Women's Health and Human Rights

The Promotion and Protection of
Women's Health through
International Human Rights Law

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CHAPTER 4
International human rights to improve women's health

The following analysis of international human rights to improve women's health starts with the right to be free from all forms of discrimination and then addresses rights to survival, liberty and security of the person, the right to family and private life, rights regarding information and education, the right to health and health care, the right to the benefits of scientific progress and the rights regarding women's empowerment (see Annex 2). Examples are given of how each of these rights has been or could be applied to women's health problems. These rights may be applied differently in each country depending on the pattern of health services, the evolving understanding of health issues and perceptions of how women's ill-health can be prevented and treated in cost-effective ways.

The application of international human rights is explored through discrete and legally distinguishable categories of rights. Women's health interests often cross the boundaries that separate one legally described right from another. Advocates tend to invoke several rights that they allege have been jointly violated. They identify the specific articles of conventions that contain particular rights, and tribunals will distinguish one right from another in their judgements. However, approaches to women's health must refer to all of the several rights often implicated in a particular grievance.

The right of women to be free from all forms of discrimination

The Women's Convention (see Chapter 1) characterizes women's inferior status and oppression not just as a problem of inequality between men and women but rather as a function of sex and gender discrimination against women. The Convention is intended to be effective in liberating women to realize their individual and collective potential, and not merely to allow women to be brought to the same level of protection of rights that men enjoy. The Convention goes beyond the goal of non-discrimination between sexes, as required by the United Nations Charter, the Universal Declaration and its two implementing Covenants, and the
three regional human rights treaties, to address the disadvantaged position of women in all areas of their lives, including health.

In contrast to previous human rights treaties, the Women's Convention frames the legal norm as the prohibition of all forms of discrimination against women, as distinct from the narrower norm of nondiscrimination between sexes. That is, it develops the legal norm from a sex-neutral norm that requires equal treatment of men and women, usually measured by the scale of how men are treated, to recognize the fact that the nature of discrimination against women and their distinctive gender characteristics is worthy of a legal response. The Convention is thereby able to address the particular nature of the disadvantages that women suffer in diseases or conditions.

The definition in article 1 of the Women's Convention reads:

... the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Where the law makes a distinction that has the effect or purpose of impairing women's rights, it constitutes discrimination violating the Convention's definition and must accordingly be changed by the State Party. Discrimination against female gender offends the object and purpose of the Women's Convention.

The inclusion in the title of the Women's Convention of the phrase "all forms" emphasizes the determination described in paragraph 15 of its preamble to eliminate "such discrimination in all its forms and manifestations". The preamble expresses concern in paragraph 8 "that in situations of poverty women have the least access to food, health, education, training and opportunities for employment and other needs". As a result, the Convention entitles women to equal enjoyment with men not only of the so-called "first generation" of civil and political rights, such as the right to marry and found a family, but also of the "second generation" of economic, social and cultural rights, such as the right to health care.

The Women's Convention, in prohibiting all forms of discrimination, including private discrimination, is intended to be comprehensive. It recognizes that women are subject not only to specific, obvious inequalities but also to pervasive and subtle forms of sex and gender discrimination that are woven into the political, cultural and religious fabric of their societies. In addressing "all forms" of discrimination that women suffer,
the Women's Convention requires States to confront the social causes of women's inequality in all systems, including the health system.

Article 12 of the Women's Convention prohibits all forms of discrimination against women in the delivery of health care. It provides:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Laws governing women's health should be scrutinized to ensure that they do not discriminate against women, by, for example, perpetuating negative or trivializing sex-role stereotypes that prevent women from being treated on their merits. Liability to pregnancy distinguishes women from men on biological grounds. Pregnancy-related disadvantages, such as exclusion from education, public office or employment (except when non-pregnancy is a bona fide work-related requirement), may accordingly be shown as illegally discriminatory against women because only women will suffer those disadvantages. Laws that deny or restrict women's access to health services, or make access dependent on another's authorization, impair women's rights. Such laws also impair women's power to protect their lives and health and to found families of a size and structure that best protect their health and that of their families. Laws restricting health services in this way can have a disadvantageous impact on women as opposed to men and can thereby constitute discrimination against women.

Some countries that have ratified the Women's Convention have moved to give effect to the Convention in domestic law. The Colombian Ministry of Public Health, for example, has recently interpreted the mandate of the Women's Convention to introduce into national health policies a gender perspective that considers "the social discrimination of women as an element which contributes to the ill-health of women" (56). To incorporate the Women's Convention into Colombian law (57, 58), article 12 on delivery of health care was made part of the country's new 1991 Constitution (59).
In Brazil in 1992 the State of São Paulo and many of its municipalities developed their own Convention based on the principles of the Women's Convention. This Convention, named the Paulista Convention on the Elimination of All Forms of Discrimination against Women, requires implementation of the Programme for Comprehensive Care of Women's Health. The programme emphasizes the need for a range of women's health services, including services for reproductive health, cancer prevention, menopause and old age, victimization by violence and, for example, for groups of women among whom conditions such as anaemia are of greater incidence. The programme also calls for measures to encourage normal birth and to fight the indiscriminate use of caesarean deliveries (60).

