CENTER FOR REPRODUCTIVE RIGHTS

BRIEFING PAPER

Governments in Action

Legal and Policy Developments Affecting Reproductive Rights

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It is up to governments worldwide to translate reproductive rights into laws and policies that promote women's health and empowerment. Many are taking up that charge. In the years since the International Conference on Population and Development (ICPD) held in Cairo in 1994, governments have developed national instruments to implement women's globally recognized rights to reproductive health care, autonomy and nondiscrimination. Laws and policies that address sexual abuse and exploitation, female genital mutilation (FGM), contraception, abortion, and HIV/AIDS give force to the principles adopted in Cairo. Only a few countries have run counter to international trends by restricting access to abortion and adopting measures that elevate the status of the fetus.

The following summaries of recently adopted laws and policies provide some indication of how governments are approaching reproductive rights in the 21st century. These developments span the globe and respond to a host of pressing reproductive rights issues. Most, but not all, reflect an understanding that government action affecting women's reproductive lives must be grounded in respect for women's dignity and equality.

Reproductive Health and Rights

Governments use a variety of legal tools to secure women's reproductive rights. As stated in the ICPD Programme of Action, "reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents."[1] *National constitutions that protect the rights to health, physical security and equality support advocacy for women's access to reproductive health services and their right to make independent decisions about their fertility. Some governments have gone beyond broad constitutional protections and have adopted legislation or policies explicitly enumerating reproductive rights, usually in line with the provisions of the ICPD Programme of Action.*

AFGHANISTAN ADOPTS NEW CONSTITUTION

In January 2004, Afghanistan adopted the **Constitution of Afghanistan, 1382**. The constitution establishes Afghanistan as an Islamic Republic and requires all laws to conform to the tenets of Islam. It calls upon the state to build a society based on social justice and respect for human rights. It guarantees 37 fundamental rights of citizens, including the rights to nondiscrimination and equality before the law, as well as the rights to life, liberty, dignity, education, and employment. It also obligates the state to develop and implement special programs for the promotion of women's education; provide free preventive health care to all citizens; and adopt measures to ensure the physical and mental well-being of the family, especially mothers and children. In provisions relating to the structure of government, the constitution requires that a specified number of seats in the legislature be reserved for women.

AFRICAN UNION RECOGNIZES REPRODUCTIVE RIGHTS IN NEW REGIONAL INSTRUMENT

On July 11, 2003, the African Union adopted the **Protocol on the Rights of Women in Africa** to supplement the African Charter on Human and Peoples' Rights, adopted in 1981. The Protocol, which will enter into force once it has been ratified by 15 African states, provides broad protection for African women's human rights in numerous domains. Among the Protocol's extensive guarantees is a provision requiring states to "ensure that the right to health of women, including sexual and reproductive health, is respected and promoted." The rights specifically enumerated include those to control one's fertility; determine the number and spacing of one's children; choose any method of contraception; protect oneself and be protected against sexually transmissible infections (STIs), including HIV/AIDS; be informed about one's health status and the health status of one's partner; and have access to family planning education. States are called upon to provide adequate, affordable and accessible health services; establish and strengthen prenatal, delivery and postnatal health and nutritional services for women during pregnancy and while breast-feeding; and protect women's reproductive

rights by authorizing abortion in cases of sexual assault, rape, incest, fetal impairment, and when the continued pregnancy endangers the mental and physical health or life of a woman. The Protocol also requires states to "prohibit and condemn" harmful practices negatively affecting women's human rights, including FGM. It guarantees women's right to consent to marriage and sets the minimum age of marriage at 18. The Protocol further calls upon states to, among other things, protect women during armed conflicts; eliminate discrimination against women in education; promote equality in the workplace; ensure women's access to food and adequate housing; and guarantee women's right to inherit property.

ALBANIA ADOPTS REPRODUCTIVE HEALTH LAW

The Republic of Albania, on April 4, 2002, adopted **Law No. 8876 on Reproductive Health**, which provides for the organization and delivery of reproductive health care and sets forth guarantees of individuals' reproductive rights. The law incorporates the principles of the ICPD Programme of Action in its definitions of reproductive and sexual health, listing the following services as components of reproductive health care: family planning services and services and education for safe pregnancy and childbirth; health-care services and education for children and adolescents; prevention and treatment of STIs, including HIV/AIDS; safe abortion services and management of abortion complications; information, education and counseling about sexuality and reproductive health; and prevention and treatment of infertility.

In addition, the law provides broad protection for the principles of gender equality and reproductive self-determination, providing explicit guarantees of the right to family planning, consent to reproductive health–care interventions, safe pregnancy and childbirth services, access to reproductive technologies, health education, and basic medical care. The law further affirms the right of consenting individuals to undergo sterilization, provided they are of the legal minimum age. It also provides for the rights of adolescents to age-appropriate reproductive health information and services, including programs aimed at preventing unwanted pregnancy and sexual abuse. Finally, the law guarantees treatment for infertility and use of reproductive technologies, specifying that couples must jointly agree on the use of these technologies.

The remaining provisions of the law deal primarily with the administration of reproductive health services. The law specifies that pregnant women enjoy free medical care during pregnancy, delivery and the postnatal period, referring in particular to mandatory pre- and postnatal examinations. The law further specifies that children under six years of age are entitled to free preventive health care. Finally, under the law, adolescents receive reproductive health and sexual education services free of charge.

BENIN ADOPTS REPRODUCTIVE HEALTH LAW

On January 24, 2003, Benin enacted **Law No. 2003-04 on Reproductive and Sexual Health**. The law adopts the broad concept of reproductive and sexual health affirmed in the ICPD Programme of Action. It states at the outset that all men and women have the right to use the family planning method of their choice; that they are entitled to methods that are safe, effective, affordable, and acceptable; and that women are guaranteed health care during pregnancy and childbirth aimed at preserving the health of the pregnant woman and the newborn. The law further guarantees universal enjoyment of a number of basic reproductive rights, including those to equality between men and women in matters of reproductive health; reproductive self-determination; free choice in matters of marriage; access to information and education relating to reproductive and sexual health care; access to health services that are of the best possible quality; nondiscrimination in access to health care; confidentiality; and security of the person. Couples and individuals are called upon to promote familial harmony and care for all members of their families, including children and the elderly. Other provisions of the law deal with the administration of reproductive health services, including the creation of primary care and reproductive health services and separate services for adolescent reproductive health care.

The law addresses several reproductive health matters with greater specificity. It states that the full range of legal methods of contraception shall be available upon medical consultation, and affirms the right of individuals to decide on the number and spacing of their children and to have the information and means to do so. The law also affirms the legality of manufacturing, importing, selling, and publicizing contraceptive methods. It further declares that abortion shall be legal when a pregnant woman's life or health is in danger, in cases of rape and incest, and in cases of fetal impairment. The law pledges special care to those who have an STI, particularly those living with HIV/AIDS, guaranteeing their right to nondiscrimination. Persons who declare that they are affected by HIV/AIDS shall benefit from psychological support, counseling and other services, and receive special medical care. Lastly, the law criminalizes the following acts: all forms of sexual violence targeting women and children; FGM; pedophilia; intentional transmission of HIV/AIDS; sexual exploitation and forced prostitution; and forced marriage.

CHAD ADOPTS REPRODUCTIVE HEALTH LAW

On April 15, 2002, Chad enacted **Law No. 66/PR/2002 on the Promotion of Reproductive Health**. The law adopts the broad concept of reproductive health affirmed in Paragraph 7.2 of the ICPD Programme of Action. It guarantees enjoyment of a number of basic reproductive rights, including those to nondiscrimination on the basis of age, sex, financial means, religion, ethnicity, marital status, or any other grounds; independent decision-making regarding reproductive health and the number

and spacing of one's children; free choice in matters of marriage and family; access to information and education relating to methods of family planning; use of health services that are of the best possible quality and freedom from harmful practices; access to local health-care services that are safe, effective, affordable, and acceptable; and freedom from torture and cruel, inhuman or degrading treatment, particularly with regard to one's reproductive organs. The latter protection specifies that all forms of violence—including FGM, early marriage, domestic violence, and sexual cruelty—are prohibited. Other provisions of the law relate to reproductive health–care personnel and the professional norms that regulate their work.

The law lists as "reproductive health services" the following interventions: all services related to family planning, including outreach, education, research, and distribution of contraceptive methods; care during pregnancy and childbirth and the postnatal period; prevention and treatment of sterility, infertility and impotence; prevention of abortion and care for its complications; care for reproductive tract disorders; and the prevention and care of STIs, including HIV/AIDS. The law specifies that termination of pregnancy should not be considered a method of family planning, but authorizes its practice when a pregnancy threatens the life or health of a woman and when the fetus has been diagnosed with a grave impairment. Pregnancy termination on authorized grounds requires approval from a medical council following notice to a judge. The law also authorizes care for assisted reproduction. Individuals living with HIV/AIDS are entitled to basic care and are guaranteed confidentiality. Willful transmission of HIV/AIDS is a crime.

