

CONSIDERATIONS FOR FORMULATING REPRODUCTIVE HEALTH LAWS

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List of Abbreviations

ADR – Alternative Dispute Resolution

Beijing Platform – United Nations’ 1995 Fourth World Conference on Population and Development Platform for Action

Cairo Programme – United Nations’ 1994 International Conference on Population and Development Programme of Action

CEDAW – Committee on the Elimination of Discrimination Against Women

FGM – Female Genital Mutilation

RTIs – Reproductive Tract Infections

STDs – Sexually Transmitted Diseases

WHO – World Health Organization

Women’s Convention – Convention on the Elimination of All Forms of Discrimination Against Women

Executive summary

The purpose of this Discussion Paper is to consider how laws can be developed in order to improve protection of reproductive and sexual health, and how they can be applied to facilitate rather than obstruct the availability of reproductive and sexual health services. It addresses legal principles governing relations between providers of health services in general and of reproductive and sexual health services in particular, and intended recipients of those services. The legal principles that are examined include those governing free and informed decision making, privacy and confidentiality, the competent delivery of services and the use of conscientious objection. The Paper explores how human rights found in national constitutions and laws, regional and international treaties have been and can be more effectively applied to protect and promote reproductive and sexual health. The human rights that are addressed include:

- those that govern the delivery of clinical care, such as the rights to liberty and security of the person and the right to information and the right to private life, and
- those nondiscrimination rights that require government to ensure equal access to health care, irrespective of sex, marital status, age, race and sexual orientation.

It identifies sources of duties binding states to respect, protect and fulfil the different human rights. In conclusion, the Paper outlines means by which observance of legal principles and human rights can be enforced through national and international procedures.

Introduction

Significant advances in the recognition, promotion and protection of reproductive health were achieved in the Programme of Action¹ resulting from the United Nations' 1994 International Conference on Population and Development, held in Cairo, and in the Platform for Action² resulting from the United Nations' 1995 Fourth World Conference on Women, held in Beijing. The Cairo and Beijing documents provide an important basis on which health care providers and organizations can build in order to develop reproductive health laws.

Countries in different regions of the world are reassessing their laws, policies and practices to achieve the goals of reproductive health. Some are considering legal and policy reforms for this purpose, and others have recently made changes. For example, in 1983 the Brazilian Ministry of Health initiated the Program of Integral Assistance to Women's Health. The Program includes access to contraception, treatment of infertility, assistance for pregnancy and childbirth, and treatment of sexually transmitted diseases (STDs) and for breast and cervical cancers. The People's Republic of China enacted a law on Maternal and Infant Health Care in 1994 to promote the birth of healthy children. The Russian Federation received a proposal for a farsighted Law on the Reproductive Rights of Citizens and Guarantees of their Implementation.

Other countries, at governmental, judicial and professional levels, are addressing the application of their existing legal systems and institutions to the newly recognized requirements of reproductive health. Different legal traditions apply their internal processes to the achievement of goals of reproductive health that are commonly shared. The ways in which countries attempt to achieve reproductive health outcomes will follow from their own traditions and techniques. International human rights instruments accommodate countries' own means to give effect to internationally agreed goals and to achieve at least minimum common standards of performance.

The purpose of this report

Reproductive health law has not been a separate branch of law, but is built from each legal system's basic components of broad principles and specific judgements. Some judgements come from cases involving reproductive health issues, but law is often developed through applying legislation and court judgements directed to one issue by analogy to new issues, such as those raised by developments in reproductive health.

This report is intended to provide guidance for the formulation of national reproductive health laws by:

- suggesting minimum standards of professional practice in reproductive health care that legal systems should enforce;
- illustrating a number of applications of laws, both that conform to these standards and that have been found by national and international judicial tribunals to violate them;
- equipping reproductive health care providers to understand the background and orientation of legal advice that they receive, and to inform lawmakers

and lawyers of the impact of legal rules and options on effective clinical care of patients; and

- facilitating public health agencies' promotion of sexual and reproductive health of all individuals throughout their lifespan.

The paper is directed primarily to the legal rights of women and men to limit their fertility, because legislation and judicial experience have been concentrated in this area. An additional purpose, however, is to address reproductive health needs to which the law has not historically attended, particularly the reduction of high levels of maternal mortality and morbidity, and of sexual abuse of women in circumstances of domestic, ethnic and international violence. It recognizes the burden of infertility and the need of prevention, but does not focus on legal regulation of medically assisted reproduction through advanced reproductive technologies.

Regarding both the limitation of fertility and overcoming infertility, the paper considers strategies that can be promoted by law at the level of public health, since it is recognized that the health status of individuals, including their reproductive health, is affected by social, economic and cultural determinants. Much can be achieved to promote reproductive health through appropriate clinical practice, but much can also be achieved by health services planned and delivered through public health agencies. They bear responsibility for promotion of safe motherhood, protection of health against STDs, and, for instance, education of health care providers and of women to protect themselves against violence.

An ambitious agenda for reproductive health promotion would address social, economic and institutional reforms, including redefining the roles of women in their societies and of men in responsible reproduction and care of children, that would require cultural and social reconfiguration. This paper is addressed at a considerably more modest level. It aims to show how laws and legal institutions can be shaped to serve the goals of reproductive health, and to assist health care professionals to collaborate with legislators, public health providers and lawyers for this purpose.

The principles that will be drawn on are not new to legal systems. Health care providers will recognize aspects of these principles that they apply in delivering routine reproductive health care. These principles, which are common to many legal systems, fit within a wider framework of national constitutions and regional and international human rights conventions. Such conventions raise an issue to which attention has been given only more recently, however, namely the power of states to ensure conformity by all health care providers and institutions with these legal principles. States' accommodation of health care providers and institutions triggers related questions of the accountability of states themselves to ensure observance of human rights concerning reproductive health within the territories for which they are responsible, and of means to enforce state accountability.

