services. The Beijing Platform for Action reinforced these principles by calling on governments to "increase women's access throughout the life cycle to appropriate, affordable and quality health care, information and related services" and requiring that governments take all appropriate measures to "promote, research and disseminate information on women's health."⁴⁶

An important legacy of the ICPD Programme of Action, as well as the Beijing Platform for Action, is international recognition of the principle that laws and policies related to population and reproductive health should cease prioritizing solely the provision of contraception. Instead, these policies should deal comprehensively with women's broad reproductive health care needs, including:

- family planning counseling, information, and education;
- prenatal care, safe delivery, and postnatal care services and education;
- prevention and appropriate treatment of infertility;
- prevention and management of the consequences of abortion;
- abortion services, where legal;
- treatment of reproductive tract infections, HIV/AIDS and other STIs, and breast cancer;
- active discouragement of FC/FGM and other harmful traditional practices; and
- education and information on human sexuality and responsible parenthood.⁴⁷

Because international human rights norms set out broad principles rather than defining the precise content of laws and policies needed to implement those norms, one of governments' great challenges is to develop appropriate legislation and policies on population and reproductive health that promote and protect human rights.

III. Characteristics and Coverage of Population, Reproductive Health, and Family Planning Laws and Policies

A. The nature of policies

Most countries address population, reproductive health, and family planning through national policies issued by the executive branch of government. Because most systems of government enable the executive branch to promulgate policies without legislative involvement, it is often preferable from the executive's perspective to regulate these issues itself rather than work with the legislature to agree on the content of legislation. One drawback to this approach to policymaking is that policies may be replaced when governments change, creating the potential for instability in the manner in which health care services are provided. It is important, therefore, to ensure that national priori-

ties and respect for human rights are protected by law. Legal guarantees provide a nation's people with greater certainty regarding their rights and enhance their ability to exercise and enforce such rights.

Another issue that arises from executive action on issues of population and reproductive health is that when existing laws are not amended to conform to new policies, the resulting inconsistency can create uncertainty. For example, **Benin's** Penal Code prohibits the dissemination of "propaganda" on contraception. This law, inherited from France where it was adopted in 1920, remains in effect in Benin despite the current government's policy of permitting the dissemination of information on contraception.⁴⁸ Such discrepancies tend to curtail the free and open flow of accurate information on contraception.

B. Health policies

Health policies often outline the infrastructure of the country's public health system, the cost and coverage of health services, and the manner in which health care providers are regulated. For example, the health policy of **Tanzania** establishes the infrastructure of health care facilities, requiring that facilities include village health posts, dispensary services, health care centers, district hospitals, regional hospitals, and referral/consultant hospitals.⁴⁹ The health policy also determines the distribution of these facilities, as well as the kinds of buildings that should house each facility, the medical equipment each should have, and how many health care workers are needed at each site. In many countries, despite a high degree of government involvement, the health service infrastructure remains extremely inadequate.

Similarly, health policies often dictate the cost of government-provided health services. This includes mandating the sources of funding for the national health system. Health policies also determine which services are to be provided free of charge and to whom, or how much certain health services are to cost. Some countries regulate the cost of health care services through health care insurance laws. For example, **Poland's** Law on Health Insurance entitles every insured person to use the public health system at no cost.⁵⁰ As of January 1999, every employed citizen was required to pay 7.5% of his or her income into the health insurance funds to finance the system. Unemployed people must register officially at the Bureau of Unemployment and Social Welfare Centers. Family members are covered as dependents.⁵¹ Under this system, almost 97% of the population are entitled to free medical care.⁵²

C. Population and family planning policies

1. Policy goals

Reproductive health and family planning are often addressed in population policies. Because they are concerned principally with increasing or decreasing population-growth rates, population policies may not necessarily focus on the rights of women to comprehensive reproductive health care and to autonomy in reproductive decision-making. In countries in which population stabilization is a primary concern, such policies may seek to achieve quantitative objectives, such as extending long-term contraceptive methods to a greater percentage of women, reducing birth rates, and reducing the number of children a woman bears over her lifetime. These policies may not mandate respect for human rights in their implementation.

For example, **Indonesia's** 1992 Law on Population Development and Prosperous Family, explicitly lists "control of the quantity of the people" as one of its objectives.⁵³ The law regulates the advertising, sale, and distribution of contraceptives with the purpose of creating a "small, happy, and prosperous family," but fails to provide for improved comprehensive reproductive health services, counseling, or education.⁵⁴ **Jamaica's** population policy states that one of its objectives is to ensure that the population does not exceed the number of persons who can be satisfactorily supported by the nation.⁵⁵ The population policy specifically aims to restrict population growth to a maximum of 0.8% per annum over the next three decades.⁵⁶

In contrast, in some countries where there has been a substantial decline in population growth in recent years, population policies may encompass pro-natalist approaches to reproductive health and family planning. In **Croatia**, for example, the National Program for Demographic Development for the Republic of Croatia was adopted in 1995 to promote the demographic renewal of Croatia in response to "depopulation" and the "failure" of women to sufficiently reproduce.⁵⁷ The Program defines measures to increase the number of newborns while decreasing the number of emigrants; it also seeks to add to the number of Croatians returning from diaspora, and better distribute the Croatian population over its entire territory.⁵⁸

2. Aspects of implementation

Population policies also contain implementation strategies, which may impact women's access to reproductive health care. For example, in **Ethiopia**, the country's implementation strategy includes expanding contraceptive distribution, promoting breast-feeding as a means of birth-spacing, and integrating women into the "modern" sector of the economy.⁵⁹ Ethiopia's strategy also involves amending all laws "impeding, in any way, the access of women to all social, economic, and cultural resources" and amending relevant laws to remove unnecessary restrictions on the "advertisement, propagation and popularization of diverse contraception control methods."⁶⁰

Population policies often contain provisions on governmental delivery of family planning services. These provisions mandate what services are to be provided, in what type of facilities, and at what cost. Governments in a number of countries provide some or all family planning services free of charge. For example, in **Kenya**, the government provides sterilizations and contraceptives, but charges a fee for the removal of long-term contraceptive devices.⁶¹ In **China**, family planning services are provided free of charge and are readily available to both sexes.⁶² However, in reality only women and men who are married have access to free contraceptives.⁶³

Population, reproductive health, and family planning policies often fail to deal with reproductive health needs comprehensively. These policies sometimes address only one aspect of reproductive health, such as the provision of contraception or maternal and child health. The consequence is that women are left vulnerable to such reproductive health problems as unwanted pregnancies, fertility problems, or to STIs, because a policy does not provide for services to address these issues. However, since the adoption of the ICPD Programme of Action, there has been a clear trend among some countries, particularly in the Latin America region, towards meeting women's reproductive and sexual health needs comprehensively.⁶⁴

Another important issue that may be overlooked in population, health, and family planning policies is the issue of clients' right to voluntary, informed choice and consent in the provision of health care

services. Enabling clients to exercise an informed choice is a process aimed at ensuring that clients have access to the information they need and that they fully understand that information. Through this process, a client should be able to make a free and informed decision about whether or not to obtain health services, and which methods or procedures, if any, to receive.⁶⁵ Informed consent is particularly important for medical procedures with permanent effects, such as sterilization. In some countries, government policies and/or health care provider practices have resulted in violations of clients' right to informed consent in the provision of sterilization.⁶⁶

IV. Developments Since 1995

In different regions of the world, examples can be found of attempts to address issues of population, reproductive health, and family planning in a comprehensive manner and with the aim of protecting reproductive rights.