COLOMBIA ADOPTS NATIONAL POLICY ON SEXUAL AND REPRODUCTIVE HEALTH

In February 2003, Colombia's Department of Public Health of the Ministry of Social Protection adopted a **National Policy on Sexual and Reproductive Health**. The policy, which covers the period from 2002 to 2006, adopts the rights-based approach to sexual and reproductive health endorsed in the ICPD Programme of Action. The policy analyzes the state of sexual and reproductive health in Colombia, identifying the following priority areas for action: safe motherhood, family planning, adolescent sexual and reproductive health, uterine cancer, domestic and sexual violence, and STIs, including HIV/AIDS. The policy reviews the legal framework for action in the area of sexual and reproductive health, making reference to United Nations conferences—particularly the ICPD and the Fourth World Conference on Women—as well as the national constitution and its jurisprudence. Its guiding principle is that sexual and reproductive rights are human rights and that protecting health is a government responsibility.

The policy's general objective is to improve the population's sexual and reproductive health and promote its enjoyment of sexual and reproductive rights. It emphasizes a reduction in vulnerability and risk while promoting safer practices and assisting groups

with special needs. The more specific objectives include promoting health care and disease prevention; strengthening health services; implementing mechanisms to promote quality of care; improving health information systems; promoting research as a component of government decision-making; and involving actors from multiple sectors and civil society to achieve set goals. The policy, which emphasizes gender equality and women's empowerment, further outlines strategies for implementation, with a focus on education and outreach activities, coordination of institutional interventions, social participation, research, and the development of social support networks.

EL SALVADOR ISSUES DECREE PROHIBITING MANDATORY PREGNANCY TESTING BY EMPLOYERS

On February 25, 2004, El Salvador adopted **Decree No. 275,** which amends the 1972 Labor Code to prohibit mandatory pregnancy testing as a condition for employment. The decree recognizes that all persons have a constitutionally protected right to work, the enjoyment of which does not require disclosure of information relating to one's physical status. The decree further acknowledges that pregnancy testing is an obstacle to women's access to employment. Given that women are often the sole economic contributors to their households, such mandatory testing impedes both women's advancement and that of their families. The decree specifically amends Article 30 of the Labor Code, which enumerates several actions that are prohibited for employers. The revised article includes a new provision explicitly prohibiting employers from requiring, as a condition for employment, that job applicants take pregnancy tests or present medical certificates with the results of such tests.

MALI ADOPTS REPRODUCTIVE HEALTH LAW

On June 24, 2002, Mali enacted **Law No. 02-44 on Reproductive Health**, which came into effect on December 24, 2002. The law adopts the definition of "reproductive health" affirmed in Article 7.2 of the ICPD Programme of Action. Citing the needs of "vulnerable groups" such as women, children and young adults, the law states that the aim of reproductive health care is to reduce maternal and child mortality and morbidity and promote the well-being of all individuals. The law affirms the equality of men and women in matters of reproductive health, stating that all persons are entitled to enjoy a safe and responsible sex life and that men and women have equal rights to information and access to the family planning methods of their choice. The law provides that any individual or couple has the right to reproductive health services that are of the best possible quality. In particular, it ensures the rights of women to health care during pregnancy and childbirth. The law lists the components of reproductive health care, which include services and activities related to family planning; information and counseling on sexuality and responsible parenthood; care for safe pregnancy and child-

birth; services to promote infant survival; prevention and treatment of sterility, infertility and impotence; abortion prevention and postabortion care; prevention and treatment of reproductive tract infections; treatment of genital disorders; treatment of complications of FGM; reproductive health care for older adults and young people; and treatment and prevention of STIs, including HIV/AIDS.

The law pledges special care to those living with HIV/AIDS, but calls upon them to inform their partners and take measures to avoid its transmission. It further provides for criminal penalties for individuals who intentionally transmit HIV. The law affirms the legality of manufacturing, importing, selling, and publicizing approved contraceptive methods, while setting penalties for the sale and promotion of unapproved methods. The law further declares that abortion shall be legal when a pregnant woman's life is in danger and in cases of rape and incest. Incitement to abortion, other than under circumstances in which abortion is legal, is prohibited. Finally, the law permits consenting adults to undergo sterilization, but requires that married individuals, in the absence of medical necessity, obtain their spouse's consent prior to undergoing the procedure. A medical provider who fails to obtain informed consent prior to performing a sterilization procedure faces criminal sanctions and may lose his or her professional license.

RWANDA ADOPTS NEW CONSTITUTION

In a public referendum held on May 26, 2003, Rwandan citizens voted overwhelmingly to adopt the **Constitution of the Republic of Rwanda, 2003**, which the president signed into law on June 4, 2003. The document establishes respect for fundamental human rights as the basis of Rwandan nation-building; reaffirms the government's commitment to international human rights treaties that it has ratified; and promises to ensure equal rights among all Rwandans, specifically between women and men. It devotes 35 articles to enforceable fundamental human rights, which guarantee the inviolability of the human person and the rights to nondiscrimination; life; physical and mental integrity; equal protection of the law; free consent to marriage and equality in marriage and divorce; free choice of employment and equal pay for equal work; education; and health. The constitution also obligates the government to undertake activities aimed at promoting good health, and to enact special laws and create institutions for the protection of families, particularly mothers and children. In addition to guaranteeing fundamental rights, the constitution establishes several duties of citizens, including the duty to respect the principles of social justice and equality. It also calls for political parties to ensure that women and men have equal access to elective office, and requires that a certain number of parliamentary seats be reserved for women. The constitution establishes several special national institutions to further promote human rights and gender equality, including the National Commission for Human Rights, the Gender Monitoring Office and the National Council of Women.

SLOVAKIA LEGISLATES TO PROTECT PATIENTS' RIGHTS AND PREVENT COERCIVE STERILIZATION

On October 21, 2004, Slovakia adopted **Act No. 576 on Health Care and Services Related to the Provision of Health Care**. Among other things, the law sets out requirements for ensuring informed consent; establishes patients' right to access their medical records; and specifies conditions under which sterilizations may be performed. With regard to informed consent, the law requires providers to inform patients about the purpose, character, consequences, and risks of a procedure; about options for alternative courses of treatment; and about the risks of rejecting treatment. The information is to be provided in a manner that is noncoercive, understandable to the patient, and offered within a sufficient time frame to allow the patient to decide whether to consent. Patients have the right to refuse medical information, as well as the right to withdraw consent to a procedure. A court may override a patient's refusal to consent to treatment only when a patient is incompetent and treatment would be in the patient's best interest. Informed consent is not required in cases of medical emergency and when patients' conditions pose a threat to others or, in the case of a mental disorder, to the patients themselves.

Regarding patients' right to their medical records, the law enumerates who may review a patient's records and under what conditions. A patient is entitled to review his or her own records, as is a spouse, child, and parent or guardian of that person after his or her death. A person may also designate another by power of attorney to review medical records. Anyone entitled to look at medical records has a right to make notes or copies of the records on the spot. A person who believes that he or she was wrongly denied the right to examine his or her medical records may seek recourse in a court of law.

Finally, the law defines "sterilization" as a procedure that prevents fertility without removing or harming a person's genitals. The law provides that a sterilization may only be carried out once 30 days have passed after the receipt of a patient's written application and written informed consent. Where a patient is not competent, a legal guardian may file the application and written consent. Before obtaining consent, providers must inform patients about the following:

a) alternative methods of contraception and family planning;
b) the ramifications of possible changes in a patient's life circumstances;
c) the medical consequences and irreversible nature of sterilization; and
d) the possible failure of sterilization.

TANZANIA ENACTS EMPLOYMENT LAW PROHIBITING DISCRIMINATION AND REGULATING HOURS, LEAVE FOR PREGNANT EMPLOYEES AND MOTHERS

On June 4, 2004, the United Republic of Tanzania enacted the **Employment and Labour Relations Act, 2004**, which guarantees fundamental labor rights and estab-

lishes basic employment standards. The act provides broad protection against discrimination. Specifically, the act mandates that employers "promote equal opportunity in employment and strive to eliminate discrimination in any employment policy or practice." The act prohibits direct or indirect discrimination and harassment by employers, trade unions, and employers' associations on a number of grounds, including: sex, gender, pregnancy, marital status or family responsibility, disability, HIV/AIDS status, and age. The act also requires employers to take "positive steps" to guarantee women and men equal pay for work of equal value. Affirmative action measures intended to promote equality or eliminate workplace discrimination do not constitute discrimination under the act. Contravention of any of the act's antidiscrimination provisions is an offense punishable with a fine of up to five million Tanzanian shillings.