Terminology

Providers

In this report, health care practitioners who provide care are described as "providers". Traditionally, health care law has developed from court decisions primarily involving

physicians, but in practice many more practitioners than physicians deliver reproductive health care services, including nurses, midwives, traditional birth attendants and counsellors from various backgrounds who work in various environments outside customary health care facilities such as hospitals and clinics. In many parts of the world, recipients of services have little if any contact with qualified physicians. Health care providers of all types will be included in the description “providers”, and distinctions will be drawn among them only when they are of particular legal significance.

Legal differences concern:

- relations between providers and recipients of services, and
- relations between providers and the institutions or agencies for which they work.

Different expectations arise in relations between professionally qualified providers and recipients of their services from those that arise between unqualified providers and recipients. Professionals such as physicians and nurses practice according to standards of skill that are independently monitored by licensing authorities and according to standards of ethical integrity. Recipients of care and employing institutions and agencies are entitled to expect professional proficiency, and may complain to licensing authorities of unskilled or unethical practice. Other providers are not held to equally high standards or such institutional accountability, but like professional providers, are legally bound to recognize and avoid reckless acts, exercise the competent judgement they claim to possess and refer patients to appropriately qualified providers for procedures beyond their own skills.

Physicians are often legally distinguishable from other providers in employment relations, because they do not act as “servants” under an employing “master”, whereas other providers including nurses are usually in a master-servant relationship. Physicians are often independent contractors. Servants are told what to do and how to do it, while independent contractors agree on what they will do but exercise independent judgement on how to do it. Subject to legislation on employment contracts, servants may be dismissed at will, and receive compensation if wrongfully dismissed, but nevertheless lose their jobs. Physicians enjoy a status terminable only by due process of law, and improper termination is legally void, so that they retain their status.

These legal matters are not generally relevant to this report, and will be addressed below only in special cases.

Patients

Recipients of services may be described in various terms, but in this report will be described as “patients”. Other descriptions are increasingly used, such as “consumers” or “clients”. These descriptions are often intended to eliminate the inferior status of the patient role, and to relieve recipients of care from association with sickness, dependency and subjection to “doctor’s orders”. The description “client” may be appropriate for reproductive health care, since many who seek such care are not sick, but are requesting assistance to achieve lifestyle and family-building goals. Descriptions of consumers and clients are increasingly associated,

however, with commercialization of health care services, and the impersonal legal rules that govern market economies. These include the equal bargaining power of parties, and principles such as “let the purchaser beware”. Under this concept of self-reliance, a party must not actively deceive the other but has no duty of full disclosure of relevant facts, and may profit from recognizing the other’s mistaken beliefs.

In this report, recipients of care will be described in the traditional term “patients”. This recognizes not only the description on which relevant judicial decisions are based, but also the common reality of inequality of bargaining power between recipients of care and providers, and providers’ ethical or fiduciary duties not to exploit their superior knowledge to that of those requesting their help. Fiduciary duty is owed by more powerful parties to those they encourage to trust and rely on them to act in good conscience to protect weaker parties’ interests. In usual health care, healthy people requesting preventive health care such as vaccination or contraception are described as patients. The description preserves the origins of relevant law and recipients’ frequent dependency on the special skills and knowledge of providers. Any imputations of patients’ inferiority and subordination are relieved through providers’ legal and ethical duties to inform patients appropriately of the implications of the health care choices that patients may exercise.

Challenges in sexual and reproductive health

Sexual and reproductive health

The Cairo Programme defined reproductive health as

“a state of complete physical, mental and social well-being and ... not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.” (para. 7.2)

The Platform for Action, developed at the 1995 Fourth World Conference on Women in Beijing, reaffirms the Cairo Programme’s definition of reproductive health, but advances the wider interest of sexual health. The Platform’s focus on women makes explicit that:

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.”(para. 96)

Law must, of course, protect the sexual health of men no less than that of women, but because women bear the burden of gestation, and their lives and health are more at stake in pregnancy and childbirth than are those of men, women are more centrally concerned than men in legal protection and promotion of reproductive health.

Reproductive health policy

Law is a powerful instrument that may be used by the state and by individuals to advance the purpose of reproductive health, but the law as such has no inherent purpose of its own. The law is an instrument that the state, health care professions and individuals may use to advance policies to which they commit themselves. Reproductive health policies may be advanced by law, but policies must be clarified before the appropriate use of law can be determined. Laws may be used in different ways to advance policy, and policy may be influenced by legal means available and favoured for the application of policy, so that policy and law interact with each other. Before legal means can be determined, however, the challenge of policy making has to be resolved.

Reproductive health policy must resolve the challenge of ordering priorities. Reproductive health goals and values must be pursued with a realistic assessment of how laws that are used to pursue them are likely to operate in practice. For instance, to protect intended spouses against their partners' HIV infection, several jurisdictions conditioned the grant of marriage licenses on couples' exchange of HIV test results. The effect in many cases was that couples went to marry in other jurisdictions, or cohabited and started families without marriage. Further, in many cultures sexual relations were more likely among courting couples during prolonged engagements, and same-sex couples, legally precluded from marriage, were unaffected by this condition. Laws prohibiting marriage without information exchange risked violation of the internationally protected human right to marry and found a family,³ and have been largely replaced by education, counselling and voluntary testing provisions.⁴

Many countries have similarly determined their policies on abortion by reference to principles, based on religious and other grounds, that favoured severe criminal condemnation. Evidence associates such policies with widespread illegal and unskilled abortion practice, however, resulting in women's death, infection and impairment of future reproductive capacity. Liberalization of restrictive abortion laws combined with policies for delivery of safe abortion services is almost invariably associated with reduction in death, mutilation and impairment of reproductive function among women, and reduced demand for emergency care in public hospitals' gynaecology services.