The removal of female stereotypes
Perhaps the greatest challenge faced in the improvement of women's health is the need to give effect to article 5(a) of the Women's Convention, by which States Parties commit themselves to take all appropriate measures:

To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

Female genital mutilation, for instance, reflects a stereotypical perception that women may legitimately be exposed to non-therapeutic surgery in order to comply with the gender-specific norms of their community. While the sexes may rank equally as initiators of unchastity and adulterers may be equally condemned, loss of virginity is a greater stigma and barrier to marriage in women than in men, and men bear no health risks for premarital preservation of their virginity.

Article 5(a) points more widely to the need to examine such customs and might be used to require states both to educate those condoning and practising female genital mutilation on the record of its harmful effects (61, 62), and to use legal prohibitions where appropriate (63, 64).

Where food is scarce - whether due to poor agriculture, poor climate or the family's poor socioeconomic circumstances - the sequence of feeding often gives priority to males over females so that food goes first to a husband, then to sons, then to the mother and any daughters of the family. This practice may be reinforced in certain cultures where women see the survival of their husbands and sons as being of paramount importance to their own survival. Similarly, in some cultures newborn daughters are breast-fed for fewer months than sons. The incidence of
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malnutrition and anaemia in girls is directly related to rates of sickness and mortality.

The elimination of spousal authorization practices
Laws may often be formulated in ways that are disadvantageous to women's health. This may be because the motive of the laws is not promotion of health as such but preservation of another social value, such as the paternalistic protection of women's modesty. For example, spousal veto practices require a wife, but not a husband, to secure the authorization of her spouse in order to be physically examined for health care. This practice persists contrary to women's health interests and contrary to their right to be free from all forms of discrimination (65). It violates the Women's Convention and would accordingly have to be ended by a State applying the terms of that Convention.

Relevant ministries or departments of health might be encouraged to issue corrective regulations that stipulate that spousal authorization is not required by law, that it is contrary to rights to non-discrimination between sexes, and that it contravenes the professional ethics of health providers, who have obligations to safeguard women's health interests and to respect women's privacy and autonomy in resort to confidential health services. A regulation was issued by the Ministry of Health of Swaziland, pointing out that the practice of seeking the authorization of the client's spouse or relative "is contrary to the professionalism of the health worker" (65).

Rights to survival, liberty and security
The right to survival
The most obvious human right violated by avoidable death - not simply in pregnancy or childbirth but also as a cumulative result of health disadvantages - is a woman's right to life, also described as the right to survival. Article 6(1) of the Political Covenant provides that: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

This right has traditionally been discussed only in the legal context of the obligation of States Parties to ensure that courts observe due process of law before capital punishment is imposed (66). This understanding of the right to life is essentially male-oriented since men assimilate the imagery of capital punishment as more immediate to them than death from pregnancy or labour. Feminist legal approaches suggest that this inter-

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interpretation of the right to life ignores the historical reality of women, which persists in regions of the world from which come almost all of the 500 000 women estimated to die each year from pregnancy-related causes. The Human Rights Committee established under the Political Covenant (67) has noted that:

the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot be properly understood in a restrictive manner, and the protection of this right requires that states adopt positive measures.

The Committee considered it desirable that States Parties to the Political Covenant take all possible measures to reduce infant mortality and to increase life expectancy. A compatible goal is reduction of maternal mortality by, for instance, promotion of methods of birth spacing.

An argument that a woman's right to survival entitles her to access to appropriate health services (68, 69), and that legislation obstructing such access violates international human rights provisions (70), can be made with regard to an individual woman. The argument must be expanded, however, to apply where the threat to a woman's survival is indicated not by her individual medical condition but by her membership of a group at high risk of maternal mortality or morbidity. The collective right to survival of women in groups at risk raises the question of whether States have a positive obligation to offer these groups appropriate health services or, at least, education and counselling services that alert them both to risks and to means to minimize risks. The African Charter, given its emphasis on collective rights,' might well be invoked to impose obligations on African governments to give effect to rights of groups of individuals who are at highest risk of death through unintended pregnancies.

Rights to liberty and free and informed consent
Major abuses of women's liberty and autonomy occur in the delivery of health services, in part because of lack of enforcement and misapplication of the legal concept of informed consent. The manner in which a health service is offered and rendered can in some cases be a significant element in the service's success or failure to promote health. The strongest defence of individual integrity under the Political Covenant exists in article 9(1), which provides that:

See, for example, the preamble and articles 4, 16, 18 22 and 29 of the African Charter.
Everyone has the right to liberty and security of the person ... No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.