The act's provisions on basic employment standards include several relating specifically to female employees who are pregnant or are mothers. With respect to employment hours, employers are generally prohibited from requiring or permitting pregnant employees and mothers to work at night (between the hours of 8 p.m. and 6 a.m.) during the two-month periods prior to and following childbirth. With respect to employment leave, the act provides for at least 84 days of paid maternity leave (with up to four terms of leave per employee) and at least three days of paid paternity leave for employees with at least six months of service, subject to certain conditions. The act entitles pregnant employees to resume employment after their maternity leave on the same terms and conditions as before. Employers may not allow an employee to work during the first six weeks after giving birth unless a medical practitioner certifies that she is fit to do so. Employers may also not allow or require pregnant or nursing employees to perform work that is hazardous to their health or to that of the children they are nursing. The act further requires employers to allow nursing employees up to two hours' worth of breaks per day for breast-feeding.

Violence against Women and Sexual Abuse and Exploitation, including Trafficking

Violence against women is a reflection of women's low status in their families, communities and societies. Whether the violence is perpetuated by government officials or family members, it is a violation of a woman's human rights and fundamental freedoms. Like other forms of violence, sexual abuse and exploitation pose an acute threat to women's right to health, bodily integrity and autonomy. Governments worldwide are taking action to stop violence against women by stepping up penalties for abusers and traffickers, developing national policies to prevent sexual abuse and exploitation, and creating protective measures for women and girls who are vulnerable to abuse.

BANGLADESH TARGETS SEXUAL ABUSE AND EXPLOITATION IN NATIONAL PLAN

In February 2002, the government of Bangladesh adopted the **National Plan of Action against the Sexual Abuse and Exploitation of Children including Trafficking**. The prevention measures outlined in the National Plan of Action (NPA) include adopting educational measures, with an emphasis on human rights and life skills; increasing economic alternatives for families; instituting legal reform; and eliminating child marriage. To improve child protection, the NPA calls for such measures as a reactivation of the birth registration system, better mechanisms and structures for reporting abuse, and the creation of safe havens for victims and children at risk. The NPA notes that special protection is needed for children affected by natural disasters and for child refugees. It also emphasizes recovery and reintegration of the victims of sexual abuse and trafficking. To that end, it calls for ensuring children's access to necessary support services and creating a receptive environment for reintegration through outreach to families, local community leaders and the public. In addition, a key objective of the NPA is to increase the apprehension and prosecution of child traffickers. It emphasizes the need for a coordinated approach to monitoring and law enforcement, particularly regarding cross-border trafficking, and calls for increased coordination among Bangladeshi ministries, other governments, national missions in "receiving" countries, and concerned non-governmental organizations. Finally, the NPA cites measures to address the risks of STIs, including HIV/AIDS, and substance abuse faced by abused, exploited and trafficked children.

The NPA encourages and promotes the full participation of children in carrying out its strategies. The views of children helped shape the content of the NPA, and children have an ongoing role in its implementation and monitoring.

BRAZIL CRIMINALIZES DOMESTIC VIOLENCE

On June 17, 2004, Brazil enacted **Law No. 10.886**, which amends the 1940 Penal Code to make domestic violence a cognizable offense. The law imposes a prison sentence of six months to one year on a person who injures his or her mother or father, grandmother or grandfather, child, spouse, or domestic partner. The law also applies when the victim is a person with whom the perpetrator lives or has lived, or when the perpetrator is a guest of the victim.

In addition, the existence of a domestic relationship as defined in Law 10.886 is an aggravating factor in crimes of assault (defined elsewhere in the Penal Code), and it causes penalties for those crimes to be raised by 30%.

NEW ZEALAND ENACTS LAW TO PROTECT HEALTH AND RIGHTS OF SEX WORKERS

In June 2003, New Zealand enacted the **Prostitution Reform Act 2003**. The law

decriminalizes prostitution and aims to create a framework that safeguards the human rights of sex workers and protects them from exploitation. Its other objectives include promoting the welfare and occupational health and safety of sex workers, furthering public health goals, and prohibiting the use of persons under 18 for prostitution. Under the law, prostitution is defined as "the provision of commercial sexual services involving physical participation by a person in sexual acts with, and for the gratification of, another person for payment or other reward, irrespective of whether the reward is given to the person providing the services or another person."

The law requires that all people involved in the commercial sex industry, including prostitution business operators, sex workers and their clients, adopt safer sex practices. All parties involved must take reasonable steps to ensure that condoms or other appropriate barriers are used in services that involve a risk of STIs. In addition, operators must give health information to sex workers and clients and prominently display such information in brothels. Failure to act accordingly is punishable with a fine of up to NZD 10,000 (around USD 6,100) in the case of an operator, and up to NZD 2,000 (around USD 1,200) in the case of a sex worker or client. Under the law, advertisement of commercial sexual services is restricted. Additionally, the law prohibits inducing or compelling another person to provide commercial sexual services or paying for such services (punishable with up to 14 years of imprisonment) and it protects the right of sex workers to refuse to provide or continue to provide these services, regardless of any contract for such services. The law further specifies that it is a crime to cause a person younger than 18 to provide commercial sexual services. Deriving a profit from, contracting for or receiving commercial sexual services from a person under 18 is also prohibited. Parties that violate these prohibitions may be punished with up to seven years in prison, except for those under the age of 18, who are excluded from criminal liability.

NIGERIA ENACTS ANTI-TRAFFICKING LAW

In July 2003, the Federal Republic of Nigeria enacted the **Trafficking in Persons (Prohibition) Law Enforcement and Administration Act**. This law establishes a national agency assigned to oversee its enforcement and coordinate all national laws and measures aimed at preventing trafficking. The agency's specific duties include enhancing the effectiveness of law enforcement agents in stopping trafficking; improving communication, research and international cooperation; reinforcing measures in treaties signed by Nigeria to counter human trafficking; collaborating with other agencies and bodies to eliminate the root causes of trafficking; strengthening legal means for international cooperation in criminal matters; and enhancing cooperation between the judiciary, law enforcement services and other agencies within Nigeria. In addition, the agency is responsible for supervising the rehabilitation of trafficked persons and is empowered to participate in legal proceedings related to trafficking. It may also initiate investigations.

The law specifies the different crimes related to human trafficking and sets criminal penalties. The export or import of persons under the age of 18 for purposes of prostitution is punishable with life imprisonment, as is the dealing in persons as slaves. Other acts related to the procurement of persons under the age of 18 for purposes of prostitution are subject to varying prison terms, fines or both. Tour operators and travel agents are obliged to notify their clients that they are prohibited from aiding or abetting the offenses of trafficking, pornography and exploitation. Airline companies are also expected to promote public awareness of the new trafficking law in in-flight magazines and videos, and on ticket jackets. The law charges the above-mentioned national agency with ensuring that trafficked persons are not subjected to discrimination, that they have access to adequate health care and social services, and that they are able to return home safely. The agency must further ensure that investigations intrude minimally into the personal history of a trafficked person, that his or her identity is protected, and that the person is protected from intimidation, threats and reprisals from traffickers. Trafficked persons are not to be prosecuted for offenses related to being a victim of trafficking, which include nonpossession of valid travel permits or use of false travel documents. The law further notes that a trafficked person, regardless of his or her immigration status, has the right to bring a civil action against a trafficker and others who have contributed to his or her exploitation. Convicted traffickers are liable for their victims' economic, physical and psychological damages.

THE PHILIPPINES ENACTS ANTI-TRAFFICKING LAW

On May 26, 2003, the Philippines enacted **Republic Act No. 9208**, entitled the Anti-Trafficking in Persons Act of 2003. Citing international human rights instruments, the law announces a state policy to develop measures and programs aimed at supporting trafficked persons and ensuring their recovery and reintegration into mainstream society. Under the law, it is a crime, for the purpose of buying, selling or trading a person, to recruit, transport or receive a person by any means, including under the pretext of domestic or overseas employment; introduce or match for marriage a person to a foreign national for money or other consideration; or offer or contract marriage, real or simulated. It is also illegal to organize tours for the purpose of prostitution, pornography or sexual exploitation; maintain or hire a person to engage in prostitution or pornography; or adopt or facilitate the adoption of persons for the purpose of prostitution, pornography, sexual exploitation, forced labor, slavery, involuntary servitude, or debt bondage. It is also illegal to recruit, hire, adopt, transport, or abduct a person for the purpose of removal or sale of his or her organs. Finally, the law penalizes the recruitment, transport or adoption of a child to engage in armed activities in the Philippines or abroad. A number of activities deemed to "promote" trafficking are also prohibited. Elevated penalties, including life imprisonment, are imposed when, *inter alia*, the trafficked person is a child; the offender is a parent or guardian of the trafficked person; or the trafficked person dies, develops mental illness, suffers mutilation, or becomes infected by HIV/AIDS.