Policy on reproductive health draws inspiration from various perceptions of values and ordering of priorities, but must take account of its anticipated consequences, balancing competing advantages over disadvantages. Some policies prioritize the value of unborn human life over, for instance, the value of recognizing women as responsible decision-makers, but others conclude that the resulting costs of inhuman treatment of women and of maternal mortality are excessive. This illustrates a type of challenge that reproductive health policy must resolve, namely balancing the conscientious pursuit of high but abstract principles against inadvertent harmful consequences, such as causing inhuman treatment and avoidable death that violate conscience. Principles that oppose inhuman treatment and avoidable death of women are reflected in human rights treaties to which countries legally commit themselves.

The role of law

It has been seen that law is an instrument by which states regulate their affairs, giving effect to the reproductive health policies that states find appropriate. The credibility of law often depends on the respect it enjoys among those expected to obey it, since there are limits to the ability of non-military governments to enforce their will by coercive means. The habit of popular obedience to rules depends on their general acceptability. Laws may be based on custom in a community, but in modern times laws tend to be expressly enacted by politically composed legislatures. Their practice of law-making is generally seen to follow one of two models. The first is based on principles of virtue to which those governed by law are expected to conform, in order for society to achieve moral goals. The second is pragmatic, based on experience and practices that individuals are empowered or required to follow that are believed likely to produce desired results.

Principle-based law may derive its principles from a moral vision rooted in religion or, for instance, political philosophy. Some legal systems such as Islamic law give priority to sacred texts, and require that secular laws conform with authoritative interpretations. Practice-based or pragmatic law aims to achieve behaviours by public and private agencies and individuals that are considered to promote public good, or limit harmful consequences. Experience shows that laws based on moral principles may be pursued in ways that prove harmful in practice, and that pragmatic purposes may be pursued in ways that moral authorities consider to ignore or violate important values.

Activities relevant to reproductive health have historically been regulated by moral or principle-based law. Sexual relations and human reproduction have been areas in which religious authorities have been accustomed to exercise moral influence. They invoke the belief that human conception and birth are divinely regulated, and that such authorities have been specially called to interpret and express truths that are divinely revealed to them. The emergence of a concept of reproductive health that is of secular origin, requiring implementation by pragmatic rules that associate the validity of laws with their practical consequences, presents a special challenge to religious authorities. Their discomfort with and opposition to the formulation of the concept of reproductive health, articulated in the Cairo Programme of Action, remains an obstacle to enactment of laws designed pragmatically to achieve reproductive health.

Nevertheless, democratic governments that are accountable to their electorates and that have endorsed the Cairo Programme bear responsibility to formulate and advance laws that serve their populations' reproductive health. Accordingly, laws must protect

“the right of men and women to be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as to other methods of their choice for regulation of fertility...”
(para. 7.2)

The Cairo Programme protects access to such methods “which are not against the law”. This provision respects the religious traditions to which many countries endorsing the Cairo Programme adhere, and provides legislators and judges with means to exercise judgement on the relative weight to be given to moral or religious law that promotes spiritual values and secular law designed to achieve practical results.

Epidemiological and social science research have disclosed the dysfunctions of many laws for women's reproductive health and wider interests. Modern critiques of laws have arisen that are sometimes described as feminist, although not all representatives of women's interests describe themselves as such, and not all advocates of sensitivity to women's concerns are women. The practical effect of moral or principle-based law on women's health and status has historically been discounted, since institutions of moral authority such as religious institutions, legislatures, academic institutions and professional associations have historically tended not to include women, and in many cases have expressly excluded women. Accordingly, the law, as an instrument of the state, served purposes identified by men, and applied techniques that men considered appropriate but whose dysfunctions men did not experience or appreciate. Under

advancing conditions of equity between the sexes promoted by national constitutions and international human rights law, all laws affecting reproductive health require review in order to assess their particular impact on women.

Approaches to legal reform

Laws are expressed in instruments that fit within each country's traditions of legal development. Local lawyers and relevant legal literature need to be consulted to understand the particular laws and legal traditions of each country.⁵ Some countries embody their law in comprehensive codes that contain all of the rights that may be claimed. Other countries set their law within a framework of custom that judges declare, and into which particular enacted laws will fit. Yet other countries fit enacted laws within a framework of sacred law interpreted by religious authorities, which may declare an enacted law to be in violation of sacred principles and accordingly inoperative.

Where all legal claims to rights are comprehensively codified, a section of the code may be devoted to reproductive health. Reproductive health rights are all expressed within the detailed provisions of that section, and any apparently inconsistent provisions in other parts of the code will be subordinate and subject to provisions contained in the reproductive health section.

In contrast, many countries develop laws limited to advancing a particular goal in reproductive health care. For instance, in 1995 Guyana replaced its law that rendered abortion a serious criminal offence with a new law that gave priority to women's rights to avail themselves of safe abortion services.⁶ Ghana enacted a law in 1994 explicitly prohibiting the practice often described as female genital mutilation (FGM),⁷ and in 1990 the United Kingdom brought reproductive technologies and research under the general control of the Human Fertilisation and Embryology Authority.⁸

Several countries in different regions of the world developing new constitutions have included provisions for the protection of reproductive rights. For example, Article 40 of the 1991 Colombian Constitution protects the right to decide on the number and spacing of one's children. Other constitutions have more general provisions, such as on the right to liberty and security of the person, that have been applied to protect reproductive rights. For instance, in 1982 Canada adopted a Charter of Rights and Freedoms that included this right in general terms. In 1988, the Supreme Court of Canada found that provisions of the Criminal Code that limited women's choice of abortion violated the right to security of the person, and were unconstitutional and therefore inoperative.⁹