A great deal can be done to improve the application of the principle of consent in order to ensure that women are provided with adequate information to decide on a proposed course of medical or other health treatment. The legal concept of informed consent is better understood as the right to make informed choices for one's own future. Even courts that have not accepted detailed doctrines about medical consent accept that medical choice involves individual liberty. The concept is an articulation of a broader ethical principle of respect for persons, which requires respect for the autonomy of competent individuals and protection of the vulnerable when they are incapable of making decisions, such as when a person is young or mentally handicapped (71).

The concept of informed consent to proposed treatment has two requirements, namely:
• that choice in health care be adequately informed;
• that consent to care be freely given or withheld.

The concept of "informed consent" is often used to cover both aspects of choice - informed consent or dissent and the right to uncoerced choice. The right to informed choice in health services, self-help and preventive health care is related to rights both to education and literacy and to rights to information and freedom of thought and association. The human rights of prospective recipients of health services have to be understood compatibly with the associated obligations of persons qualified to deliver health services.

Simple consent may consist only in agreement to comply with what is proposed. Such agreement is sometimes classified as "assent", as in the case of young persons who agree to be treated on the authorization of their parents. To exercise truly informed choice, a woman deciding whether to receive a health service must have sufficient understanding of:
• the proposed intervention;
• the implications of refusal of that treatment;
• alternative forms of management of her circumstances.

The role of information is to contribute to the individual's liberty to choose whether or not to accept a proposed form of management; it is

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not to persuade or condition a person to decide in a particular way, even if that way may appear to the health professional who gives the information to serve the person's best interests. In other words, the right to informed choice includes the right to make choices that health professionals may consider to be poor choices. Paternalistic medicine has been prone to conclude that women's choices are incompetently made if they do not follow health professionals' recommendations and that therefore women can be displaced as decision-makers concerning their medical treatment.

Information for the exercise of choice normally includes a fair description of the form of management proposed, as well as fair descriptions of alternatives to what is proposed (including postponing and not having any treatment), the known outcomes of each management option (i.e. their rates of successful outcome), the risks associated with each option (whether successful or not) and the likely effect of each form of management on the individual's lifestyle. Inadequate research into and understanding of the distinctive features of women's health and sickness have meant that the base of knowledge on which health professionals rest the information they give is not necessarily sensitive to women's health circumstances and requirements, and that proposed action may in fact aggravate women's health impairments. Research is needed to obtain health data specific to women in order to fulfil women's human rights to relevant information.

A major failure of personal liberty and autonomy specific to women occurs when a patient has not been adequately informed of the failure rate of a method of family planning she is thinking of accepting and when use of the method results in an unintended pregnancy or unintended infertility. Health professionals have ethical and legal duties to individuals to provide accurate information on contraceptive failure rates so that clients may make truly informed health choices about contraceptive methods.

The decision whether or not to accept medical treatment is not itself a medical decision. It is a personal decision unique to each individual. The individual must make the decision in accordance with her personality, likes and dislikes, comforts and discomforts, and coal in life as influenced by personal, family, social, philosophical and related perceptions. The role of health professionals is to give the individual decision-maker medical and other health-related information that contributes to the individual's power of choice and does not distort or unbalance that power.

Further, a woman must be free from coercion and over-inducement in exercising choice. The health professional giving information must not add to the pressures and hopes that the woman will naturally experience. Women seeking health services often feel dependent on care-givers.
Because they are reluctant to appear non-compliant or ungrateful, women frequently feel obliged to agree to whatever is proposed to them, particularly when those with the power of superior knowledge of medicine tell them that what is proposed is for their own good.

In order for women to exercise choice freely, they must act according to their own preferences. They should not be conditioned to comply with others’ preferences by being dependent on current or future assistance for themselves or their families, and they should not feel obliged to undertake acts of self-sacrifice in order to pay for help they have received.

In Brazil, sterilization is legally available only for “therapeutic” reasons (72). A therapeutic reason is that a patient has had a surgical procedure. As a result, women may reluctantly choose caesarean sections for deliveries of children in order subsequently to meet the “therapeutic” requirement for sterilizations (73). This is ethically an unacceptable conditioning of women’s choices of caesarean sections. The choice might be informed, but it is not free.

The conditioning of choice raises human rights concerns, not necessarily regarding any individual case but concerning the general capacity of women to control the medical choice of methods by which they deliver children. This is an area where indicators of percentages of natural and caesarean deliveries could be relevant.