Other provisions of the Act mandate the implementation of programs to prevent trafficking, and protect and rehabilitate trafficked persons. The law recognizes trafficked persons as victims, according them exemption from criminal liability and entitlement to enter the Witness Protection Program. Trafficked foreign nationals are provided the same protection. The law calls for the establishment of an Inter-Agency Council against Trafficking. It enumerates mandatory services to trafficked persons, such as emergency shelter, counseling, free legal services, medical or psychological services, livelihood and skills training, and educational assistance to a trafficked child. It further provides for the repatriation of foreign trafficked persons and the inclusion of trafficking among extraditable offenses.

THE PHILIPPINES ENACTS LAW PROTECTING CHILD WORKERS

On December 19, 2003, the Philippines approved **Republic Act No. 9231** aimed at preventing child labor in its worst forms and affording stronger protections for working children. The law adapts the definition of the worst forms of child labor set out in International Labor Organization Convention 182, which the Philippines ratified in November 2000. Among the types of child labor included in this definition are all forms of slavery or practices similar to slavery, such as the sale and trafficking of children; using, procuring, offering, or exposing a child for prostitution, the production of pornography or pornographic performances; and any work that is hazardous or likely to be harmful to the "health, safety or morals" of children, including work that "exposes a child to physical, emotional or sexual abuse, or is found to be highly stressful psychologically or may prejudice morals." The law also prohibits the use of children in advertisements promoting alcoholic beverages, tobacco, gambling, or any form of violence or pornography.

The law sets a minimum age of employment at 15, with some exceptions, and states the maximum number of hours a child may work, with some variations according to the child's age. The law also addresses the proper use and administration of a child's income. Employers of children are required to ensure access to at least primary and secondary education, and the Department of Education is charged with promoting the education of working children by taking such measures as designing courses and conducting training for the implementation of appropriate curricula. Employers that violate the law are subject to penalties that include imprisonment and fines. Parents and legal guardians who violate the law are subject to fines, community service or both. Businesses face immediate closure if violation of the law results in death or serious injury or if they are engaged in prostitution or in obscene or lewd shows.

TUNISIA ENACTS LAW CRIMINALIZING SEXUAL HARASSMENT

On August 2, 2004, Tunisia enacted **Law No. 2004-73** amending the 1913 Penal Code to criminalize sexual harassment and certain offenses "against morality." The provision relating to sexual harassment defines the offense as persistent harassment of another

through repeated humiliating or offensive actions. It also designates as sexual harassment words or gestures that are intended to cause the victim to submit to one's own sexual overtures (or to those of a third party) or to weaken the victim's efforts to resist those overtures. The provision penalizes offenders with imprisonment of one year and a fine of 3,000 Tunisian dinars, and doubles the punishment where the victim is a child or a person with physical or mental disabilities. Criminal charges for sexual harassment or other offenses under the new provisions may be initiated only by a public prosecutor on the basis of a victim's complaint. An individual tried or convicted under the provisions may still be subject to proceedings for other offenses that carry more severe penalties. A defendant acquitted of charges under the provisions may seek damages for any harm suffered, as well as initiate criminal proceedings for libel or slander.

See also Reproductive Health and Rights: Benin, Chad and Colombia

Female Genital Mutilation (FGM)

FGM is the collective name given to several different practices that involve the cutting of female genitals. While some countries began taking action to stop FGM several decades ago, it is primarily since the 1990s that governments have used legislation to address the practice. This approach has generally entailed criminal penalties for those who perform, assist or solicit FGM. Provisions prohibiting FGM also appear in national constitutions and reproductive health laws. Some governments have adopted laws or decrees creating government programs or mechanisms to discourage FGM through outreach and education. While legislation by itself cannot stop FGM, it can be a crucial element in a broader campaign to change attitudes and behavior.

BENIN ADOPTS LAW PROHIBITING FGM

On January 21, 2003, Benin's National Assembly adopted **Law No. 2003-03** prohibiting the practice of FGM. The law bans FGM in all its forms, defining it as any ablation, partial or total, of a female person's external genitalia, or any other operation on such genitalia. Surgeries that are performed for medical purposes are not criminalized under the law. A person who performs FGM shall be imprisoned from six months to one year and required to pay a fine. If the cutting is performed on a woman under the age of 18, the punishment is imprisonment from three to five years and an increased fine. Should the victim die as a result of the cutting, the punishment is forced labor for 5 to 20 years and heightened financial penalty. Anyone who assists, participates in or solicits an act of FGM, or provides the means or gives instructions to the perpetrator, is deemed an accomplice and is subject to the same penalty as the principal perpetrator. Recidivists face the maximum penalty, with no possibility of a reduced sentence.

Anyone with knowledge of a planned genital mutilation who does not act to prevent it shall be prosecuted for failing to assist a person in danger. Likewise, anyone with knowledge that FGM has occurred must immediately inform the nearest law enforcement authorities. Failure to report is punishable with a fine. Finally, the law requires public and private health institutions to care for those who have undergone FGM and ensure that they receive appropriate services. These institutions are further required to inform local authorities.

MALI CREATES GOVERNMENT PROGRAM TO STOP FGM

On June 4, 2002, the President of Mali issued **Order No. 02-053/P-RM** creating a government program aimed at stopping the practice of FGM. The National Programme for the Prevention of Excision is charged with coordinating, monitoring and evaluating government policy and strategies targeting FGM. Its duties include planning, coordinating and evaluating activities; conducting research; developing a strategy for information, education and communication that targets individuals and communities; creating a database on FGM; and supporting the development and introduction of training curricula for personnel in the fields of health and education.

NIGER ADOPTS LAW PROHIBITING FGM AND OTHER THREATS TO WOMEN'S INTEGRITY

On June 13, 2003, the Republic of Niger adopted **Law No. 2003-025** amending the Penal Code of 1961. Among the new offenses recognized by the amended Penal Code is the crime of FGM, which is defined as "any assault on the female genital organ by total or partial removal of any of its parts, excision, infibulation, desensitization or any other means." The law calls for a minimum criminal sentence of six months in prison and a fine, and for elevated penalties when FGM results in death and when the practitioner is a member of a medical profession. In its provisions on "slavery," the amended Penal Code recognizes as a form of slavery any institution in which a woman, with no right to refuse, is promised or given in marriage in exchange for money or goods, is transferred to a third party, or is forced to engage in sexual relations with a "master." Also characterized as slavery is any institution or practice in which a minor under the age of 18 is given by a parent or guardian (or a person having control over a parent or guardian) to a third party, with or without compensation, for the purpose of exploitation or labor. It is also an offense to profit from the prostitution of a woman in a "servile position." In addition, the amended Penal Code recognizes the crime of sexual harassment, defining it as "the use of orders, threats or constraints to obtain favors of a sexual nature." Penalties, which include a minimum of three months in prison and a fine, are elevated when the harassment is an abuse of authority. Finally, the law redefines the crime of rape as "any act of sexual penetration, in any form, committed on the person of another by means of violence, constraint, threat or surprise."

See also Reproductive Health and Rights: African Union, Benin, Chad, and Mali

NORWAY CRIMINALIZES FAILURE TO ACT TO PREVENT FGM

On May 28, 2004, Norway adopted **Law No. 33** amending its 1995 law prohibiting FGM. The new provision imposes a fine or prison sentence of up to one year on child-care personnel, health providers, social workers, and persons of authority in religious communities who intentionally refrain from taking action to prevent an act of FGM. The failure to report an unsuccessful attempt to commit an act of FGM is not punishable.