Less certain in their effects on reproductive health are constitutional amendments intended to protect human life from the moment of conception, such as have been introduced in the Irish¹⁰ and Philippines¹¹ Constitutions. These prioritize protection of unborn human life over lesser interests, but do not necessarily compel women to subordinate their interests in their own lives or the lives of their born dependent children to the interests of their unborn children. Accordingly, where the lives or health of women or their dependent children would be endangered for instance by close birth spacing, this constitutional provision would not necessarily limit legal

recourse to abortion. For instance in Ireland, following an amendment to the national constitution by which the state acknowledged and guaranteed the right to life of the unborn child, with due regard to the equal right to life of the woman, the Supreme Court held that abortion is legally allowed where it is probable that there is a real and substantial risk to the woman's life from continuation of pregnancy, including risk of suicide due to psychological imbalance.¹²

Legal principles governing provider-patient relations

Overview

The legal principles applicable to reproductive health that legal systems contain and express in their distinctive forms are relatively few, but are capable of applications that can maximize the protection and promotion of reproductive health. Each legal system surrounds these core principles with refinements at different levels of detail and abstraction, developed in legislation or by judicial interpretation of customary or enacted law. The key principles that follow are widely found, however, as minimum basic principles that national legal systems contain to satisfy prevailing standards of justice through private and public accountability for reproductive health outcomes.

The key legal principles in the provision of services are:

- informed decision-making
- free decision-making
- privacy
- confidentiality
- competent delivery of services
- safety and efficacy of products

Where a provider-patient relationship precedes a patient's request for reproductive health care, usually in the relationship between physician and patient, the provider may invoke a legally limited right of conscientious objection, notably to voluntary sterilization and abortion (see page 32).

Principles in the provision of services will be explained and amplified in the context of the components of reproductive health, including:

- contraceptive information and services;
- antenatal, delivery and postpartum care, including access to emergency obstetrical services and perinatal care of newborns;
- screening for and diagnosis and treatment of obstetric and gynaecological morbidity, including reproductive tract infections (RTIs) and cervical and breast cancers;
- screening for and diagnosis and treatment of STDs in both women and men;
- services for treating abortion complications, and, where legal, safe abortion services;
- infertility services for women and men;
- well organized and dependable referral systems for complications requiring specialized care;
- counselling and information on preventive care, health promotion, and access to treatment options; and
- elimination of induced hazards to reproductive health, such as FGM and violence against women.

Decision-making

Informed decision-making

It has become conventional to express informed decision-making as “informed consent”. This expression is inaccurate and often dysfunctional. Unless very deeply entrenched in a country’s medico-legal literature, it should be abandoned in favour of an expression such as informed decision-making or informed choice, in order to emphasize providers’ duty to disclose information, rather than any purpose to obtain consent. The legal duty is to present information that is material to the choice that the patient has to make, in a form that the patient can understand and recall. The purpose is to equip the patient to exercise choice, and to review a choice that was previously made. Studies suggest that when female family planning patients are able to exercise informed choice, family planning outcomes are enhanced and satisfaction with and commitment to treatment are increased.¹³

Decisions both to accept recommended care and to decline it must be adequately informed. A patient who declines a recommended option of reproductive health care after being given adequate information must not be supposed to have done so because of a lack of understanding, or to be in need of any emphasis or amplification of information already given. However, clinical judgement is required since a physician has been held liable for failing adequately to explain to a patient the significance of her decision to decline a pap smear test in several successive annual health checks when the prevailing advice was that women should receive the test at least every three years.¹⁴ Patients are clearly free to decline any test, but physicians and other providers are required to react more actively to refusal for a third year than to refusal of a pap smear test for a first or second year.

Information that a provider is usually required to disclose will include:

- the patient’s currently assessed reproductive health status regarding liability to unplanned pregnancy, STDs, conception and birth of a handicapped child, and infertility;
- reasonably accessible medical, social and other means of response to the patient’s condition and reproductive intentions, including the predictable success rates, side effects and risks of each option;
- the implications for the patient’s reproductive, sexual and more general health and lifestyle of declining any of the options; and
- the provider’s reasoned recommendation.

Underlying the duty to disclose is legal recognition that decisions on medical care are not themselves medical decisions. They are personal decisions that patients make, in accordance with their own priorities, that have to be medically informed. The legal duty to supply patients with adequate information for their decision-making is not limited to the time of initiation of the provider-patient relationship, or of consideration of a new option for care. The legal duty to ensure that patients are duly informed continues throughout the health-care relationship.

Although a provider is not required periodically to repeat information previously given, the physician is required to address any new occasion that should cause him or her to question whether the patient would want to make a different decision than was previously made. The occasion to refresh or add to the patient's information may arise out of the patient's treatment, out of the provider's awareness of a new treatment option that may be more suited to the patient's care or circumstances or, for instance, from anecdotal data indicating that maintaining prevailing treatment may present the patient with previously unrecognized risks.

There is no general duty to present new information to those who have declined previously offered care on the basis of appropriate information that was adequately presented at the time it was given. However, patients for whom providers have a continuing responsibility after they have completed a process of care may have to be given follow-up information of any material fact relevant to that care that has become available after that patient's care has been completed. For instance, a physician has been held legally liable for failing to inform a patient that blood he had previously received by transfusion was later shown to have been contaminated by a donor who had the AIDS virus, and that the recipient was unknowingly exposing his wife to risk of infection.¹⁵

Relevant law on due disclosure is not specific to particular procedures, tests or options, but addresses such matters through provisions governing providers' competence to practice, and continuing fitness where attendance at programs of continuing education is a condition of periodically renewed licence to practice. Continuing education is of particular significance in areas of more intensive research. For instance, newly arising information on genetic causes of disease and on prevention and management of genetically-derived pathologies should be available to patients in a timely fashion. Similarly, improved techniques and new outcome studies regarding reproductive technologies may present patients with fresh options, or, for instance, indicate the unsuitability for them of options that previously appeared appropriate.