- **Brazil** passed the Family Planning Law in 1996, which prohibits forcing or requiring anyone to practice family planning as a means of demographic control.⁶⁷
- Also in 1996, the Ministry of Health in **Peru** approved the Program on Reproductive Health and Family Planning 1996-2000. Despite progressive provisions recognizing reproductive health as a fundamental human and social right, and notwithstanding the stated objective of "attend[ing] to women's reproductive health in all stages of their lives,"⁶⁸ serious abuses in Peru's reproductive health services were nonetheless uncovered during the period from 1996 to 1998.⁶⁹ The abuses stemmed, at least in part, from the government's imposition of sterilization "targets" and its sponsorship of "sterilization fairs" aimed at increasing the number of individuals using this permanent method of contraception. In large part because of negative publicity, the government ended the sterilization targets and campaigns and enacted a resolution to create a Special Defender of Women's Human Rights within the framework of the Program on Reproductive Health and Family Planning. This official receives complaints of violations of women's right to free and informed choice of contraceptives.⁷⁰
- **Ghana's** Ministry of Health issued the Reproductive Health Service Policy in 1996, which seeks to address directly the provision of reproductive health care. This policy provides for more comprehensive delivery of reproductive health services, focusing not only on the provision of affordable family planning services, but also on the empowerment of women, public education on sexual health matters, and the sensitization of legislative bodies to population issues. The Policy also outlines provisions for safe motherhood, adolescent reproductive health, the prevention and management of unsafe abortion, and reproductive tract infections including STIs and HIV/AIDS.⁷¹

V. Recommendations

- Governments should adopt comprehensive laws or policies that ensure universal access to a full range of high quality and affordable sexual and reproductive health services to all individuals and couples of reproductive age. These services should include family planning and information; prenatal, safe delivery, and postnatal care services and education; prevention and treatment of infertility; safe abortion; treatment of STIs including HIV/AIDS, reproductive tract infections and cancers; and education and information on sexuality through the primary health care system.

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- Population, reproductive health, and family planning policies should ensure the equitable distribution of resources and facilities to implement all aspects of reproductive rights.
 - In regulating population, reproductive health, and family planning, governments must ensure that laws and policies incorporate the principles of free and informed consent and choice, non-coercion, confidentiality, privacy, non-discrimination, and quality of care.⁷²
 - Governments should remove unnecessary legal, medical, clinical, and regulatory obstacles to information on and access to reproductive health services, including family planning.
 - Governments, in collaboration with NGOs, should develop policies and programs aimed at effecting significant reductions in maternal, infant, and child mortality.
 - NGOs should evaluate the content, implementation, and impact of all policies related to population, reproductive health, and family planning to ensure such policies promote, protect, and fulfill women's reproductive rights.

Chapter 2

CONTRACEPTION

“Reproductive health . . . implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition [is] the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law . . .”

Beijing Platform for Action, para 94.⁷³

“. . . All countries should take steps to meet the family-planning needs of their population as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice.”

ICPD Programme of Action, para. 7.16.⁷⁴

I. Introduction

A woman's ability to plan her reproductive life depends upon her having access to the full range of contraceptive methods, provided in a setting in which she may make an informed choice. An estimated 350 million couples worldwide do not have access to the family planning services they need.⁷⁵ In many countries, access to contraception is inhibited by laws, policies, or government inattention to women's reproductive health needs. This chapter provides an overview of the impact of law and policy on a woman's ability to choose a contraceptive method that is right for her. It begins with a review of the international legal support for women's right to access contraception and examines some of the impediments to access that women continue to face. It also considers some instances in which governments have permitted the use of coercive practices to impose contraceptive methods upon women without their informed consent. The chapter reports on some legal and policy developments and technological advances from the last five years and closes with recommendations.

II. The Right to Plan Pregnancy

Women's sexual and reproductive rights include the right to plan their pregnancies. This is a fundamental aspect of reproductive self-determination. The right to determine “freely and responsibly” the number and spacing of one's children and to have the information and education necessary to do so was first articulated by the international community at the International Conference on Human Rights in Teheran in 1968. As noted in the Introduction and Chapter 1, this principle has been reaffirmed in a number of international conferences since then, including the Beijing Conference in 1995. The Women's Convention, adopted in 1979, gave legal force to this principle, providing that states shall ensure men and women “[t]he same rights to decide freely and responsibly on the number and spacing of their children. . . .”⁷⁶ The Women's Convention guarantees access to necessary information and education and entitles women and men to the means to control their family size.⁷⁷

The right to determine the number and spacing of one's children is complemented by the right to family planning, which is recognized explicitly in the Women's Convention. Article 12(1) of that Convention requires states to ensure women and men equal access to "health care services, including those related to family planning."⁷⁸ Article 10(h) further requires states to ensure women and men equal access to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."⁷⁹ CEDAW, in its General Recommendation on Health, calls upon governments to "[p]rioritize the prevention of unwanted pregnancy through family planning and sex education"⁸⁰

Taken together, these provisions require governments to ensure access to a full range of contraceptive methods. A full range of methods includes: condoms, vaginal barrier methods, oral contraceptives, implants, injectables, intrauterine devices, male and female voluntary sterilization, and emergency contraception (EC).⁸¹ In addition, women are entitled to accurate information regarding the risks and benefits of each method.