Contraception

A woman's right to plan her family can only be realized if she has access to the full range of contraceptive methods provided in a setting in which she can make an informed choice. The United Nations Population Fund reports that an estimated 350 million couples worldwide do not have access to the family planning services they need.[2] *While few governments impose formal barriers to contraceptive access, many fail to take the affirmative steps needed to put contraceptives in the hands of individuals and couples seeking to control their fertility. Legislative and policy measures aimed at facilitating access to contraception are a first step. Of the governments that have adopted such measures, several have made special provisions to ensure that emergency contraception (EC) is made available to those who are among the most vulnerable to unwanted pregnancy—adolescents and survivors of rape.*

CHILE'S MINISTRY OF HEALTH WILL PROVIDE EC TO SURVIVORS OF RAPE

On April 6, 2004, Chile's Ministry of Health issued **Resolution No. 527** on the conditions for delivery of EC to victims of sexual violence. The accompanying Norms and Technical Guidelines on Emergency Care Service for Victims of Sexual Violence are intended to provide health-care clinics and health personnel with tools to ensure that victims of sexual abuse are given appropriate care and necessary information on the risks associated with the crime inflicted, as well as access to different treatments to prevent unwanted pregnancy, STIs, hepatitis B, and HIV. Persons who have been victims of sexual violence shall receive EC upon request. Parental consent is required in cases where victims of sexual assault are minors.

Under the guidelines, health professionals must guarantee that victims who seek assistance are treated with dignity and respect, that their confidentiality is protected, and that they have access to a fair grievance procedure. The guidelines further guarantee psychological support and counseling for victims of sexual assault. Other provisions offer direction for health clinic personnel on how to manage cases of sexual assault by calling for such health clinic initiatives as developing systematized institutional

mechanisms that respond to victims' needs; creating a nonjudgmental and welcoming atmosphere; and formulating a sensitization program that responds to the needs of victims of sexual violence. Should an attending physician decide not to provide treatment for personal or religious reasons, he or she must refer the case to a practitioner capable of handling the patient's request for treatment. In an effort to respect the person's privacy and ease the reporting process, the guidelines require that rape victims not be asked to undergo questioning and a physical examination more than once. In addition, a physician's report on the medical examination of a victim of sexual violence should be limited to clinical observations; he or she is not authorized to assert or qualify the criminal act.

COLOMBIA ISSUES REGULATION PROVIDING FOR ADOLESCENTS' ACCESS TO CONTRACEPTION

On February 18, 2004, Colombia's Ministry of Social Protection issued **Circular No. 18**, a regulation that outlines goals, activities and standards for the delivery of primary health-care services. The regulation provides guidance for implementing the National Policy on Sexual and Reproductive Health, the principal elements of which are safe motherhood, family planning, adolescent sexual and reproductive health, uterine cancer, STIs, and domestic and sexual violence (see REPRODUCTIVE HEALTH AND RIGHTS: Colombia). Among the actions called for are information, education and outreach campaigns; the development and diffusion of technical norms; and the monitoring of compliance with those norms.

The regulation specifically addresses adolescents' access to contraception. It requires the provision of hormonal and barrier contraceptive methods, as well as EC, to uninsured adolescents living in communities that are displaced, economically disadvantaged and at risk. In addition, the regulation calls for providing EC and STI preventive care to victims of sexual and domestic violence.

ENGLAND ISSUES GUIDANCE ON CONTRACEPTIVE SERVICES FOR ADOLESCENTS UNDER 16

On July 29, 2004, the British Department of Health issued **Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health**. The guidance specifically addresses health professionals' duties of confidentiality and care to patients under 16, and recognizes that concerns about confidentiality are the biggest deterrent to seeking care among adolescents in this age-group. The guidance calls for all health facilities that provide contraceptive services to young people to develop and prominently advertise a confidentiality policy that explicitly guarantees adolescents under 16 the same right to confidentiality as adults. It condemns deliberate breaches of confidentiality, however minor, as serious disciplinary matters. The guidance quali-

fies the duty of confidentiality in cases where health professionals believe there is a serious risk to the health, safety, or welfare of a young person. In considering whether to disclose information, health professionals should weigh disclosure against factors such as the young person's right to privacy, the degree of current or likely harm, and the potential benefits of disclosure to the young person's well-being. In all but exceptional circumstances, the guidance cautions health professionals to consult the young person and offer support for voluntary disclosure before taking unilateral action.

With regard to health professionals' duty of care to patients under 16, the guidance authorizes the provision of contraceptive and sexual and reproductive health services without parental knowledge or consent provided that two conditions are met: the young person understands the advice provided and its implications; and the young person's physical or mental health would likely suffer if advice or treatment were not provided. The guidance emphasizes health professionals' duty of confidentiality to the patient, regardless of whether advice or treatment is ultimately provided. It also discourages health professionals from letting personal beliefs prejudice their care to a young person; any provider who is unable to provide confidential contraceptive services should make alternative arrangements for the patient to be seen by another professional and prominently advertise that such alternatives are available. The guidance also provides several specific "good practices" for health professionals to consider when providing services to patients under 16. For example, in dealing with a request for contraception by a young patient, providers should "establish rapport" with the patient and offer counseling on issues such as the emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmissible infections; the nature of consent in the relationship (i.e., presence of coercion or abuse); and the benefits of informing the adolescent's general doctor and her parent or other caregiver. In cases of abortion, if a young woman is capable of giving consent and does not wish to involve a parent, the guidance urges providers to make "every effort" to help the patient find another adult who can provide support. The guidance also specifically notes that the Sexual Offences Act of 2003 does not implicate health professionals and others who provide confidential contraceptive and reproductive and sexual health services to young people under 16.

FRANCE SETS TERMS FOR IMPLEMENTING MINORS' ACCESS TO EC

On January 9, 2002, the Republic of France issued **Decree No. 2002-39** on the conditions for delivery of EC to minors. Pursuant to previous legislation, minors under the age of 18 may receive EC free of charge from a pharmacist without a prescription or parental approval. The decree requires pharmacists dispensing EC to offer counseling on the correct use of EC and to ensure minors' confidentiality. Pharmacists are also required to interview minors to determine whether use of EC is appropriate to their situation. The interview is an opportunity for the pharmacist to counsel and provide

documentation on regular birth control, prevention of STIs and the benefit of regular medical examinations. In addition, pharmacists should provide minors with information on the nearest family planning education centers.

MEXICO INCLUDES EC AND FEMALE CONDOM IN OFFICIAL FAMILY PLANNING REGULATIONS

On January 21, 2004, the federal government of Mexico amended its **Official Family Planning Regulation NOM-005-SSA2-1993** to include EC and the female condom. The regulation refers to EC as "postcoital hormonal contraception," which it defines as "a method that may be used by women within three days following unprotected sex in order to prevent an unplanned pregnancy." The definition specifies that postcoital methods should not be used regularly and are indicated solely under the circumstances outlined in the regulation. The regulation, which approves several different postcoital contraceptive regimes, indicates that EC is appropriate for women of childbearing age, including adolescents, who wish to avoid an unplanned pregnancy under the following circumstances: after voluntary or forced sex without contraceptive protection; after delay in administration of injectable contraception; and after presumed contraceptive failure (broken condom, failed attempt to withdraw prior to ejaculation, suspended use of oral contraceptive pills for more than three days, expulsion of an IUD, and inaccurate calculation of "safe periods" when using the rhythm method or periodic abstinence). The regulation specifies that prescribing EC must be accompanied by thorough guidance and counseling regarding its effects. In particular, providers should emphasize that EC cannot interrupt an established pregnancy and that when a pregnancy occurs despite use of EC, the product will have no harmful effects on the pregnant woman or the fetus. Counseling should also emphasize that EC is less effective than conventional oral contraception and that it does not protect against STIs, including HIV/AIDS. The regulation further provides that it is not necessary to conduct a gynecologic examination or pregnancy test prior to prescribing EC. It does call for counseling on regular birth control methods, as well as examination of the patient's risk of having acquired an STI.

The regulation also lists the female condom as an approved barrier method. It provides instructions on how to use the method, emphasizing that it is important for women to familiarize themselves with the female condom prior to using it during intercourse. The regulation states that condoms may be made available through community distribution and social marketing programs. They may also be sold in pharmacies or other commercial establishments.

Abortion

Respect for reproductive rights requires recognition of a woman's right to make deeply personal decisions about her body and her fertility. When faced with an unwanted pregnancy, only she can decide whether she will carry the pregnancy to term. Governments are bound to fulfill women's basic human rights by ensuring that women have access to the full range of quality reproductive health services, including abortion. A growing number of governments have reduced legal barriers to abortion services, which is a first step toward ensuring that safe and high-quality abortion services are accessible to all women.

NEPAL LEGALIZES ABORTION ON BROAD GROUNDS

On September 26, 2002, the King of Nepal signed the **Country Code (Eleventh Amendment) Bill**, which, among other things, sets forth the conditions under which abortion may be performed. Abortion is now legal in Nepal at the woman's request during the first 12 weeks of pregnancy. It is permitted during the first 18 weeks of pregnancy in cases of rape and incest, and at any time in the case of fetal impairment and when a woman's life or health is in danger. The law prohibits and sets forth penalties for both sex-selective abortion and prenatal testing for the purpose of sex selection.