General providers are expected to maintain general awareness of developments in the same way as other general providers, but specialists in a field are legally required to maintain the level of awareness of other specialists. They are not expected to monitor developments recorded in recent volumes of, for instance, general medical journals, but are expected to be familiar with literature in the journals of their speciality.¹⁶

Providers must exercise sound judgement about incorporation into their practice of suddenly arising perceptions in advance of reliable data, and should not delay application of findings based on sound evidence. If in doubt about adoption of new ideas or abandonment of discredited practices, they should consult leaders within their speciality and available professional literature, particularly research findings published in their specialized journals, that have been peer reviewed.

Legal systems apply different levels at which health care providers should pitch the information they aim at patients. Some require a "professional standard", according to which a provider is required to disclose information that would be disclosed by other, similarly situated providers of the same health care speciality. Others require disclosure pitched at what a reasonable person in the general circumstances of the patient would consider material.

Both levels require that providers relate the information they give to what they reasonably should know about their patients, and to what they actually do know. That is, providers are required to present information based on a realistic sense of their patients' lifestyles and reproductive intentions. They must have a sense of the probable sexual practices of their patients, and of their patients' probable sexual partners, and treat their knowledge and suppositions non-judgementally. They must also adjust the information they give to more specific knowledge they acquire about their patients, gained from questions that patients ask them in discussion, and for instance from medical or other examinations. It must not be supposed that patients necessarily conform to a limited range of sexual practices, or to prevailing stereotypes. For instance, sexual activity may not be confined to members of the other sex, and does not necessarily decline with advancing age, disability or with loss or absence of a marital partner.

The legal duty to be non-judgemental can impose a burden on providers' professionalism. As professionals, physicians may feel that they must act as social leaders and role-models in their communities, and express high moral standards, perhaps associated with religious teachings. Care of patients' needs may require, however, that they recognize and accommodate sexual practices that conventional religions find immoral and even unnatural. As health care professionals, providers must restrain any instincts they may have for moral condemnation, and must act non-judgementally to discharge their legal responsibilities to their patients. Their attitudes must not deny patients, or deter patients from requesting, reproductive or sexual health care they need in their circumstances.

Free decision-making

In addition to providers ensuring that patients are adequately informed for decision-making, they must be alert to how far patients are free to exercise independent choice. Many patients are never entirely free, because they are subject to factors in their social and family surroundings that are liable to influence their choices. Patients' hopes and fears, the well-being of those they care for and who depend on them and, for instance, their material resources and their dreams for the future will limit the options among which they may feel themselves free to choose.

Legal doctrine on free decision-making concerns patients' freedom from any bias exercised, consciously or unconsciously, by those to whom they turn for reproductive health advice or care. Providers' recommendations are liable to be influential and perhaps decisive, but recommendations must be made on the basis only of patients' best interests, directed by patients' reproductive health status and their expression of their wishes, goals and preferences. Patients' informed choices may not appear to be in their medical interests, but since health relates to physical, mental and social well-being, providers must tolerate their patients to exercise informed choices according to patients' own ranking of their physical, psychological and social interests. Patients are not obliged to put their medical interests first.

Providers must not permit patients' free decision-making to be distorted to favour providers' own material or other advantage, or mere convenience. For instance, a provider's recommendation or bias in favour of more expensive care when less expensive care would be equally appropriate may both compromise a patient's free

decision-making, and constitute illegal and unethical conflict of interest on the part of the provider. A recommendation must be uninfluenced by the provider's personal advantage. A conflict of interest in possible performance of tests by laboratories of which providers are proprietors, for instance, should at least be disclosed to patients with identification of alternative facilities.

Providers concerned that their approach to a patient or their style of practice may distort the patient's freedom of choice may consult their professional leaders or experienced colleagues who are able to offer an independent assessment. In clinical care of vulnerable patients, providers must exercise caution, for instance, in directing them towards forms of contraception on the basis of providers' convenience or third party payers' interests in economy, when alternative methods would be more suitable to patients' circumstances and better preserve patients' options for reproductive health.

How far providers should go to liberate patients from restrictions on choices that arise from patients' social and family circumstances will depend on the features of each case. Providers are under no general legal duty to isolate or protect patients from the normal influences that affect their lives. They face legal liability only if they impose treatments on patients when it is obvious that patients' resistance is being overborne by the insistence of third parties, such as partners, parents or parents-in-law. They may be equally liable for instance for negligence for denying care that patients prefer because of knowledge of third parties' opposition.

The compromise of patients' freedom of decision-making that arises from their social vulnerability, poverty or oppressive cultures presents providers with similar challenges. For instance, when long-acting implantable contraceptive methods, such as Norplant, are offered to disadvantaged patients, they must be ensured adequately free choice with respect both to the initial implantation and to subsequent use and removal.

The introduction of untested medical methods of fertility control on inadequately informed patients may raise direct and indirect legal concerns. Direct legal liability to patients is unlikely to be pressed when patients are not accustomed to bringing legal proceedings. However, providers who fail to observe ethical guidelines and requirements of independent ethical review, for instance concerning patients' free participation in research, may face indirect legal liability. Providers may be exposed to legal sanctions in discipline proceedings by licensing authorities and by institutions with which they are associated, such as hospitals, universities and professional bodies.

The role of third parties

Partner authorization

Health care providers must exercise great caution in supposing that their power to give sexual and reproductive health care to one partner in a marriage requires the authorization of the patient's spouse. Unless their patients explicitly approve consultation with spouses, disclosure of the patients' consultation on sexual and reproductive health care may be illegal. Even where disclosure is a legal discretion it may still be unethical, exposing providers to legal proceedings for breach of

employment contracts that require ethical practice, and/or professional disciplinary sanctions.