Respect for women's right to reproductive self-determination also requires governments to ensure that women give their full, informed consent before being given a contraceptive method. Government policies that disregard women's own wishes and life circumstances in order to meet demographic goals may give rise to coercive and violent practices. Subjecting women to surgical sterilization or administering contraceptive injections or implants without women's informed consent, for example, are practices that violate women's core reproductive rights.⁸²

III. Access to Contraception

As noted in Chapter 1, many national governments are involved in the distribution of contraceptives in public health care facilities. In **Mexico**, for example, where the government provides contraceptive services and methods free of charge, public-sector family planning services meet the contraceptive needs of 72% of the population.⁸³ Other countries ensure that access to family planning is available to those who cannot afford to pay for it in the private sector. In the **United States**, under Title X, the federal government provides direct grants to both private and public entities, such as family planning clinics and state health departments, to provide a full range of services, including contraception and education.⁸⁴

In a number of countries, despite policies that provide for full access to contraception, governments are unable to meet the needs of those wishing to plan their families. In **Nigeria**, for example, the National Policy on Population for Development, Unity, Progress and Self-Reliance, adopted in 1988, has the goal of making family planning services easily accessible to all couples and individuals at an affordable cost.⁸⁵ Government family planning clinics provide contraceptives at low cost. However, there is often a shortage of contraceptives at these clinics. In addition, because clinics within the public primary health care system are located mostly in urban areas, the availability of modern contraceptives in rural areas is extremely limited.⁸⁶

IV. Regulation of Contraception

Governments usually regulate contraceptives as they do other pharmaceuticals. Laws and regulations regarding labeling, adulteration of drugs, and approval of new drugs are therefore usually applicable to contraceptive methods. Some countries specifically regulate certain contraceptive methods. For example, in **Kenya**, pursuant to the Pharmacy Act, hormonal contraceptives delivered as oral pills, implants (including NORPLANT[®]), and injectibles (including Depo-Provera[®]) may be

purchased only from a pharmacist with a medical prescription or dispensed by a medical practitioner directly to the client for the purpose of medical treatment.⁸⁷

More commonly, reproductive health, population, and family planning policies contain guidelines or protocols on contraceptive methods and contraindications for their use. In **Peru**, for example, the Manual on Reproductive Health, a manual of procedures and norms for health care providers, regulates the use of EC (see discussion of EC below).⁸⁸ This manual, which is legally binding throughout the country,⁸⁹ provides that EC may be used in cases of unprotected sexual relations, rape, or failure of barrier contraceptive methods.⁹⁰

Some governments place obstacles in the way of women's access to the full range of contraceptive choices. They may regulate certain methods strictly or prohibit them altogether; place limits on advertising or public information about contraception; or limit women's reproductive self-determination by requiring a husband's consent for the use of contraception.

A. More strictly regulated or prohibited methods

One of the most regulated forms of contraception is sterilization. This method of family planning is illegal in some countries. For example, in **Argentina**, sterilization is a crime. The Penal Code defines as a criminal offense the infliction of either a "grave injury" resulting in permanent debilitation of a reproductive organ or limb,⁹¹ or a "very grave injury" resulting in the loss of the capacity to conceive or procreate.⁹² The punishment for such acts is imprisonment for three to fifteen years.⁹³ Despite the law's lack of exceptions, sterilizations are performed on women whose lives would be put at risk by future pregnancy.⁹⁴ Similarly, in **Poland**, sterilization as a method of family planning is illegal. Even with the written consent of the patient, sterilization is considered a criminal injury, which carries a penalty of up to 10 years in prison.⁹⁵ Sterilization is legal only when performed upon "mentally incompetent individuals."⁹⁶ The Penal Code of **Côte d'Ivoire** strictly prohibits sterilization, classifying it as an offense that is punishable by the death penalty.⁹⁷

There has been an effort by conservative forces to regulate strictly and even make illegal the use of EC — including emergency contraceptive pills, minipills, and the copper-T intrauterine device.⁹⁸ These methods are used post-coitally (after intercourse) and may prevent pregnancy by delaying or inhibiting ovulation, by inhibiting fertilization, or by inhibiting implantation of a fertilized egg.⁹⁹

At the recent five-year review of the 1994 International Conference on Population and Development and the Programme of Action (ICPD+5 Conference), EC was the subject of a clash among government delegates during the drafting of the conference consensus document. In a passage advising UN agencies and donors to provide sufficient resources to meet the demand for family planning methods, the United States, the European Union, and other nations sought to insert the phrase "including female-controlled methods such as female condoms and emergency contraception, and underutilized methods such as vasectomy and male condoms."¹⁰⁰ This proposal was strongly resisted by the Holy See and a number of countries, including **Argentina, Libya, Nicaragua, Sudan, and Syria**.¹⁰¹ Representatives from these delegations argued that EC is tantamount to abortion, despite a statement by the WHO explaining that the medical community does not regard EC as an abortifacient because the treatment works prior to implantation.¹⁰² In a final compromise, the passage was left to read "including new options and underutilized methods" — language that surely encompasses EC without naming it explicitly.¹⁰³

B. Limits on advertisement

Some countries around the world place limits on the dissemination of information about contraceptives. For example, in 1986, **Ghana** banned the advertisement of contraceptives in the mass media.¹⁰⁴ The government, however, encourages dissemination of contraceptive information in some settings. Ghana's Reproductive Health Service Policy requires service providers to give clients an array of information and counseling, including that regarding family planning and contraceptives.¹⁰⁵

Similarly, in countries in which the so-called 1920 French Law is in effect, such as **Benin**,¹⁰⁶ contraceptive advertising may be inhibited. As noted in Chapter 1, the 1920 French Law proscribes "incitement" to "the crime of abortion" and the distribution of information or "propaganda" on pregnancy prevention. This law was in force in countries that were formerly subject to French colonial rule, but most repealed it following independence. It is important to note that in Benin, despite this law, the government has stated in its Population Policy its objective to increase contraceptive prevalence.¹⁰⁷ However, the 1920 French Law has been identified as a hindrance to the administration of a comprehensive family planning program.¹⁰⁸ The situation is similar in **Cameroon**. Although the 1920 French Law has been repealed, a 1990 law regulating the practice of pharmacies prohibits "contraceptive propaganda."¹⁰⁹

C. Third-party authorization requirements

Some countries require women to obtain the authorization of a husband or a parent before receiving contraception. In **Chad**, for example, where reversible contraceptive methods — which include barrier and hormonal methods — are considered medications available only with a medical prescription, married women may be given a prescription only with the permission of their spouses.¹¹⁰ Likewise, minors must have the written consent of their parents or guardian.¹¹¹ In **Chile**, a woman must obtain the consent of her spouse in order to be sterilized in public health facilities.¹¹²

V. Violations Indicating Coercion

A woman's right to reproductive self-determination is also violated when methods of controlling her fertility are imposed upon her without her informed consent. Worldwide, there have been a number of cases of violations of women's rights involving coercion in the use of contraception. Where sterilization is a common method of family planning, health care workers may pressure women to undergo sterilization without informing them of the irreversible nature of the operation or of alternative contraceptive methods.¹¹³ For example, as described in Chapter 1, human rights advocates in **Peru** reported that from 1996 to 1998, in response to government-imposed sterilization quotas, many women were subjected to sterilization without their informed consent.¹¹⁴ A number of cases were documented of women who were coerced, deceived, or induced into undergoing sterilization.¹¹⁵ The United Nations Special Rapporteur on Violence against Women (Special Rapporteur on Violence) brought these abuses and others to the attention of the international community in a 1999 report.¹¹⁶

Women also may experience coercion at the hands of health workers who refuse to remove contraceptive devices. For instance, because Norplant® requires surgical insertion and removal, a woman who wishes to have the device removed is fully dependent upon the assistance of health workers. The Special Rapporteur on Violence has reported that among women in **Bangladesh** with Norplant®, only 15% were aware that the implants could be removed upon request.¹¹⁷ Furthermore, some

women who suffered serious side effects and requested removal of the implants were routinely refused.¹¹⁸ Similarly, in the **United States**, the Special Rapporteur on Violence reports that government-funded Medicaid programs that provided Norplant® to African-American women in rural Georgia would pay for the implants but would only remove them for “medical reasons.”¹¹⁹ Women’s complaints of continuous bleeding, headaches, heart palpitations, and hair loss were deemed “inconveniences” rather than medical problems justifying removal of the implants.¹²⁰ To have the implants removed before the end of two years, women had to reimburse the state for the insertion, which cost US \$300.¹²¹

VI. Developments Since 1995

There have been some significant legal and policy developments affecting contraceptive access since 1995.