REPUBLIC OF URUGUAY ADOPTS NORMS TO PREVENT UNSAFE ABORTION

On August 6, 2004, Uruguay's Ministry of Public Health issued **Ordinance No. 369** adopting norms and guidelines aimed at preventing unsafe abortion and minimizing injuries associated with it. In the ordinance, the ministry notes that while Uruguay's health indicators are generally acceptable, the number of the country's abortion-related deaths has grown, particularly in the public health sector. The norms and guidelines adopted to address this problem were formulated by Uruguay's Society of Gynecologists, Physicians' Union, and Faculty of Medicine.

Although the norms and guidelines acknowledge that abortion is legally restricted in Uruguay, they emphasize the need to provide patients with information that will allow them to make informed and responsible decisions. The strategy includes pre-abortion consultations that provide gynecologic and mental health care, as well as psychosocial support and education. Postabortion care includes early diagnosis and prevention of complications, counseling, and comprehensive sexual and reproductive health education.

The ordinance calls for the creation of a commission to develop a plan for implementing the norms and guidelines. It is to be composed of representatives from the Ministry of Public Health and the National Health Services Department, as well as one representative each from Uruguay's Society of Gynecologists, Physicians' Union,

and Faculty of Medicine. The commission will also be open to various other members of civil society.

See also Reproductive Health and Rights: African Union, Benin, Chad, and Mali

HIV/AIDS

HIV/AIDS is one of the most pressing sexual and reproductive health concerns of our time. Because women's subordinate role in society heightens their risk of HIV infection, prevention strategies must take women's circumstances into account. 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. Governments must therefore work to minimize the impact of the disease upon women's enjoyment of their civil, political, social, economic, and cultural rights. Many governments have adopted legal and policy measures aimed at preventing the spread of HIV/AIDS and protecting the rights of people living with HIV/AIDS.

CANADA AUTHORIZES MANUFACTURE OF GENERIC DRUGS TO ADDRESS PUBLIC HEALTH PROBLEMS IN LOW-INCOME COUNTRIES

On May 14, 2004, the Canadian government enacted amendments to the **Patent Act and the Food and Drugs Act**, which seek to facilitate low-income countries' access to certain essential medicines to address public health problems resulting from HIV/AIDS, tuberculosis, malaria, and other infections. The amendments implement an August 2003 decision of the World Trade Organization (WTO) authorizing countries to produce generic versions of patented medicines for export to low-income countries that lack the capacity to manufacture such medicines domestically. Canada is the first high-income country to pass legislation in response to the WTO decision.

Under the amendments to the Patent Act, which add a new section entitled "Use of Patents for International Humanitarian Purposes to Address Public Health Problems," Canadian firms may apply for a license to manufacture in Canada specific, patented medicines for export to certain low-income countries. Licenses are issued for a two-year period and limit the manufacture of a medicine to a specific quantity and for use in a specific country. The amendments include four schedules that identify eligible medicines and countries under the new system. Schedule 1 lists the qualifying medicines, which consist of 46 products on the World Health Organization's "model list of essential medicines" that are currently under patent in Canada. Schedules 2–4 list the countries that are eligible to import the medicines under the act; these include all countries that the United Nations identifies as "least-developed," as well as certain other "developing" countries that are WTO members. The amendments provide a mecha-

nism for the Canadian Cabinet to revise the schedules according to changing needs or international consensus. The amendments also mandate the Ministry of Industry to review the new provisions three years after they come into force. The amendments to the Food and Drug Act address the regulatory approval process for generic medicines intended for export under the new system.

GHANA ADOPTS NATIONAL GUIDELINES ON HIV VOLUNTARY COUNSELING AND TESTING

In November 2003, Ghana adopted **National Guidelines for the Development and Implementation of HIV Voluntary Counseling and Testing**. The guidelines set out the minimum acceptable standards for the establishment of voluntary counseling and testing (VCT) centers, including staff qualifications and training requirements. They provide instruction on how to set up an appropriate VCT facility, ensure adequate counseling, administer tests, ensure quality services, and offer patients referrals. The guidelines' provisions on counseling emphasize confidentiality and respect for patients' basic human rights, including patients' rights to privacy, nondiscrimination, equality, marriage, and informed consent. Guidance is offered for counseling in "special circumstances," including when testing is provided to pregnant women and adolescents. Testing during pregnancy is the first step in preventing transmission of HIV to newborns. The guidelines emphasize that in order to encourage pregnant women to be tested, strict procedures for maintaining the confidentiality of test results must be observed. Pregnant women should be given counseling that ensures that they fully understand the benefits and risks of HIV testing as well as the types of additional services they will receive if they test positive. Pregnant women who decline HIV screening should not be denied prenatal care, nor coerced into accepting testing. As for adolescents, the guidelines call for staff sensitivity to the particular vulnerability of adolescent girls to HIV infection. Services should be youth-friendly, understanding, and nonjudgmental. Where an adolescent is younger than 18, if a counselor assesses that the minor can understand the reasons for the test and its implications, then the adolescent should be considered "mature" and capable of giving informed consent. Counselors are instructed to encourage adolescents to inform parents or guardians of the test results, and to assist young people in doing so if it is in their best interest.

NEW ZEALAND ADOPTS HIV/AIDS PREVENTION STRATEGY

In December 2003, the government of New Zealand adopted the **HIV/AIDS Action Plan—Sexual and Reproductive Health Strategy** to respond to HIV/AIDS in New Zealand. The HIV/AIDS Action Plan has four goals: (1) to increase societal awareness and understanding of the risk factors and implications of HIV/AIDS, as well as community-wide commitment to preventing HIV transmission; (2) to ensure that individuals, particularly such "target groups" as men who have sex with men, refugees from high-prevalence countries, injecting drug users, sex workers and people living with HIV/

AIDS, have the knowledge, skills and confidence to protect themselves; (3) to establish accessible and effective programs and services that work together regionally and nationally to prevent HIV transmission; and (4) to create an information and evidence base to enable policy and program development, surveillance of HIV/AIDS, and monitoring of progress and clinical decision-making.

In furtherance of the first goal, to increase awareness of HIV among all members of society, the plan calls for measures to ensure that HIV awareness and prevention training is a key component of sexual and reproductive health education programs, particularly those targeting young people. It also emphasizes the importance of decreasing the stigma and discrimination surrounding HIV/AIDS, and calls for legislative and policy frameworks for HIV/AIDS that maximize the impact on public health while minimizing the impact on human rights and privacy. To meet the second objective of ensuring that target groups have the knowledge and skills to protect themselves, the plan calls for measures that include building upon existing HIV/AIDS prevention, education and skills training programs; ensuring that target groups have access to condoms, clean needles and syringes; making sure that peer education and community-based leadership is maintained within target groups; and providing information on the availability of voluntary HIV testing and counseling to target groups. To advance the third goal of establishing effective and accessible programs and services, the plan calls for measures to improve access to and coverage of services; create pathways of care between preventive, primary and specialist health care; and strengthen services at every level. Finally, to achieve the fourth goal of creating an information and evidence base, the plan emphasizes the need to better understand the trends of HIV/AIDS prevalence, the behaviors driving increases in HIV incidence and the trends in populations at highest risk of HIV infection. The plan underscores the importance of ensuring that surveillance methods are flexible enough to move with the needs arising from the epidemic.

NIGERIA ADOPTS NATIONAL POLICY TO PREVENT HIV/AIDS

In June 2003, the federal government of Nigeria issued its **National Policy on HIV/AIDS 2003**. The policy's goals are to control the spread of HIV/AIDS, to provide equitable care and support for those infected by HIV, and to mitigate the impact of the disease. To achieve these goals, the government commits itself to pursuing a number of specific objectives, including promoting a national multisectoral and multidisciplinary response to the epidemic and assigning appropriate roles to the different sectors; increasing awareness among the general population about HIV/AIDS and encouraging behavior change to control the epidemic; fostering acceptance of every person's responsibility to prevent transmission of HIV and to support those affected; providing cost-effective care for those infected; protecting the legal rights of those infected; removing all barriers to HIV/AIDS prevention and control; empowering those infected and affected by HIV/AIDS; developing standards and guidelines in order to institutionalize best practices to mitigate the impact of AIDS; stimulating research and monitoring and

evaluation of programs; and developing prevention programs that target vulnerable groups. The policy names five broad strategies for achieving its overall goals: working to prevent HIV/AIDS transmission; ensuring respect for and protection of the rights of all Nigerians, including those living with and affected by HIV/AIDS; providing for the care and support of those infected or affected by HIV/AIDS; engaging in effective communication; and promoting and enhancing program management and development. As a means of monitoring and evaluating Nigeria's progress and implementation of the policy over time, the policy sets as its principal target the achievement of at least a 25% reduction in the adult HIV prevalence rate every five years.