It is widely recognized in law that mentally competent adults enjoy autonomy of choice in their medical and health care, that they do not require the consent of any third party, including a wife or husband, and are not subject to the veto of any third party. Providers who are advised by their own lawyers that partner consent is required, particularly in cases such as artificial insemination by sperm donor, should, of course, comply. Without such advice, however, providers may be in peril of legal violation if they suppose that such consent is required simply because it has been obtained in the past, or because it is customary in their community or facility to obtain it. Indeed, initiating discussions with spouses without patients' clear prior consent may constitute a serious legal breach of confidentiality.

Young girls incapable of freely consenting to their marriage usually cannot be legally married simply on parental consent. Where such consent is a legally necessary condition of their marriage, because they are not of legal age for independent marriage, parental consent is not a legally sufficient condition. Marriage requires both partners' free approval, and human rights are violated if individuals of any age are married against their will. However, parental consent to a legal minor's voluntary marriage makes her of adult status in the eyes of the law, and does not place her under the legal control of her older husband. She can independently approve and disapprove medical procedures for herself, and make health care decisions for her child.

Husbands have no legally recognized cause of action against health care providers who treat their wives, on their wives' adequately informed and competent consent, without the husbands' authorization. Husbands' authorization may be requested where health care services are payable only from family resources that husbands control, but husbands' legal duties are to provide their wives with medically necessary care that they have the means to provide. Health care providers who provide services that are desirable but not strictly necessary to the preservation of patients' health, or that may be beyond the families' means to pay for, are legally entitled to seek assurances in advance that the services will be paid for. Nevertheless, such assurances sought from prospective patients do not justify any breach of their confidentiality by providers' discussions with spouses unless they are authorized in advance by patients or prospective patients.

Providers may discuss with patients or prospective patients whether delivery of services without husbands' approval would provide husbands with rights of divorce or other matrimonial remedies against such patients, for instance on grounds of cruelty or breach of a marriage contract between the parties or their families. A provider uncertain whether delivery of services to a patient that render her liable to divorce would constitute professional misconduct that renders the provider liable to sanctions by licensing authorities or by professional associations should resolve the issue by discussion in point of principle with relevant authorities or associations.

Parental Consent

As children grow in intelligence, experience and maturity, their ability grows comparably to discharge different functions and take responsibility for their

decisions. The Convention on the Rights of the Child requires attention to “the evolving capacities of the child”¹⁷. Although adolescents acquire full legal empowerment on the day they reach majority age, they have usually gained growing legal rights earlier in their development. They may be empowered by legislation before majority age for instance to buy tobacco, to go unaccompanied to forms of entertainment, to vote, to drive motor vehicles, to leave school, to consent to sexual activity and to marry. For many activities of adolescence, however, no chronological age is legislated.

In many countries there is no legally recognized age of consent to medical treatment, although health care providers are not uncommonly faced with literature that mistakenly states that there is. Such literature confuses law relevant to health care with laws on the legal age of consent to sexual intercourse, and, for instance, on the legal age of independent consent to marriage.

In health care law, there is generally no “age of consent” but only a condition of consent, which is reached when a person, of whatever age, is capable of sufficient comprehension to give adequately informed consent. Where legislation sets an age of majority or medical consent, it usually affects only the point at which the governing presumption changes. At adult age, individuals are presumed capable unless evidence, such as of intellectual impairment, indicates that they are not. Legal minors or those below an age set for medical consent are presumed incapable, unless evidence of maturity and comprehension indicates that they are capable.

Providers who deny indicated sexual and reproductive health care to the mentally competent and mature children of families for whose care they have accepted responsibility, because they do not have consent of parents or other adult guardians and the children refuse to have their parents or guardians informed, face legal liability for negligence and for abandonment. Further, where children of families for whose care providers are responsible are not clearly mentally competent or mature, but their parents or guardians have failed to exercise responsibility for their sexual or reproductive health and well-being, the children may lawfully seek and receive relevant health care services from providers independently. Providers who refuse such children’s requests for services may bear some legal responsibility for predictable STDs, pregnancies and other foreseeable consequences that requested services would prevent, particularly when the children are subject to sexual pressures against which they are not afforded the protection of their parents or guardians.

In some countries, legislation clearly states that medical services are not to be provided to legal minors without consent of parents or other adult guardians. Where such laws apply, there are usually parallel laws of equal effect that provide that parents or guardians are legally bound to provide their dependants with medically indicated health care services, which include preventive health care services, and violate the law in refusing to authorize such services and to pay for them within their means. Health care providers have no legal responsibility to enforce or monitor parents’ and guardians’ duties owed to their dependants. However, providers violate no right of parents or guardians by delivering services that they are legally obliged to make available to children who seek or consent to them. This applies to such sensitive services as contraceptive care and abortion.¹⁸

Legislation on medical care of minors outside comprehensively codified legal systems frequently provides additional powers of care available to adult guardians, but does not remove powers of consent to care that mature minors can give independently. That is, the legislation empowers certain others to approve procedures, but does not disempower mature minors. They remain subject, however, to the financial disability that they may not have the means to pay fees for services that are not covered by public or other funding. They may then remain dependent on payments by guardians who expect to know the services for which they are required or asked to pay. Guardians' legal duties to pay for indicated services may entitle them to learn in advance what services minors have requested, compromising minors' confidentiality. A justification for informing parents or guardians may be that, since they are legally responsible for the well-being of those under their care, they must know the medications and medical treatment their dependants receive. Providers will therefore have to discuss with legal minors who seek sexual and reproductive health care services which services can be given in confidence, and which services will require disclosure to parents or guardians.

Substitute decision-making

Legislation on mentally impaired individuals that justifies their compulsory detention almost invariably affords those in charge of them the legal power to approve health care services that are indicated for their well-being, including appropriate sexual and reproductive health care services. The capacity of such individuals to give legally effective consent to sexual intercourse may be questionable, but experience shows that they may engage in sexual behaviours with others that are not exploitive. It may be appropriate that they be allowed unchaperoned companionship with members of the other sex, and give sexual expression to affection when protected against harmful consequences.