- In 1999, **Japan** approved the use of oral contraceptives. Prior to that, Japan was the sole member state of the United Nations to prohibit this method of contraception.¹²²
- In **Ethiopia**, a 1998 Proclamation repealed a Penal Code provision prohibiting the advertisement and promotion of contraceptive methods.¹²³
- Worldwide, several countries in recent years have approved explicitly the use of EC, either by licensing drugs for use as EC or by incorporating EC into government-regulated family planning services. **Brazil’s** Ministry of Health, for example, included EC in its family planning program guidelines in 1997.¹²⁴ In 1999, **France** became the first country to permit the sale of EC over-the-counter.¹²⁵ In 2000, similar initiatives have followed in British Columbia, **Canada**¹²⁶ and in **Great Britain**, where a pilot program in Manchester, England making EC available over-the-counter may be implemented nationwide.¹²⁷

In addition to these legal and policy advances, recent technological developments may also serve to widen women’s choices and improve their health.

- Recently, scientists have intensified their work to develop contraceptive technologies to prevent diseases such as AIDS and other STIs, especially those methods that are controlled by women. A new set of methods for women, vaginal microbicides, which are not yet available, are being tested in a number of countries.¹²⁸ Vaginal microbicides, which may be produced as gels, creams, suppositories, film, sponges, and vaginal rings,¹²⁹ may be used without a partner’s knowledge or cooperation.¹³⁰ Early safety trials and focus-group discussions are underway in a number of countries, including **Zimbabwe**.¹³¹
- Another female-controlled contraceptive method, the female condom, has gained wide recognition in recent years. Unlike a diaphragm or an oral contraceptive, no prescription or medical help is necessary for a woman to use the female condom. The woman places it into her vagina manually, and can do so anytime from hours before to immediately prior to sex.¹³² The female condom provides women with another important option to prevent HIV infection and STIs. However, many women who could benefit from the product do not yet have access to it.¹³³ When left entirely to commercial markets, the price of female condoms in the global south is between US \$2 and \$3 per condom.¹³⁴ UNAIDS has been working with the manufacturer of the female condom to increase its availability and affordability in the global south, particularly in sub-Saharan Africa and Southeast Asia.¹³⁵

VII. Recommendations

In countries where restrictive laws or policies related to contraceptives are in force:

- Governments should eliminate restrictions on contraception, including excessive regulation, requirements for third-party authorizations, and prohibitions on the dissemination of information regarding contraceptives;
- NGOs should establish coalitions with legal and medical groups to conduct effective advocacy campaigns for liberalizing restrictive laws or regulations regarding contraceptives; and
- Family planning associations should offer the widest range of methods permitted by law, and should provide accurate information on these methods to users.

In countries where all medically accepted contraceptive methods are legal:

- Governments should ensure access to the full range of contraceptive methods, as well as information on the relative benefits and risks of each method;
- Family planning services should be provided to anyone requiring them, regardless of marital status and age;
- Governments should regulate the quality of contraceptive methods and implement appropriate safeguards for efficacy, safety, and full, informed consent by the users;
- NGOs should work to ensure that accurate information is available regarding all contraceptive methods and that contraceptive use occurs with full and informed consent; and
- Family planning associations and other reproductive health care providers should work to ensure that they are offering a full range of contraceptive methods, with accurate information for full and informed consent.

Chapter 3

ABORTION

"In light of Paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, which states: "In no case should abortion be promoted as a method of family planning. All governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion", consider reviewing laws containing punitive measures against women who have undergone illegal abortions."

Beijing Platform for Action, Para. 106(k).¹³⁶

"The obligation to respect rights requires States parties to refrain from obstructing action taken by women in pursuit of their health goals . . . [B]arriers to women's access to appropriate health care include laws that criminalize procedures only needed by women and that punish women who undergo those procedures."

CEDAW, General Recommendation on Women and Health, Para. 14.¹³⁷

I. Introduction

At the core of reproductive rights is the principle that a woman has the right to decide whether and when to have a child. When faced with an unwanted pregnancy, only she can decide whether she will carry the pregnancy to term. Governments are bound to respect this basic human right by ensuring that women can access the full range of quality reproductive health services, including abortion. Not only should governments remove legal barriers to abortion services, they should ensure that safe and high-quality abortion services are accessible to all women. This chapter places abortion within a human rights framework and reviews the types of laws and policies that regulate abortion around the world, with an emphasis on legal developments since 1995. In light of the devastating effects of abortion restrictions on women's health and rights, this chapter recommends a concerted effort on the part of governments and non-governmental actors to make abortion safe and accessible to all women.

II. Abortion and Human Rights

International legal support for a woman's right to safe and legal abortion can be found in numerous international treaties and other instruments. The right to choose abortion has support in guarantees of autonomy in reproductive decision-making, freedom from discrimination, and protections of health and life.

A. The right to autonomy in reproductive decision-making

Only a pregnant woman knows whether she is ready to have a child. International human rights law has traditionally protected independence in decision-making in matters as intensely personal as reproduction. The right to physical integrity ensures freedom from unwanted invasions of one's

body.¹³⁸ When a pregnancy is unwanted, a legal requirement to carry it to term constitutes a governmental intrusion upon a woman's body. Recognition of this principle has been reinforced with international acknowledgement of the right to decide freely and responsibly the number and spacing of one's children.¹³⁹ This right entitles women access to all safe, effective means of controlling their family size, including abortion. Finally, because decisions one makes about one's body, particularly one's reproductive capacity, lie squarely in the domain of private decision-making, the right to privacy protects women's right to choose abortion.¹⁴⁰

B. The right to non-discrimination

Restrictive abortion laws are a form of discrimination against women. Freedom from discrimination in the enjoyment of protected human rights is ensured in every major human rights instrument.¹⁴¹ According to the Women's Convention, "discrimination against women" includes laws that have either the "effect" or the "purpose" of preventing a woman from exercising any of her human rights or fundamental freedoms on a basis of equality with men.¹⁴² Whatever their stated purpose, restrictions on abortion discriminate against women by criminalizing a health care procedure that only they need and by relegating them to the traditional roles of mothers and nurturers.