Health professionals who provide improper counselling or treatment to individuals, and health professionals who wrongly withhold indicated treatment from patients for whom they are responsible, face three primary sources of legal liability (74):

- They may be charged with professional misconduct by the authorities that license them to practise and by any voluntary associations to which they belong and whose authority they have accepted to impose discipline for unethical professional behaviour.
- Where they have touched a person in a way that lacks legal authorization, or that exceeds authorization, or that differs from what was authorized, they may be sued for compensation for battery (or unauthorized touching) and/or they may be prosecuted for related crimes of assault.
- Where they have failed to make appropriate disclosures to patients whose informed choices they were required to facilitate and obtain, they may be sued for negligence. Negligence arises in law where health professionals fail to meet the legal standard of disclosure of information, resulting in their patients suffering injuries they would have escaped had different choices been made. Health professionals are often required to provide information relevant to the choices that women have to make.
Legal remedies to reinforce duties to treat patients with respect and care often serve no more than symbolic purposes. In many countries, the formal procedures of the law are in fact inaccessible to many people and the mechanisms of health service licensing authorities and professional associations are similarly beyond reach. States themselves may bear responsibility under international human rights law, and be accountable before international tribunals and agencies, if they authorize or permit delivery of health services that are beyond the control of the recipients. This may particularly be the case where providers of health services are not accountable to provide compensation or other remedies for violations of the human rights of health service recipients or those denied care.

A normal legal precondition to State responsibility is that individual complainants must first have resort to national tribunals and must exhaust local remedies before matters can be taken up at international level. States must be given an opportunity through their legal systems to correct wrongs to individuals. Where local remedies do not exist, however, or where they are inaccessible, State responsibility may be directly involved at international level.

Discussion of compensation or other remedies before local courts may seem unrealistic in many circumstances. Yet if domestic remedies are inaccessible, States are more directly accountable under international human rights law for wrongs in delivery of health services that are violations of human rights.

Where individual compensation is accessible, the disadvantaged position of women may be compounded and underscored. The basis of financial compensation is normally to put a patient in the position she would have been in had the wrong not occurred, in so far as the difference can be calculated in monetary terms. This measure of compensation usually requires a complainant to show on a balance of probabilities that, had the health service been properly rendered, she would have enjoyed a health advantage.

A party accused of wrongdoing may propose the defence that the patient's overall circumstances were so compromised or inadequate that she cannot show that she would have been better off had a wrong not occurred. Accordingly, unless a complainant can show that a health service would have made a difference to her life span and her ability to function, her claim may not warrant compensation. The position is worse when the complaint is that death resulted, since where mortality levels are high it may not be possible to show that a woman in the victim's health circumstances was likely to survive.
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The right to security of the person

In its widest sense, the right to security is equal to the right to well-being and coincides with the WHO understanding of health. Health contributes to security and security is a major component of health. In international human rights law, considerations for evaluation of security include the power of informed choice. Insecurity reflects not just a lack of health and resources but vulnerability to become disadvantaged. Security is addressed in straightforward terms in the first sentence of article 7 of the Political Covenant, which provides that:

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

How this provision applies to medical interventions and to denial of desired medical care is seen in the second and last sentence of article 7, which provides that:

In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Even without regard to experimentation, the denial of health care and the imposition of an unwanted health status appear cruel. More pervasive insecurity is generated, however, by degrading treatment of women, such as occurs when they are treated as inferior and when preservation of their lives and health is regarded as a low priority in the allocation of health care resources.

Human rights law and practice have tended to focus on security against deliberately inflicted harm. Much violence against women, which endangers and reduces their enjoyment of their lives, occurs within women’s own homes at the hands of those for whom they care and who often claim to care for them.

Exposure to violence can begin in childhood, in both sexual and non-sexual ways. Article 19 of the Children's Convention requires States:

to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.

Girls are specially vulnerable since their principal values often appear, paradoxically, to be their sexual availability and their chastity. Preservation of virginity before marriage through circumcision denies girl
children security against the known physical and mental consequences of female genital mutilation (28, 29, 61, 62). Health dangers are also associated with obstacles to termination of pregnancies of young girls, whether inside or outside marriage.

Rights to family and private life

The right to marry and found a family (75)

Article 23 of the Political Covenant and article 10 of the Economic Covenant both recognize the family as the "natural and fundamental group unit of society". The former states that "the right of men and women of marriageable age to marry and found a family shall be recognized." The latter recognizes that "special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits" (5).

The Human Rights Committee's General Comments on article 23 of the Political Covenant (76) explain that:

The right to found a family implies, in principle, the possibility to procreate and live together. When States Parties adopt family planning policies, they should be compatible with the provisions or of the Covenant and should, in particular, not be discriminatory or compulsory.

The right to found a family is inadequately observed if it amounts to no more than the right to conceive, gestate and deliver a child.

An act of "foundation" goes beyond a passive submission to biology. It involves the right of a woman positively to plan, time and space the births of children so as to maximize their health and her own (77). Article 16(l)(e) of the Women's Convention requires States Parties to ensure that women enjoy:

[equal] 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.

At its 1994 meeting, the Committee on the Elimination of Discrimination against Women (CEDAW) adopted a General Recommendation on

This article reflects article 16 of the Universal Declaration and is given further effect in, for instance, article 12 of the European Convention, article 17 of the American Convention and article 18 of the African Charter.
equality in marriage and family relations. In relation to article 16(1)(e) of the Women's Convention, CEDAW stated:

The responsibilities that women have to bear and raise children affect their right of access to education, employment and other activities related to their personal development. They also impose inequitable burdens of work on women. The number and spacing of their children have a similar impact on women's lives and also affect their physical and mental health, as well as that of their children. For these reasons, women are entitled to decide on the number and spacing of their children.