SOUTH AFRICA ISSUES GUIDELINES TO EMPLOYERS ON NONDISCRIMINATION AGAINST PEOPLE LIVING WITH HIV/AIDS

On May 23, 2003, the South African Department of Labour issued the **HIV/AIDS Technical Assistance Guidelines**. The guidelines are intended to provide employers and other actors with tools to ensure that people living with HIV/AIDS do not face discrimination in the workplace. The guidelines complement South Africa's Code of Good Practice on Key Aspects of HIV/AIDS and Employment, which was issued in 2000 pursuant to the Employment Equity and Labour Relations Act of 1998. The guidelines affirm employers' duty not to discriminate against people living with HIV/AIDS, as well as the following employer responsibilities: to ensure a nondiscriminatory work environment; to ensure that HIV testing be done in compliance with the law, with confidentiality assured; to promote a safe work environment and ensure that employees who become occupationally infected with HIV may apply for compensation; to ensure the sustained and equitable distribution of employee benefits; and to protect employees from unfair dismissals and provide for a fair grievance procedure. The guidelines also offer direction on how to manage HIV/AIDS in the workplace by calling for such employer initiatives as mainstreaming HIV and gender programming, developing institutional mechanisms for responding to HIV/AIDS, determining the impact of HIV/AIDS in the workplace, developing an HIV/AIDS policy, and creating a workplace HIV/AIDS–prevention program. Intended as a manual, the guidelines summarize the relevant legal framework, provide checklists of employer responsibilities, offer examples of "good practices," and include case studies to illustrate how norms are applied.

SOUTH AFRICA RELEASES PLAN FOR COMPREHENSIVE CARE FOR PEOPLE LIVING WITH HIV/AIDS

On November 19, 2003, the government of South Africa adopted the **Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment**. The plan has two interrelated goals: (1) providing comprehensive care and treatment for people living with HIV/AIDS and (2) facilitating the strengthening of the national health system in South Africa. As its timeline, the plan aims to establish at least one service point in every health district in South Africa by the end of the first year of

implementation, and to ensure equitable access to care to all South Africans and permanent residents needing treatment for HIV/AIDS within a period of five years. With regard to the plan's first goal of comprehensive care and treatment, the plan seeks to meet the holistic needs of individuals at all stages of HIV infection, expand voluntary counseling and testing services, promote prevention programs, monitor the health of HIV-positive patients seeking treatment, and, where medically indicated, provide counseling and the option of antiretroviral therapy, among other measures. In order to promote its second goal, the strengthening of the national health system, the plan provides for significant investments in developing the health system's human resources and physical infrastructure, improving access to laboratory services, and developing new strategies for drug distribution and procurement. The plan organizes the tasks necessary for its realization by chapter. The first chapter contains guidelines for prevention, care and treatment, which have been developed in conformity with international and local norms and standards of practice. Additional chapters address nutrition-related interventions, traditional medicine, accreditation of service points, human resources, provincial site assessments, drug procurement and distribution, laboratory services, social mobilization and communication, patient information systems, monitoring and evaluation, and research priorities.

See also Reproductive Health and Rights: African Union, Benin, Chad, and Mali

Population Policies

Governments often address reproductive health and rights in their national population policies. Such policies set out a government's broad objectives on population, usually while providing a framework for the delivery of reproductive health care. While a number of governments call for women's empowerment and self-determination in their population policies, those objectives may be at odds with their nations' laws and social norms, as well as with other provisions in the policies themselves that emphasize demographic targets over women's decision-making. National population policies and measures for their implementation should recognize women's reproductive and sexual health needs and take a rights-based approach.

CAMBODIA LAUNCHES FIRST NATIONAL POPULATION POLICY

On February 4, 2004, the prime minister of Cambodia launched the **National Population Policy**, the first in the country's history. At the core of the policy is the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, and to have access to the information and means to do so. The policy further describes the underlying principles that guided its formulation, including the values of Khmer culture and tradition, the human rights guarantees in the Cambodian Constitution, and the government's commitments under international human rights treaties and agreements. The policy's overall goal is to achieve sustain-

able development, reduce poverty, and improve the quality of life of all Cambodians through changes in the size, composition and distribution of the population. Its specific objectives are to support couples and individuals in their ability to decide freely and responsibly on the number and spacing of their children, and to provide them with the information, education and services to do so; reduce infant, child and maternal morbidity and mortality rates; reduce the potential negative impact of rural-urban migration; promote gender equality; enhance human resource development; alleviate the burden of population on the environment and natural resources; strengthen efforts to stop the spread of HIV/AIDS; and integrate population issues into social and economic policies, plans and programs at all levels. A series of strategies accompany each objective. A forthcoming action plan, known as the National Population Strategy, will provide detailed strategies and programs to implement the policy. The policy charges the National Committee for Population and Development with responsibility for monitoring its implementation.

NEPAL TARGETS REPRODUCTIVE HEALTH IN POVERTY REDUCTION STRATEGY

On February 4, 2003, the government of Nepal adopted its **Tenth Plan** (Poverty Reduction Strategy Paper). The plan aims to expedite poverty reduction through economic growth, social sector development, targeted programs aimed at inclusion of marginalized groups, and good governance. Among the plan's priority areas are "population management," health sector improvements, and promotion of the status of women. With regard to population, the plan cites as long-term objectives the reduction of the fertility rate and the development of an "educated, healthy and skilled" population. Strategies to those ends include programs to promote adolescent health and education, increased coordination of programs to promote late marriage and breast-feeding, increased access to reproductive health services, and improvement of women's status. In the area of health care, the plan's long-term objectives include ensuring all Nepalis equal access to quality health-care services. Health-care objectives also include creating demand for smaller families; maintaining "balance" between population growth and economic, social and environmental development; and promoting "healthy and capable human power." Among the key indicators of progress are the availability of reproductive health and maternity services provided by trained health workers, use of family planning services, and a decrease in the infant and maternal mortality rates. Priority programs include safe motherhood services, reproductive health care for teenagers and programs to limit the spread of HIV/AIDS. The plan aims to improve the management of health-care services at every level and promote health service decentralization. Finally, it also calls for the improvement of women's status as a means of advancing development, citing in particular the importance of gender mainstreaming, gender equality and women's empowerment. Among the strategies raised are reforming discriminatory laws, including women in poverty reduction programs and increasing "gender awareness."

VIETNAM ADOPTS POPULATION ORDINANCE

On May 1, 2003, Vietnam issued a **Population Ordinance**, which establishes the objectives, implementing measures and guiding principles for managing activities relating to population. The ordinance also enumerates the rights and duties of individuals and the responsibilities of government agencies with respect to population-related activities. Several of the ordinance's provisions have implications for women's reproductive health and rights.

The ordinance sets forth fundamental principles, including autonomy and equality of all individuals and families in matters relating to birth control and reproductive health care. The ordinance also prohibits certain acts, including obstructing or forcing the practice of family planning; practicing sex-selection techniques; producing, dealing in, importing, or supplying fraudulent, substandard or unapproved contraceptives; and human cloning.

In addressing population size, the ordinance cites reproductive health care and family planning programs among its principal strategies to render population growth compatible with socio-economic development, natural resources and the environment. The government is required to provide high-quality, accessible and safe family planning services; offer material and moral incentives for family planning; and create favorable conditions for the implementation of family planning programs, giving priority to low-income individuals and minors, among others. The ordinance provides that couples and individuals have certain rights related to family planning, including the right to decide the timing, number and spacing of their children. At the same time, the ordinance states that couples have "an obligation" to use contraceptive methods and take steps to prevent STIs, including HIV/AIDS.
Additional directives to the government include adopting policies and measures to prevent sex-selection techniques, and meeting the demands of ethnic minorities for reproductive health care and family planning services. To advance the health of the population, the ordinance requires the state to ensure fundamental human rights, implement reproductive health measures, and adopt policies and measures to eliminate all forms of gender discrimination. The ordinance also provides for the incorporation of population education into school curricula and textbooks at all levels of education, to be coordinated by the Ministry of Education and Training, and the Committee for Population, Families and Children.