C. The right to health

International law guarantees women the right to "the highest attainable standard of physical and mental health."¹⁴³ WHO defines "health" as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity."¹⁴⁴ In countries where abortion services are prohibited by law or inadequately funded by the state, a woman who wishes to terminate a pregnancy faces a threat to her physical, mental, and social well-being. If she turns to an illegal provider or attempts to self-induce an abortion, she may undergo an unsafe procedure with devastating effects upon her physical health. Between 10 and 50% of women who undergo unsafe abortions require post-abortion medical attention due to complications.¹⁴⁵ The most common complications due to unsafe abortion include: incomplete abortion, infection, hemorrhage, and injury to internal organs. Where these complications do not result in death, they may result in life-long injury or infertility.¹⁴⁶

The health effects of unsafe abortion were addressed at two recent UN conferences, the ICPD of 1994 and the Beijing Conference of 1995. The Programme of Action adopted at the ICPD called upon governments to consider the consequences of unsafe abortion on women's health.¹⁴⁷ In 1999, at the ICPD+5 Conference, governments declared: "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health."¹⁴⁸

A woman who chooses not to risk her physical health by undergoing an unsafe abortion must jeopardize her mental and social well-being by carrying an unwanted pregnancy to term. For a woman who is not ready to be a mother, having a baby can cause a severe strain on her mental and emotional health. Her social well-being may be damaged if she does not have the resources to care for a child. If she is an adolescent, giving birth may limit her education and thus her capacity to support herself financially.¹⁴⁹

D. The right to life

Every year, approximately 13% of maternal deaths worldwide are attributable to unsafe abortion.¹⁵⁰ Laws that deny women access to safe abortion therefore pose a threat to women's right to life. The right to life is protected in most of the principal human rights instruments, including the Universal Declaration and the Civil and Political Rights Covenant.¹⁵¹ While traditionally read to protect individuals only from arbitrary execution by the state, the right to life has been interpreted by the Human Rights Committee, the body that monitors compliance with the Civil and Political Rights Covenant, to require governments to adopt "positive measures" aimed at preserving life.¹⁵²

Governments could save tens of thousands of women's lives every year by ensuring access to safe abortion services. Unsafe abortion, one of the most easily preventable causes of maternal mortality and morbidity,¹⁵³ is at the root of an estimated 80,000 women's deaths worldwide every year.¹⁵⁴ The Human Rights Committee, in its 1996 evaluation of the report of the Peruvian government, acknowledged that prohibitions of abortion may violate women's right to life. In reference to Peru's restrictive abortion law, the Committee noted:

The Committee is . . . concerned that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality. These provisions not only mean that women are subject to inhumane treatment but are possibly incompatible with articles 3, 6 and 7 of the Covenant [protecting, respectively, the right to nondiscrimination; the right to life; and the right to freedom from torture or cruel, inhuman or degrading treatment].¹⁵⁵

III. Overview of World's Abortion Laws

About 41% of the world's population live in the 50 countries that permit abortion without restriction as to reason. In these countries, which include **China**, **France**, the **Russian Federation**, **South Africa**, and the **United States**, a woman may have an abortion without offering a justification. She must, however, observe whatever procedural requirements are prescribed by law.¹⁵⁶

Another 21% of the world's people live in the 14 countries that permit abortion on broad social and economic grounds. These laws permit abortion when a woman can show that carrying a pregnancy to term would cause social or economic hardship. Medical personnel are typically permitted to consider a woman's economic resources, her age, her marital status, and the number of her living children. **Barbados**, **Great Britain**, **India**, and **Zambia** have laws in this category, which generally receive broad interpretation.¹⁵⁷

In 53 nations, home to roughly 13% of the world's people, abortion is available only when necessitated by a threat to a woman's health. In some countries, such as **Peru** and **Zimbabwe**, the threatened injury must be either serious or permanent.¹⁵⁸ Other laws, such as those of **Argentina** and **Ethiopia**, do not define or qualify the term "health." Still others, such as those of **Botswana**, **Jamaica**, and **Malaysia**, explicitly recognize that threats to mental health can be grounds for abortion.¹⁵⁹

Finally, about 26% of the world's people live in the 74 nations that either permit abortion only to save a woman's life or prohibit the procedure altogether. Many countries in this category, including **Brazil**, **Nigeria**, and **Indonesia**, explicitly permit abortion when a pregnancy threatens

a woman's life. In other nations, such as the **Dominican Republic**, **Senegal**, and **Egypt**, laws that make no explicit exception to protect life may be interpreted to permit abortion under such circumstances on the grounds of "necessity."¹⁶⁰ This is a general principle of criminal law, according to which certain crimes may be excused when they are committed as the sole means of saving one's life or the life of another. In some countries, the availability of the defense of necessity has been called into question by recent legal developments. For example, in **Chile**, a health code provision permitting abortion on "therapeutic grounds" was repealed in 1989, making abortion illegal on all grounds.¹⁶¹ Similarly, in **Colombia** — where there is no explicit exception under criminal law to save the life of the woman — a 1994 case challenging the restrictive abortion laws resulted in the Constitutional Court holding that the right to life is constitutionally protected from the moment of conception.¹⁶²

Most nations that permit abortion — even those that make no restriction as to the reason for the abortion — establish conditions that must be observed for an abortion to be classified as legal. These include: limits on the gestational age or the type of medical facility in which the procedure may be performed; requirements for third party authorization, such as requiring a husband or a parent to authorize the procedure; mandatory waiting periods; and mandatory counseling. Finally, fees often pose a barrier to a woman's access to abortion. Even governments that allow for abortion on broad legal grounds may not fund the procedure in the absence of medical necessity or other extreme circumstances.¹⁶³

A woman's ability to have an abortion is also contingent upon the availability of services. The availability of abortion services can depend on factors as diverse as the interpretation given to the existing law, the enforcement of the law, and the attitudes of the medical community and the public at large. In countries with restrictive laws, health professionals may be unaware of the conditions under which abortion is allowed. Sometimes, health providers refuse to comply with the law or are not properly trained to do so.¹⁶⁴ Administrative regulations are often cumbersome, leaving health professionals who are willing to provide abortion services confused about what they may and may not do. Often, this confusion and fear of criminal liability make them unwilling to take a risk.¹⁶⁵

India is an example of a country where a liberal abortion law does not ensure that women can access safe and legal procedures. India's Medical Termination of Pregnancy Act permits abortion on socio-economic grounds, and even recognizes that the anguish of an unwanted pregnancy resulting from contraceptive failure could constitute a "grave injury to the mental health of the pregnant woman" that could justify an abortion.¹⁶⁶ However, only 1,800 of the 20,000 primary health centers have legally certified abortion facilities. Women with unwanted pregnancies are forced to rely on low-cost procedures, which are often undertaken by untrained practitioners under unsanitary conditions.¹⁶⁷