Some reports disclose coercive practices which have serious consequences for women, such as forced pregnancies, abortions or sterilization. Decisions to have children or not, while preferably made in consultation with spouse or partner, must not nevertheless be limited by spouse, parent, partner or Government. In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10(h) of the Convention.

There is general agreement that where there are freely available appropriate measures for the voluntary regulation of fertility, the health, development and well-being of all members of the family improve. Moreover, such services improve the general quality of life and health of the population, and the voluntary regulation of population growth helps preserve the environment and achieve sustainable economic and social development.

In commenting on article 16(1)(e) of the Women's Convention, CEDAW explained that "women's right to full and free exercise of their reproductive functions, including the right to decide whether to have children or not, must not be limited by spouse or government, and women must also be guaranteed access to information about safe contraceptive methods, sex education and family planning services" (78, 79).

One Latin American country has adopted a new ministerial resolution that orders all health institutions to ensure that women have the right to decide on all issues affecting their health, their lives and their sexuality (80). The resolution guarantees rights "to information and orientation to allow the exercise of free, gratifying, responsible sexuality which can not be tied to maternity." The new policy requires provision of a fun range of reproductive health services, including infertility services, safe and effective contraception, integrated treatment for incomplete abortion and, for example, treatment for menopausal women. The policy emphasizes the
need for special attention to high-risk women such as adolescents and victims of violence.

In some parts of the world, the right to found a family is most threatened by reproductive tract infections. In Africa, for example, reproductive tract infections cause up to 50% of infertility (81, 82). Government inaction to prevent or remedy this source of infertility violates the right to found a family. This is so whether or not the right is classified in law as a positive right, i.e. a right that governments must serve through positive action. If the right is negative, in that a State must not obstruct its exercise by those who are capable of founding their families without reliance on State action, legal liability of the State for inaction might nevertheless arise not because of infertility itself but because of the differential impact that infertility has on the lives of women (83).

The right to found a family incorporates the right to maximize the survival prospects of a conceived or existing child, which can be done through birth spacing and other family planning methods. This right is complementary to the woman’s right to survive pregnancy, for instance by delaying a first pregnancy.

State laws that do not provide a minimum age for marriage, and practices that do not enforce such laws, permit young girls to marry - not uncommonly with questionably free consent - and to conceive children before they are physiologically mature. This results in high rates of maternal and infant mortality and high levels of morbidity, such as vesico-vaginal fistulae.

The right to marry and to found a family can be limited by laws that are reasonably related to family-based objectives. Laws requiring a minimum age for marriage are not incompatible with the right to marry and to found a family. The right to marry and to be a parent is a right of adults rather than of children or young adolescents. Indeed, an objection to many age of marriage laws is that they set an age that is too low for the welfare of women, and therefore of their families, and that they set lower ages for women than for men. Women are frequently induced to marry at the minimum legal age, or a lower age through non-enforcement of or exceptions to the law, in part because of lack of alternative opportunities in life.

Parental support obligations may legally terminate at the age of marriage, after which women may have no means to support themselves and no opportunities to pursue education or careers. Young women are accordingly led to early marriage and childbearing by socioeconomic and cultural influences that recognize no function or worth of women except as wives and mothers. Human rights provisions that no one shall be obliged involuntarily to enter marriage fail to recognize that many women
"volunteer" for marriage through lack of any dignified alternative following adolescence.

The right to private and family life
The American Convention on Human Rights implies the right to privacy in its article 11, which provides that:

Everyone has the right to have his honor respected and his dignity recognized.

Honour and dignity are private attributes that government has no interest to diminish. The right to private and family life is distinguishable from the right to found a family, although for some purposes the latter right may be considered to be part of the former. The right to private and family life contains liberty interests. Article 17 of the Political Covenant provides that:

No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.

The European Convention specifies conditions under which private and family life may be compromised or sacrificed to higher interests of the state, including interests in public health. Article 8 provides that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

In a case in Western Europe two women claimed that a restrictive abortion law interfered with respect for their private lives contrary to this article, in that they were not permitted privately and alone to decide to terminate their unwanted pregnancies (84). The majority of the European Commission on Human Rights rejected the applicants' claim, however,
and found that the restrictive law did not constitute an interference with private life.

Greater scope was given to a woman's right to private life in another case in Europe (85). The European Commission on Human Rights upheld a national judicial decision protecting a woman from being compelled to continue an unwanted pregnancy through her husband's legal power of veto of her abortion. The Commission gave priority to respect for a wife's private life and integrity in her decision on childbearing over her husband's right to respect for his family life in the birth of his child. The Commission found that the husband's right could not be interpreted to embrace even a legal right to be consulted on his wife's decision. A State's interest in an unborn life is not greater than that of the biological father's, so that preclusion of his right appears to preclude the State's right to prevail, at least up to some advanced stage of pregnancy.