Marriage and Family Law

A woman's rights within marriage and the family greatly affect her ability to control her life and make voluntary, informed reproductive choices. More and more governments are harmonizing their national family and marriage laws with international and regional women's rights norms. Principal among those norms is the requirement of the Convention on the Elimination of All Forms of Discrimination against Women that governments "take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations…."[3]

CHILE LEGALIZES DIVORCE

On May 7, 2004, Chile adopted **Law No. 19.947**, which amends the 1884 Marriage Code to include a provision on divorce. Previously, couples could dissolve their marriages only through annulment by a civil registrar. Under the new law, a judge can approve a divorce without a waiting period if one party proves that the actions of his or her spouse constitute a serious violation of the duties and obligations arising from marriage. Indications that these duties and obligations have been violated include assaults against the life or physical or psychological integrity of a spouse or of one's child; serious and repeated failure to meet the obligations of cohabitation, support and fidelity; conviction of any crime against family order and public morality or of a crime against persons involving a serious breach of marital harmony; homosexual conduct; alcoholism or drug addiction that constitutes a serious impediment to harmonious cohabitation of spouses and their children; and attempt to enter the other spouse or one's children into prostitution. A judge may also grant a divorce with the agreement of both parties following a one-year period of separation. A judge has discretion to grant a divorce to one partner if the couple has been separated for a minimum period of three years. The new law also requires couples seeking a divorce to participate in a conciliation hearing with the purpose of examining the causes of conflict between the parties and assessing whether it is possible to save the marriage. The law guarantees compensation upon divorce for a spouse who for the duration of the marriage served as a homemaker or cared for the children, and consequently was unable or limited in his or her capacity to sustain remunerated employment during that time. Couples seeking a divorce who wish to partake in a mediation process may choose among mediators who require remuneration and those whose services are free of charge.

Assisted Reproductive Technologies

Advances in assisted reproductive technologies have helped countless couples to conceive. The benefits of these technologies could potentially be enjoyed by many more. In addition, some of these technologies may assist in vital medical research. In order to control the manner in which these technologies are used, a number of governments have adopted legislation regulating them. While government policies should adapt to reproductive technologies as they evolve, these policies should, at a minimum, uphold the principle of nondiscrimination and protect the rights and health of women, whose bodies are most directly implicated.

CANADA ADOPTS ASSISTED HUMAN REPRODUCTION ACT

On March 29, 2004, Canada adopted the **Assisted Human Reproduction Act**, the country's first comprehensive law addressing human genetic and reproductive technologies. The law's introductory principles emphasize the need for the protection of women's health and well-being in the use of reproductive technologies; stress the impor-

tance of free and informed consent as a fundamental precondition to the use of these technologies; and prohibit discrimination in the delivery of assisted reproductive procedures on the basis of sexual orientation, marital status or other grounds. While the law permits the regulated use of human reproductive and genetic material and human embryos, it specifically prohibits certain activities deemed "ethically unacceptable," including human cloning; the creation of human embryos solely for research purposes; the practice of sex-determination or identification techniques on human embryos except to prevent, diagnose or treat sex-linked disorders or diseases; commercial surrogate motherhood contracts; the purchase of sperm or eggs; the purchase or sale of embryos; and the procurement or use for personal purposes of sperm or eggs from individuals under 18 years of age. Permitted activities include the creation of human embryos for assisted reproduction purposes and the use of existing human embryos for research, including embryonic stem cell research. Such activities must be carried out by licensed individuals in accordance with regulations issued under the law.

The law also addresses the collection, use and disclosure of personal and medical information about sperm or egg donors and individuals who have undergone or been conceived by assisted reproduction procedures. In addition, the law establishes the Assisted Human Reproduction Agency of Canada, which is charged with advising the minister of health on matters relating to the law; issuing and reviewing licenses; collecting and analyzing the personal and medical information of donors and individuals who have undergone or been conceived by assisted reproduction procedures; and enforcing the law. Engaging in any of the law's specifically prohibited activities is punishable with a fine of up to CAD 500,000 or imprisonment of up to ten years, or both. Contravention of any of the law's other provisions is punishable with a fine of up to CAD 250,000 or imprisonment of up to five years, or both. The law provides for legislative review after three years.

Setbacks

Unfortunately, reproductive laws and policies are not always compatible with women's rights. While most national-level policies since the ICPD have reflected a progressive view of sexual and reproductive rights, the last several years have not been immune to setbacks. Most of these setbacks relate to abortion, either restricting it directly or elevating the legal status of the fetus in order to set the stage for future restrictions on the rights of pregnant women.

PERU ADOPTS HEALTH REGULATIONS CALLING FOR REGISTRATION OF FETUSES AND RECOGNITION OF FETAL RIGHTS

On May 23, 2003, the government of Peru adopted **Ministerial Resolution No. 573-2003-SA/DM** approving regulations on the structure and duties of national health directorates and decentralized health network directorates. In describing the primary

mission of national health directorates, the regulations call for the protection of all Peruvians "with respect to their lives and fundamental rights, from the moment of fertilization until death, respecting the natural course of their lives and contributing to the national task of ensuring the development of all citizens." Among the national health directorate's strategic objectives is ensuring "the protection of the life and health of all persons from conception and throughout their life cycles until their natural deaths." There are also provisions calling for increases in breast-feeding, improvements in children's nutrition, significant reductions in maternal and infant mortality and morbidity, and universal health insurance. The regulation's most unusual feature is a provision making national health directorates responsible for "protecting the life and health of all unborn children from conception and officially registering them as conceived and as subjects of constitutional rights." Further responsibilities include promoting women's and families' capacity to ensure prenatal care, maternal nutrition and preparation for childbirth with paternal participation. Other prescribed goals of health directorates include giving all women access to prenatal monitoring and an adequate childbirth facility. The regulations assign more specific duties to the different organs of the national health directorates. A number of the national directorates' duties, including those aimed at protecting unborn life, are repeated in regulations concerning the decentralized health network directorates.

RUSSIA RESTRICTS GROUNDS FOR ABORTION AFTER FIRST TRIMESTER

On August 11, 2003, the Russian Federation issued **Decree No. 485**, which contains the list of **Conditions for Induced Termination of Pregnancy** restricting the circumstances under which women may legally obtain abortions from the end of the 12th week until the beginning of the 22nd week of pregnancy. The decree lists four conditions for legal abortion during this period: a court ruling suspending or restricting a woman's parental rights; pregnancy resulting from rape; incarceration in a detention center; and severe disability or death of the woman's husband at the time of pregnancy.

The decree voids Decree No. 567 of May 8, 1996, which listed eight additional indications, including unemployment of either spouse; the unmarried status of the pregnant woman; dissolution of marriage at the time of pregnancy; lack of housing or residence in a hostel or sublet apartment; a woman's status as a refugee or displaced person; a woman's status as a mother of three or more children or of a child with a disability; and per capita family income below minimum regional standards. Decree No. 485 coexists with long-standing abortion legislation and regulations that make abortion legal without restrictions through the 12th week of pregnancy and permit the procedure at later stages when continued pregnancy endangers the mental or physical health of the woman, or the life of the woman or the fetus.

UNITED STATES ADOPTS FIRST FEDERAL ABORTION BAN

On November 5, 2003, President Bush signed into law the "**Partial-Birth Abortion Ban Act of 2003,**" as enacted by the United States Congress in **Public Law 108-105**. "Partial-birth abortion" is defined as any abortion in which the person performing the procedure "deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered fetus." Criminal penalties include a fine or imprisonment of up to two years, or both. The law also subjects providers to civil liability for damages. An action can be brought by the "father," if he is married to the woman who underwent the abortion, or by the parents of the woman if she is not yet 18 years of age.

The term "partial-birth abortion" is not a medical one and does not refer to any specific medical procedure. Rather, the law's definition of "partial-birth abortion" covers a range of abortions performed starting early in the second trimester, including those performed using the safest and most commonly used techniques. The law also contains no reference to the stage of pregnancy at which penalties apply, and therefore includes abortions performed as early as 12–15 weeks of pregnancy.

While there is a limited exception where a woman's life is endangered, there is no exception for safeguarding a woman's health. A doctor would be prohibited from performing an abortion banned by the law, even if a different procedure would pose a greater risk to the woman's health.

Shortly after passage of the law, its constitutionality was challenged in three United States district courts, each of which found the Partial-Birth Abortion Ban Act unconstitutional and permanently enjoined enforcement of the law. The government has appealed the decisions in each of these three cases, and the appeals are currently pending. The Act remains unenforceable.

In 2000, in the case of *Stenberg v. Carhart*, the Supreme Court struck down a state law similar to the current Partial-Birth Abortion Ban Act, both because the broad wording of the law would have prevented doctors from performing the most common procedures in the second trimester, and because the law contained no health exception.

ENDNOTES

[1] Programme of Action of the International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, para. 7.3, U.N. Doc. A/CONF.171/13/Rev.1 (1995).

[2] United Nations Population Fund (UNFPA), *About UNFPA: Overview*, available at http://www.unfpa.org/about/index.htm (last visited Aug. 9, 2004).

[3] Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 16(1) G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981).