A legacy of the eugenics movement, including of the treatment of mentally impaired people under the Nazi administration, is the protective requirement that they not be subjected to contraceptive sterilization procedures, except perhaps when judicially approved by decisions reached on a case by case basis. Nevertheless, where sterility is an unavoidable consequence of other treatment that is clearly for the therapeutic benefit of mentally impaired people, such as hysterectomy for girls who become dangerous to themselves upon the monthly experience of menstruation or surgery for impaired men who suffer testicular cancer, treatment may be undertaken upon consent of those under whose care they are legally placed.

A number of judicial decisions have held that mental health legislation may not permit relatives of mentally impaired persons the legal power to consent to medical interventions on them, even when they are incapable of giving legal consent for themselves.¹⁹ Where legislation or judicial decisions place such persons under the charge of others who are legally empowered to consent to their health care, consent may be given to protect or advance their sexual and reproductive health care, but legal power will usually be narrowly defined so as to permit only procedures that legal guardians are obliged to provide to meet dependent persons' needs. Power would not extend, for instance, to recruitment of dependent persons in research procedures not intended for their particular benefit.

The legal principle that individuals' health care be governed by their personal wishes when they are known, rather than by their objective best interests, cannot be observed when the individuals are not able to formulate or express wishes competently, and no other persons are legally entitled to give consent on their behalf. The law then provides that such individuals be treated in ways that serve their best interests. That is, when treatment cannot be determined according to individuals' subjective wishes, and others are not legally appointed to act as their substitutes, treatment must be determined according to the objective criterion of where each individual's best interests appear to lie. The role of family members or other guardians is to assist health care providers to reach an objective assessment of such best interests. The person's reactions to past experiences, his or her intellectual and emotional status and potential and, for instance, prospects of future care may be described by those who know and care for the person to assist determination of what, if any, health care interventions will protect and advance his or her interests. Nevertheless, the eugenics legacy leaves doubts regarding irreversible, non-therapeutic surgical procedures, such as contraceptive sterilization, that are not judicially approved.

Regulation of information

Privacy

"Privacy" is sometimes considered an alternative expression to "confidentiality", but a growing legal practice is to distinguish privacy from confidentiality and to determine the relationship between them. Privacy consists in the right and power to control the information that others possess, and is almost invariably limited by the circumstances of everyday life. Individuals yield an aspect of their privacy, for instance, when they appear in public, and thereby permit others to observe them and to draw conclusions about them, such as their age, circumstances and state of health.

Medical privacy is different, in that casual observers cannot draw accurate conclusions about individuals' health, particularly their reproductive health, from simple observation. Medical privacy is surrendered when patients tell providers how they feel, how they have behaved, what they want providers to do for them, and particularly when they allow providers to examine them. The privacy they yield is particularly intimate and penetrating, because providers can learn information that patients themselves do not necessarily possess, may be unable to anticipate or do not necessarily have the ability to understand.

There are frequently legal provisions under which health providers can obtain private information about individuals without their consent or even knowledge. Medical tests and reports that reduce privacy are sometimes involuntary, for instance under occupational health and safety laws, and for immigration and school attendance. In some countries, men convicted or just accused of sexual assaults may be compelled to undergo HIV/AIDS testing for victims' health care. Health information may be compulsorily reportable, for instance to public health officers who monitor the prevalence of contagious or infectious diseases. Publicly maintained registers of births and deaths will contain identifiable information of women who have given birth and of children that have died, and may include information of miscarriages for instance after 20 weeks' gestation. Accordingly, by voluntary acts of patients and direction of various laws, individuals may find that their privacy is surrendered to health care providers.

Health care providers whose interactions with patients necessitate the compromise of patients' privacy should minimize the extent to which this is required, consistently with their obligations to obtain information of patients' health and social histories relevant to their care. Other compulsory acquisitions of information should be strictly limited to the purposes that justify the compulsion. All of those who receive information that compromises patients' privacy, whether the patients volunteer that information freely or have no option in the matter, are legally obliged to observe requirements of confidentiality.

Confidentiality

Confidentiality is the duty of those who receive private information not to disclose it without the patient's consent. The duty applies whether the patient volunteers the information to them, they receive it from another health care provider as part of the patient's care or, for instance, they receive it without patients' consent under compulsory reporting laws. Patients may consent to disclosure by clear language, but also consent by implication to their health care providers sharing the information with other providers brought into the treatment team or who act as consultants.

Confidentiality is of critical concern regarding sexual and reproductive health, because sexual and reproductive matters are of particular sensitivity and are not freely discussed in many families, communities and cultures or between the sexes. Individuals who require and would benefit from sexual and reproductive health care may prefer to forgo it if they are not certain that their confidentiality will be strictly maintained. For instance, teenagers who are sexually active or about to become so may decide not to seek counselling for avoidance of STDs and pregnancy from family physicians, school counsellors or public clinics for fear that their parents will be informed. Similarly, individuals inclined towards same sex relationships may be fearful of reactions when those whose understanding they seek may make unauthorized disclosures. The fear that confidentiality will not be maintained deters many from seeking sexual and reproductive health services. To encourage individuals to seek information, a growing practice is to create "hotlines" by which they can telephone anonymously for reproductive health advice, for instance concerning their risk of exposure to HIV infection.

There are three predominant legal aspects of confidentiality, namely

- providers' duties to protect patients' information against unauthorized disclosures;
- patients' rights to know the information that their providers possess about them; and
- providers' duties to ensure that patients who authorize releases of their confidential information to others exercise adequately informed and free choice.

Related concerns are legal provisions by which physicians have duties and discretions to release their patients' confidential information to others without their patients' knowledge, and when the patients refuse consent.