Rights to information and education

Rights to seek, receive and impart information are protected by all the basic human rights conventions, and are essential to the realization of women's health. Information concerns health services that may be available by health authorities' choice or obligation, means of self-help and preventive health care. Medical organizations at times oppose availability of information on the grounds that "quack" medicine is harmful and deters recourse to proven therapies. Some unproven treatments are indeed later proven harmful, and regulation of unproven treatments may be defensible when regulators can show a credible risk of harm to the unwary.

Sometimes, however, information is prohibited on moral grounds, as shown in the history of information regarding treatment of reproductive tract infections and in family planning. The Women's Convention explicitly requires in article 10(h) that women have the right:

- to specific educational information to help to ensure the health and wellbeing of families, including information and advice on family planning,

Article 10 (1) of the European Convention provides that:

- the right to freedom of expression shall include freedom ... to receive and impart information and ideas without interference by public authority and regardless of frontiers.

In a case before the European Court of Human Rights in 1992 (86), the Court ruled that a national ban on counselling women on where to
obtain abortions abroad violated this article. In order to comply with this decision, national law could not prohibit counselling of women on where to find reproductive health services in other countries. This was despite the fact that these services could not be rendered lawfully in the country where the counselling was prohibited. This decision applies to States Parties to the European Convention that try to restrict the counselling of women seeking health services in other countries.

The right to education serves the goal of individual and public health. Women who are literate have easier access to health information since they can read and understand about risks to their health and how to prevent them.

Questions concerning the human rights of students may arise when schools exclude medical instruction on sexual health. Both education and deliberate silence affecting schooling in sexual matters can raise conflicts between rights to freedom of thought and rights to religious observance, including instruction in religious values.

Controversy has arisen when public school systems have introduced health-oriented or family health programmes to which parents and religious organizations have objected because the sexual content of instruction offended their religious convictions.

In another case in Europe, some parents took exception to compulsory sex education in State schools. They complained that it violated the State's duty to respect "the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions" (6), and violated their right to religious non-discrimination, rights to private and family life, and/or the right to freedom of thought, conscience and religion set out in the European Convention.

The European Court of Human Rights held that compulsory sex education classes in State schools violated none of these duties or rights because the classes were primarily intended to convey useful and corrective information which, though unavoidably concerned with considerations of a moral nature, did not exceed "the bounds of what a democratic state may regard as in the public interest".

The Court recognized, however, that

the State ... must take care that information or knowledge included in the curriculum is conveyed in an objective, critical and pluralistic manner. The State is forbidden to pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions (87).
The right to health and health care

By article 12(1) of the Economic Covenant, States Parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Article 12(2) provides that the steps to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child ...  

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

This article is reinforced by article 24(1)(f) of the Children's Convention, which requires States Parties to "develop preventive health care, guidance for parents and family planning education and services". Article 12(l) of the Women's Convention requires that States Parties "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".

Through ratification of international human rights treaties and through national constitutions and laws, governments commit themselves to protect their populations' rights to health care. The right to health care is compromised when women's protection of their well-being is obstructed by barriers that are governmentally legislatively or judicially constructed. Beyond impairing women's provision to themselves of desired health care, governments may fail to provide necessary health services to women who for various reasons cannot make provision for themselves - for instance because of lack of knowledge, or because of poverty or their remoteness from main population centres. Obstruction of available health services and non-provision of reasonable access to otherwise unavailable health services deny women the right to health care that countries have acknowledged through their acceptance of international human rights treaties.

General comment on women's right to health

Treaty bodies have the power to make General Comments or General Recommendations to indicate ways in which States Parties should interpret and apply the respective treaties. These detailed comments can be

This article reflects article 25 of the Universal Declaration and is given further effect in, for instance, article 13 of the European Social Charter, article 26 of the American Convention and article 10 of its Additional Protocol in the Area of Economic, Social and Cultural Rights, article 16 of the African Charter and article 24 of the Children's Convention.
particularly useful for elaborating the specific content of broadly worded
treaty guarantees. For example, the General Recommendations of CEDAW
indicate the kind of information that States should provide in their periodic
reports to CEDAW in accordance with the Women's Convention. These
recommendations, which include recommendations on women and AIDS
and on female circumcision, establish indicators and criteria by which to
measure governments' observance of their international duties to give effect
to the rights of women. States are given latitude to choose the means; to
achieve those goals.

To date, the International Labour Organisation (ILO) is the only special-
ized agency of the United Nations that has provided expert advice to
CEDAW on the substance and working of the General Recommendations
relating to women and work (88). ILO, unlike most of the specialized
agencies, integrates its development work with its human rights activities
and provides assistance to most human rights treaty bodies on setting
standards and putting them into effect. WHO is giving consideration to
providing similar assistance to CEDAW. It should be noted that WHO is
already integrating its development and human rights work with respect to
the Convention on the Rights of the Child, including support to the
Committee and its reporting functions.