Just as a woman's reproductive autonomy is undermined by her inability to access safe and legal abortion procedures, governments violate women's reproductive rights when they do not permit women to make free and informed choices about whether they will undergo the procedure. In rare situations, governments' disrespect for women's reproductive choices can result in coerced abortions. For example, **China** restricts the number of children a married couple may have, and has reportedly enforced this policy through forced abortions.¹⁶⁸ China's one-child policy contributes to a climate of coercion, thereby violating women's right to physical integrity and security of the person, and the rights of women to control their reproductive capacities.¹⁶⁹

IV. Developments Since 1995

This section briefly summarizes the developments in national abortion laws that have occurred over the last five years. For purposes of this discussion, abortion laws are deemed to fall into one of five categories of restrictiveness. From most to least restrictive, these categories identify laws whereby abortion is: (1) prohibited altogether or permitted only to save a woman's life; (2) permitted to save a woman's life and protect her physical health; (3) permitted to save a woman's life and protect her physical and mental health; (4) permitted to save a woman's life, and to protect her physical and mental health, and on socioeconomic grounds; and (5) permitted without restriction as to reason. Countries whose laws have moved from one category to another as a result of legislation enacted since 1995 are included in the following discussion.

A. Liberalizations

At least five countries from different regions of the world have recently enacted legislation liberalizing abortion.

- In 1996, **Albania** enacted into law a 1991 Ministry of Health directive¹⁷⁰ that permits abortion without restriction as to reason during the first 12 weeks¹⁷¹ of pregnancy.¹⁷² The law requires a woman to undergo counseling on adoption and the availability of public and private assistance should she choose to carry her pregnancy to term.¹⁷³ The 1991 and the subsequent 1996 law modified a 1989 Ministry of Health order that permitted abortion only when a woman's physical or mental health was at risk, when the pregnancy was a result of violence or incest, or when the pregnant woman was under the age of 16.¹⁷⁴
- In 1996, **Burkina Faso** amended its Penal Code to permit abortion at any stage of pregnancy when a woman's life or health is endangered and in the case of severe fetal impairment.¹⁷⁵ Abortion is also permitted during the first 10 weeks of pregnancy in cases of rape or incest.¹⁷⁶ Under the previous law, abortion was prohibited unless performed to save a woman's life.¹⁷⁷
- **Cambodia** significantly liberalized its abortion law in November 1997.¹⁷⁸ Under this recently adopted law, abortion is permitted during the first 14 weeks of pregnancy without restriction as to reason.¹⁷⁹ The previous law permitted abortion only to save a woman's life.¹⁸⁰
- In **Guyana**, a 1995 law intended in part to "enhance the attainment of safe motherhood by eliminating deaths and complications due to unsafe abortion" permits abortion without restriction as to reason during the first eight weeks of pregnancy.¹⁸¹ After eight weeks, but before 12 weeks have elapsed, a woman may have an abortion on the basis of broad grounds, including socioeconomic considerations.¹⁸² The previous law permitted abortion only to save a woman's life or to protect her physical or mental health.¹⁸³
- **South Africa** enacted the Choice on Termination of Pregnancy Act in 1996, making its abortion law one of the most liberal in the world. The Act permits abortion without limitation as to reason during the first 12 weeks of pregnancy, within 20 weeks on numerous grounds and at any time if there is risk to the woman's life or of severe fetal impairment.¹⁸⁴ The Act repealed a 1975 law that had prohibited abortion unless the pregnancy was a result of rape or incest, the mother's life was in danger, or there was a fetal impairment.¹⁸⁵

B. Restrictions

Two countries have recently restricted their abortion laws.

- In 1997, **El Salvador** amended its Penal Code to eliminate all exceptions to its prohibition of abortion.¹⁸⁶ Under the previous law, abortion was permitted when necessary to protect a woman's life, when pregnancy resulted from rape, and when there was a substantial risk of fetal impairment.¹⁸⁷ In addition to the Penal Code reform, the Constitution of El Salvador was amended in 1999 to recognize life from the moment of conception.¹⁸⁸
- In **Poland**, a liberalizing abortion law adopted in 1996 was invalidated by the Constitutional Court in 1997.¹⁸⁹ The Court found that the law, which permitted abortion on social and economic grounds, violated the Constitution's protection of the right to life of the "conceived child."¹⁹⁰ In December 1997, Poland's Parliament enacted new legislation eliminating social and economic grounds for abortion.¹⁹¹ Currently, abortion in Poland is available on three grounds: when the pregnancy threatens the life or health of the woman; when there is justified suspicion that the pregnancy resulted from a "criminal act;" and in instances of fetal impairment.¹⁹²

These laws pose a significant threat to women's reproductive health, given the correlation between unsafe abortion and high rates of maternal mortality and morbidity. It should be noted that even in countries with liberal abortion laws — including **Hungary**,¹⁹³ the **Russian Federation**,¹⁹⁴ and the **United States**¹⁹⁵ — opponents of women's choice have had some success working within their judicial systems and legislatures to restrict women's access to safe abortion services. While the outcome of most of these campaigns is still undetermined, they warrant close scrutiny by supporters of women's reproductive rights.

V. Recommendations

Removing legal and other barriers to abortion services requires action on the part of governments, NGOs, and international donors. The actions needed to attain this goal differ according to the status of the law in the country.

In nations where abortion laws are restrictive:

- Governments should enact laws that permit abortion without restriction as to reason or on broad grounds;
- Governments should ensure that safe and high-quality abortion services are in place to meet the needs of women who are qualified to undergo abortions on the narrow grounds currently recognized under the law;
- Chief law enforcement officials should issue prosecutorial guidelines reflecting the most liberal interpretation possible of criminal laws pertaining to abortion;
- Law enforcement officials should refrain from prosecuting women who have undergone abortion procedures and providers who perform abortions with the consent of their patients;
- NGOs should establish coalitions with legal and medical groups to conduct effective advocacy campaigns to liberalize abortion laws;

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- Family planning associations and other reproductive health care providers should offer abortion services to the fullest extent permitted by the law;
 - Advocacy groups should research the effects of unsafe abortion to the fullest extent possible and disseminate their findings to both policy makers and the general public; and
 - International donors should support the work of NGOs engaged in advocating for legal and policy reforms aimed at increasing access to safe and legal abortion services.

In nations where abortion laws are liberal:

- Governments should work to ensure access to high-quality abortion services for all women, regardless of age, income, marital status, or level of education;
- National health programs should integrate abortion services within existing reproductive health programs; the costs of such services should be commensurate with other medical procedures;
- Governments should establish mechanisms of redress for women who are denied access to abortion services;
- NGOs should work to ensure that women and health care providers are aware that abortion is permitted under the law;
- NGOs should undertake public education campaigns to inform the public of the legal and regulatory requirements for obtaining an abortion;
- NGOs also should establish broad coalitions to monitor enforcement of abortion laws and services, and work to ensure that women who are unable to access legal abortion services have legal redress; and
- Family planning associations and other reproductive health providers should work to ensure safe, high-quality abortion services for all women.

Chapter 4

HIV/AIDS and STIs¹⁹⁶

“HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having a devastating effect on women’s health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Women, who represent half of all adults newly infected with HIV/AIDS and other sexually transmitted diseases, have emphasized that social vulnerability and the unequal power relationships between women and men are obstacles to safe sex, in their efforts to control the spread of sexually transmitted diseases. The consequences of HIV/AIDS reach beyond women’s health to their role as mothers and caregivers and their contribution to the economic support of their families. The social, developmental and health consequences of HIV/AIDS and other sexually transmitted diseases need to be seen from a gender perspective.”

Beijing Platform for Action, para. 98.¹⁹⁷

“The issues of HIV/AIDS and other sexually transmitted disease are central to the rights of women and adolescent girls to sexual health. Adolescent girls and women in many countries lack adequate access to information and services necessary to ensure sexual health. As a consequence of unequal power relations based on gender, women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, polygamy, as well as marital rape, may also expose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases. Women in prostitution are also particularly vulnerable to these diseases”

CEDAW Recommendation on Women and Health, para. 18.¹⁹⁸

I. Introduction

An estimated 33.6 million men, women, and children worldwide live with HIV/AIDS.¹⁹⁹ Over the course of 1999 alone, some 5.6 million people — 2.3 million of them women — became infected with HIV, the virus that causes AIDS.²⁰⁰ In Africa, where HIV is transmitted primarily through heterosexual contact, women are being infected at higher rates than men.²⁰¹ Moreover, recent studies indicate that the rate of HIV/AIDS is increasing faster among young women than among young men in low-income countries.²⁰² In **Uganda**, for example, the HIV infection rate among adolescent girls aged 13 to 19 years is three times higher than that for teenage boys.²⁰³

The impact on women of HIV/AIDS is one of the most pressing reproductive health concerns of our time. Because women’s subordinate role in society heightens their risk of HIV infection, governments must approach this epidemic with a gender perspective. HIV prevention strategies that do not take the special needs of women into account violate women’s human right to non-discrimination in enjoyment of the rights to health and life. Likewise, while discrimination against people with HIV/AIDS affects both sexes, women with HIV/AIDS must also contend with pervasive gender discrimination, making them doubly marginalized.²⁰⁴ Governments must therefore work to minimize the impact of the disease upon women’s ability to enjoy all of their civil, political, social, economic, and cultural rights. This chapter examines women’s health and rights in relation to HIV/AIDS, reviewing the types of legal

and policy approaches that have been taken thus far. It discusses a sampling of developments from countries around the world since 1995 and provides recommendations relating to the adoption of gender-sensitive HIV/AIDS prevention and treatment policies and the amendment of laws that discriminate against people living with HIV/AIDS.

II. Women's Rights and HIV/AIDS

A. Discrimination in prevention of HIV infection

International law guarantees women and men equal enjoyment of the rights to life²⁰⁵ and to the "highest attainable standard of physical and mental health."²⁰⁶ Yet pervasive social inequities deny many women these rights, as is revealed by the increasing impact of HIV/AIDS upon women. For physiological reasons, women are more likely than men to be infected through heterosexual contact. Aggravating this physiological vulnerability is the social subordination that many women face in the economic, social, civil, and political spheres.

The Beijing Platform recognizes that women's social subordination and unequal power relations to men are key determinants in their vulnerability to HIV/AIDS.²⁰⁷ The Platform notes that women "often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment."²⁰⁸ Furthermore, women are at higher risk of sexual abuse²⁰⁹ and may be subject to harmful traditional practices that affect their reproductive health, including forced marriage and FC/FGM.²¹⁰ In addition, many women's lack of access to quality reproductive health care may allow STIs to go undetected, leaving those women even more physiologically susceptible to HIV infection.²¹¹

Adolescent girls face heightened risks that expose them to HIV infection, such as sexual exploitation, early sexual initiation, inability to negotiate safe sex with their partners, social pressure, lack of sex education, lack of access to condoms (particularly female condoms), and lack of reproductive health services.²¹² In some parts of Africa, HIV-infected men seek out adolescent girls on the belief that sex with a virgin will cure their infection.²¹³

In light of the HIV/AIDS pandemic's impact on women, their human rights to life, health, and freedom from gender discrimination require governments to take steps to address the causes of women's vulnerability to HIV/AIDS. As CEDAW has stated: "States parties [should] intensify efforts in disseminating information to increase public awareness of the risk of HIV infection and AIDS, especially in women and children, and of its effects on them."²¹⁴ Furthermore, "programmes to combat AIDS should give special attention to the rights and needs of women and children, and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection."²¹⁵

B. Discrimination against women living with AIDS

Because the laws and customs of many countries deny women equal enjoyment of their human rights, women are particularly affected by the discrimination that is often directed toward people living with HIV/AIDS. The legal system may offer little recourse for women to vindicate their rights and thus protect themselves from discrimination and attacks at the hands of members of their fam-

ilies or communities. For example, where discriminatory laws deny women the right to own property, a woman living with HIV/AIDS who is forced to leave her home has no claim under law.²¹⁶ Similarly, in countries that do not acknowledge or pursue crimes committed by domestic partners, a woman with HIV/AIDS who is abused by her spouse may have little protection from the state.²¹⁷

The impact of these combined discriminatory forces upon women's enjoyment of their human rights has been recognized by a number of international human rights bodies. The Commission on Human Rights, the UN's principal human rights organ, issued a resolution in 1999 inviting governments "to take all necessary measures to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children and vulnerable groups, so that infected persons who reveal their HIV status, those presumed to be infected and other affected persons are protected from violence, stigmatization and other negative consequences."²¹⁸ Similarly, CEDAW has advised governments to include in their reports "information on the effects of AIDS on the situation of women and on the action taken to cater to the needs of those women who are infected and prevent specific discrimination against women in response to AIDS."²¹⁹

III. Government Actions to Address HIV/AIDS

Because the spread of HIV/AIDS depends as much upon social factors as physiological ones, efforts to prevent HIV should be focused on enhancing the ability of all members of society to protect themselves against infection. Likewise, governments must intervene to protect the rights of those living with HIV/AIDS.