While the global indicators for health for all are relevant to the right to
health care, they are intended for use in obtaining a global over-view and not
in measuring State compliance with the right to health care as protected by
human rights treaties. Moreover, WHO has indicated that the development
of national strategies aimed at achieving greater social equity in health
status would require the disaggregation of carefully selected indicators (89).
Wider consultation between those involved in the fields of health and human
rights will help to identify key measures for determining State compliance
with treaty obligations relating to the promotion and protection of women's
health.

Principles for the promotion and protection of women's health

The development of principles for the promotion and protection of women's
health is another approach that might be considered. Such principles could
draw on national women's health policies and experience in the de-
velopment of the Principles for the Protection of Persons with Mental Illness
and for the Improvement of Mental Health Care (90) which were prepared
under the auspices of the Commission on Human Rights in close
collaboration with WHO and adopted by the United Nations General
Assembly. Principles on the promotion and protection of women's health
could address, but not necessarily be limited to, the following issues:
Health status factors
- health considerations important to women at different stages of their life cycle;
- the need to determine the special impact on women of routine health procedures and products;
- the importance of improving research on women's health requirements;
- the need to consider women's health requirements and circumstances in the development of research protocols;
- the importance of basing health policies on the most up-to-date scientific and technological knowledge;

Health service factors
- the importance of treating women with dignity and respect, including the provision of adequate information so that women can make informed decisions on particular courses of treatment;
- the rights of women as patients and the importance of confidentiality and privacy;

Conditions affecting the health and well-being of women
- the importance of ensuring a healthy and safe working environment;
- the importance of eliminating traditions and practices that have detrimental health consequences for women;
- the ability to identify and respond appropriately to women who live in abusive environments.

The above list is merely suggestive of the kinds of issues that could be addressed in order to incorporate human rights relevant to women's health into health policies and health care practices. Clearly, wider consultation is needed among women and those knowledgeable about women's health, human rights and medical ethics for the development of principles for the promotion and protection of women's health.

Women's health care laws
Perhaps based upon principles for the promotion and protection of women's health, a set of guidelines might be developed for the legal promotion of women's health in particular areas, such as women's occupational health, the health of girl children and reproductive health care. Health legislation has contributed substantially to the promotion of public health, and could be used more vigorously to promote women's health.

For example, guidelines for comprehensive reproductive health laws may be particularly important in view of legal impediments to women's
access to reproductive health services. Such laws would encourage reduction of pregnancy-related deaths and sickness, and would provide services that promote reproductive health. United Nations documentation draws on extensive worldwide evidence to reach the conclusion that "the ability to regulate the timing and number of births is one central means of freeing women to exercise the full range of human rights to which they are entitled" (91).

Women's right to control their fertility through the prohibition of all forms of discrimination against women may therefore be a fundamental key that opens up women's capacity to enjoy other human rights and to achieve the physical, mental and social well-being that is the essence of health (70).

A strategy for a comprehensive reproductive health law that could facilitate and maximize reproductive health has been proposed (92):

A responsive reproductive health care strategy would attend to the reproductive health needs of all, by providing education for responsible and safe sex life, contraception for the sexually active to use as needed, and services for the management of pregnancy, delivery, and all abortion. It would also provide education and services for the prevention and management of STDs, subfertility and infertility. Its goal should be to make human sexuality and reproduction a joy, not a curse or a punishment.

This strategy is reflected in Recommendation 4 of the International Conference on Better Health for Women and Children through Family Planning (93):

Unwanted pregnancy should be recognized as a specific health risk for women and their families. Regardless of the legal status, humane treatment of septic and incomplete abortion and post-abortion contraceptive advice and services should be made available. The magnitude of the problem and its implications for the health of women and families should be documented and publicized. Where legal, good-quality abortion services should be made easily accessible to all women.

It has been pointed out by some that enactment of a comprehensive reproductive health care law would greatly facilitate women's human rights to health care. It would provide an opportunity to move the legal regulation of women's reproductive health into the realm of social justice where women are treated with dignity and respect (94, 95 96,97). Many countries with criminal laws prohibiting services for contraception, voluntary sterilization, abortion, sexually transmitted diseases and
infertility have high rates of maternal mortality and morbidity, often associated with repeated pregnancies and unskilled, including self-induced, abortions. Such criminal laws are also associated with socioeconomic inequities. Persons with private means to avail themselves of reproductive health services will do so, perhaps in foreign countries where high-quality services are legally available, but those dependent on public provision of health services will face the physical, economic and social consequences of clandestine abortion and, for instance, infertility associated with poor reproductive health and unsafe abortion (98).

Where the practice of medicine requires that competent account be taken of the impact on women's health, the laws should apply the WHO definition of health.