A number of governments have formulated comprehensive national policies to address HIV/AIDS. Many of these have a gender component, focusing on the special needs of women. For example, the Ministry of Health in **Tanzania** issued a policy in 1995 enumerating strategies for the prevention and treatment of HIV/AIDS and setting forth the rights of individuals with HIV or AIDS. The policy specifically addresses issues of AIDS and gender in a section calling for women to be provided with basic education about their bodies, human sexuality, HIV/AIDS, and other STIs. The policy also encourages criminalizing the willful spread of STIs, including HIV/AIDS.²²⁰ In **Mexico**, the AIDS Prevention and Control Program is integrated within its Reproductive Health and Family Planning Plan. The government's policy aims at reducing morbidity and mortality resulting from this disease and increasing access to information, diagnosis, prevention, and control services through communication programs, preventive actions, and AIDS treatment in primary health facilities.²²¹

Some countries have enacted laws and policies delineating the rights of people living with HIV/AIDS. For example, in **Guatemala**, the rights and duties of persons living with HIV/AIDS are defined by law. Under this law, the administration of blood tests is prohibited as a requirement to obtain goods or services, to access educational establishments, or to obtain medical treatment. Furthermore, the results of blood tests are strictly confidential. The rights of all people to dignified and respectful treatment are protected, and discrimination against people due to HIV/AIDS status is prohibited.²²²

Unfortunately, discriminatory laws and practices in many countries continue to violate the rights of

people with HIV/AIDS. In **Kenya**, for example, AIDS and HIV have been deemed “infectious diseases” pursuant to the Public Health Act. This empowers medical officers to take such actions as entering premises where the inhabitants are believed to have been exposed to the “infectious disease” and examining anyone at that site.²²³ A medical officer also may remove a person from a hospital or to another place of isolation and detain the person until he or she is no longer deemed to constitute a danger to the public.²²⁴ Such provisions can inappropriately infringe on the civil rights of individuals living with HIV/AIDS, and can perpetuate myths regarding the manner in which HIV is transmitted.

In **Uganda**, as in many other countries, the law is silent on a number of issues related to the rights of people living with HIV/AIDS.²²⁵ As a result, many are castigated and face discrimination from their families, their communities and their employers. Dismissal from work on account of an employee’s HIV status is not uncommon.²²⁶ No proactive laws to prohibit such discrimination have been adopted.

IV. Developments Since 1995

Since 1995, in response to the growing pandemic, many governments have undertaken legislative, policy, and programmatic initiatives to prevent transmission and treat HIV/AIDS, as well as to address discrimination against those living with HIV/AIDS. The following are some examples of developments:

- The government of **Zimbabwe** has attempted to combat HIV/AIDS through a number of locally-based programs. For example, in the eastern border town of Mutare, where an estimated 37% of pregnant women are HIV positive, programs include treatment of STIs, the tracing of patients’ contacts, an HIV peer-education program, outreach to commercial sex workers, the distribution of 150,000 condoms per month, and a home-based care program.²²⁷
- In 1999, the Ministry of Health of the **Russian Federation** issued an order instituting special centers for children and pregnant women who are HIV positive. These centers are to be set up in urban areas and will help children and women monitor their health. The centers will also provide training for professionals to address the needs of those who are HIV positive.²²⁸
- In 1995, before reverting to Chinese rule, **Hong Kong** passed the Disability Discrimination Bill.²²⁹ This new law bans compulsory testing for HIV/AIDS. It also makes job reinstatement a remedy in court proceedings on discrimination claims, and extends the deadline for bringing cases to court by two years (excluding time taken in conciliation proceedings).²³⁰
- In **Bolivia**, the government adopted the Regulations on the Prevention and Care of HIV/AIDS in 1996, delineating the rights and duties of healthy, infected, and sick persons.²³¹ The regulations also establish that the results of HIV/AIDS tests are strictly confidential and that counseling and psychological services should be provided in all cases of testing. The HIV/AIDS regulations provide that persons infected with HIV cannot be barred from public or private education, sports, or cultural facilities. Furthermore, no health care worker in public or private establishments can deny medical attention or inpatient services to a person who has AIDS or is HIV positive. Health care centers also are obligated to provide guidance, information, and education to the Bolivian people regarding HIV/AIDS.²³²

- In **Poland** in 1996, the Ministry of Health introduced the National Program for the Prevention of HIV Infection and the Care of Persons Living With or Suffering from HIV/AIDS. The National Program's main task is to prevent transmission of HIV, and therefore, decrease incidences of HIV/AIDS infection and its socioeconomic consequences.²³³
- New national AIDS legislation took effect in **Colombia** in the beginning of 1997. This law established the right of people living with HIV/AIDS to receive antiretroviral drugs through the national health care system.²³⁴
- In November 1997, the health ministers of the Mercosur trade bloc — comprised of **Argentina, Brazil, Paraguay** and **Uruguay**, and associate members **Bolivia** and **Chile** — pooled resources to make joint purchases of the medicines used in combination therapy, aiming to cut the cost of the treatment by up to 50 percent.²³⁵

V. Recommendations

- Governments should review, amend, and enforce laws and develop targeted initiatives to combat practices that contribute to women's susceptibility to HIV infection and other STIs. Legislation should be enacted and enforced against any practices that either increase women's risk of infection or contribute to the further marginalization of those women who are already infected with HIV/AIDS or other STIs.²³⁶
- Governments and NGOs should develop effective education and outreach programs aimed at disseminating information about the risks of HIV/AIDS and measures that can be taken to avoid infection.
- Governments should develop compassionate and supportive laws, policies, and programs to meet the needs of those living with HIV/AIDS, and should legally prohibit all forms of discrimination against such persons, including discrimination in access to health care, education, and employment.²³⁷
- Governments should ensure that all sexual and reproductive health programs, including family planning facilities, diagnose and treat HIV/AIDS and other STIs and promote and supply high-quality condoms (including female condoms) and treatment for HIV/AIDS and other STIs.²³⁸ These programs should ensure that diagnostic results and other patient information are kept fully confidential.
- Governments should develop guidelines and counseling services on HIV/AIDS and STIs within primary health care services²³⁹ and ensure training for health care workers on the treatment of clients living with HIV/AIDS.
- Governments and international organizations should support and strengthen national capacity to create and improve gender-sensitive policies and programs on HIV/AIDS and other STIs. Governments and international organizations should hasten to provide resources and facilities to women who are living with HIV/AIDS or who are the principal caregivers or economic support for those either infected with HIV/AIDS, or affected by the pandemic — such as the survivors, particularly children and older persons.²⁴⁰

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- Governments should provide or increase financial and institutional support for research on safe, effective, affordable, and acceptable methods and technologies for the reproductive and sexual health of men and women, including methods to protect against HIV/AIDS and other STIs. Governments further should ensure that these activities are carried out in strict conformity with internationally accepted legal, ethical, medical, and scientific standards for biomedical research.²⁴¹
 - Donor governments and international organizations should assist in ensuring non-discriminatory access to drug treatment, including antiretroviral drugs.