The right to the benefits of scientific progress

Article 15(1)(b) of the Economic Covenant recognizes the right of everyone "to enjoy the benefits of scientific progress and its applications". Further, under article 15(3), States Parties "undertake to respect the freedom indispensable for scientific research …". To ensure that women have access to the benefits of scientific progress, research on diseases and conditions that exclusively or primarily affect women will be necessary. Research needs will vary according to countries and regions, depending on the prevailing patterns of mortality and morbidity. In some countries, for instance, research may be necessary to understand nutritional patterns that maximize a woman's chances of preventing breast cancer. In other instances, research may be necessary to develop a better understanding of osteoporosis or fertility control or the causes of infertility. Freedom of research requires States Parties to accommodate such research and development, designed particularly from women's perspectives (99).

In order to ensure that women can take advantage of the right to the benefits of scientific progress, some medical institutions are beginning to initiate policies to ensure that scientific research produces results that are specifically relevant to women, in part as a result of the encouragement of nongovernmental organizations (NGOs) (100). For example, in the United States since 1986 the National Institutes of Health and the Alcohol, Drug Abuse, and Mental Health Administration have required that clinical research findings should be of benefit to all persons at risk, regardless of sex (101).

Once scientific research opens the way to better understanding of female physiology and anatomy and, for example, the causes of women's
poor health, the right to the benefits of scientific progress requires that women have access to treatments and technologies based on the results of scientific research.

The responsibility of States Parties to the Economic Covenant to ensure respect for access to the benefits of scientific progress might in part be met through the enactment of what are called “use it or lose it” patent provisions governing therapeutic, diagnostic and preventive health care products (102). When product patents have been granted to sponsors who subsequently fail or decline to market such products that are beneficial to health, government authorities in several countries, such as France (103), have the legal power to transfer the patents to new holders who will undertake marketing of the products. In conferring a patent on a drug manufacturer, a government is giving the manufacturer a monopoly to market a therapeutic product. In return, the government expects a health benefit for its population. The potential for involuntary transfer of a patent from a manufacturer who fails to make the product available acknowledges that a drug patent serves not only the commercial interests of the holder but also the interest of government in the health of potential users.

Rights regarding women's empowerment

The poor state of women's health in many regions of the world, including within deprived socioeconomic populations in developed countries, can be seen as one result of women's inability to protect their own interests and those of groups in which women form a majority.

Decisions to exercise individual power or to participate in the exercise of collective power are attributes of liberty and autonomy. In many settings, women have never enjoyed autonomy, the conviction that they can act autonomously, or the belief that they rightfully should be influential in the circumstances that affect their health. Principles of international human rights are available to women who want to take responsibility for their individual health and for the well-being of women in their communities. Many basic human rights and freedoms, which many countries of the world find dignity in accepting, provide women with psychological and legal instruments of empowerment. These rights to empowerment may be employed by women to realize their own health goals.

The right to freedom of religion and thought

The right to freedom of religion and thought is contained in most human rights treaties. Leaders of the religious, political and cultural institutions that define acceptable status and roles for women have traditionally been men. The goal of women’s better health affords women a benign and
sympathetic justification for presenting their communities with the need to think afresh about adherence to oppressive practices. The backdrop of women’s poor health provides advocates of women’s improved health with a convincing stage for action.

The tenets of religious faith need not be repudiated in order to characterize wrongs to women’s health as unacceptable. The United Nations (104) has adopted the position that:

states should condemn violence against women and should not invoke any custom, tradition or religious consideration to avoid their obligations with respect to its elimination.

Religious doctrines neither require nor condone violence as such, but religious texts may be cited in support of practices and social institutions whose consequences endanger the health of women (20). Women are entitled to invoke freedom from the effects of such interpretations of religious texts and to adhere to alternative understandings.

The right to freedom of assembly and association

Frequently relevant to freedom of thought and to empowerment is the right to meet with others and to identify oneself with their causes, convictions and activities. The entitlement of like-minded people to gather and collaborate has been established through claims of rights of religious and political assembly and association. Regarding women’s health, women can claim freedom to meet with others to learn about threats to health and means of prevention and protection. Many provisions on the advertising of contraceptive methods and on control of sexually transmitted diseases and abortion are located in criminal laws among sections addressing public morality and decency. Rights of assembly and association with communicators of health knowledge may be invoked to measure these provisions and laws against the standards of international human rights.

The right to political participation

The right to political participation allows women and women’s health groups to inform government of their experiences of unsatisfactory and inadequate health services and to present proposals for reform. The right to participation to enhance women’s health is at best a means to the end rather than an end in itself. Its utility to government and to the quality of public life is that it may offer women a reasonable prospect of discourse and may disclose facts and perceptions that government investigators
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overlook, devalue or omit from reports. It is for advocates of improved health for women to determine to what extent the right to political participation is adequately available in their circumstances, to what extent the right is effective and to what extent it is a priority among options for advocacy and action.