Unauthorized disclosures

Providers' protection of patients' information regarding sexual and reproductive health may go beyond the ordinary protection of family privacy, since the duty may concern information that partners in intimate relationships do not want to share even with each other. Treatment of STDs may require disclosures to providers of sexual relationships outside marriage that would hurt patients to have disclosed to their partners. Health care providers face particular challenges to their legal duties and professional ethics when both partners in relationships are patients for whose care they are responsible, and infection in one partner endangers the other.

In some settings, wives may be fearful of serving their own interests in health and comfort, and the interests of existing children for whose care they are responsible, by negating the intentions of their husbands to father further children, particularly where existing children are all female. Accordingly, providers may have to be careful concerning the confidentiality of sterilization procedures and contraceptive care. The duty of confidentiality goes beyond care in conversation, since certain methods of provision of care may become apparent to husbands, in violation of wives' intentions to control the information their husbands acquire of wives' contraceptive practices. For instance, fitted intrauterine devices may show strings, colourful containers of contraceptive pills may be difficult to conceal, and attendance for routine health checks may require explanation. Confidentiality of contraceptive care may be better secured by an injectable method, even when a less confidential alternative may be medically preferable.

Part of providers' duty of care owed to their patients, arising through both legal contracts and the law of negligence, is to be vigilant to assure intended confidentiality. Counselling on methods of contraception, methods of sterilization and, for instance, preventing spread of an STD affecting a patient, must be conducted in terms not only of comfort and effectiveness, but also of confidentiality.

Infertility may damage the self-esteem of patients, and in some cultures be a legal ground for divorce. Further, a partner in a marriage may have psychological or other incentives to attribute the source of childlessness to the other partner. Practice shows that men may suppose their childlessness to be caused by their wives' inadequacy rather than by their own. While infertility is a common concern to both partners in marriage for which they seek treatment, they may be disposed to attribute blame on the basis of information about the contribution the other makes to their failure to become a parent.

Treatments to overcome childlessness that are acceptable to one partner may be unacceptable to the other, and options must be discussed, negotiated and if possible agreed between partners. It may be illegal and unethical to initiate treatment resulting in birth within a marriage unless the treatment, such as use of donated sperm, receives the informed consent of both partners. Once agreement is reached and treatment is proposed, however, confidentiality of their joint care may be essential, because the method, such as sperm donation, would deny the child legitimacy within the families of both partners, their community and perhaps fellow adherents to their religious faith. The well-being of patients and the children intended to be reared in

their families will turn not only on the success of their reproductive health care, but also on its confidentiality.

Disclosure to patients

Patients' rights to know the information that their health care providers possess about them are widely recognized, but are subject to variations among different cultures. In some, it may be offensive to provide information damaging to patients' self-esteem without their request or careful preparation. For instance, adolescent patients have been harmed by sudden information, presented to them without counselling, as to the probability that any children they might later conceive would be at risk of inheriting a severe genetic disability.

An important legal distinction is that, while patients may have no right to demand the transfer into their possession of health care providers' records and correspondence, because such documents are the legal property of the providers, patients are legally entitled to control the information about them that the documents contain.

Accordingly, they are entitled to information concerning themselves, and their requests cannot be rejected by claims that their providers have interests of their own in confidentiality of the documents. The right of confidentiality in their information belongs to the patients, who can direct providers in its use, including its disclosure to them.

It does not follow, however, that patients legally entitled to information of their own health status are entitled as of right to take hold of and read the records that providers have made about them. Providers' legal duties are to make patients' information available to them in a form they can adequately understand, and in a way that will not result in their misunderstanding of their health circumstances and reproductive potential. Providers are not entitled to deny information, but should inquire what purposes patients intend to achieve by their access to it. Providers are then obliged to serve such purposes to the full extent of their information and ability.

For example, where patients are fearful of venereal infection, they should be informed, when true, that their records show absence of infection. They may misunderstand a record that they read when it shows that they were tested to see whether or not they had been infected with named STDs. Patients may focus on references in their records to particular diseases they fear, rather than on negative results of tests. Providers must inform patients of the conditions by which they are found to be affected, counsel them on appropriate treatments and recommend what care they consider best. However, providers must exercise their judgement concerning conditions that patients are found not to have, neither alarming patients concerning conditions their behaviour risked nor giving them a false sense of security against future risks. The legal duty is to give patients an adequate understanding for their purposes of information about their reproductive health, including both their present status and their potential future according to scenarios that patients indicate.

Authorized disclosures

Patients are entitled to require their health care providers to disclose to third parties, such as potential employers and insurance companies, the information that the providers possess about them. A precondition to compliance with such requests is

that patients have some clear sense of what information providers possess about them. Whether or not patients have requested such disclosure to themselves (see b. above), providers have a legal duty to ensure that patients who request a transmission of health information about themselves to third parties have an adequate understanding of what information is then liable to be disclosed. This is an element of patients' adequately informed consent, although in law patients may be held to have voluntarily assumed the risk of disclosure of true but unfavourable information by requesting its disclosure to others without knowing the implications of the request.

Providers have to consider not only how to present information in accordance with their patients' requests, but also whether patients have an adequate understanding of how requested disclosures may be of disadvantage to them, for instance by excluding them from opportunities or by transfer of sensitive information to third parties who are under no legal duty or moral compulsion to treat it as confidential. Patients are entitled to insist on disclosure of information and even of copies of records, but providers should offer an explanation when they fear patients' unawareness of unintended but likely effects of disclosure.

Providers' release of information in compliance with patients' requests is authorized only within the scope of such requests, which providers should interpret very conservatively. In case of uncertainty, they should consult further with patients about the scope of requested disclosure, but should be aware that initiation of such consultation with patients in indiscreet ways may itself jeopardize patient confidentiality. For instance, providers should exercise great caution in leaving messages with third parties for patients to contact them, since this may inform the third parties that the patients are receiving care from these particular specialists, and expose the patients to unwelcome questioning or suspicion of why this is so.

A request from patients with which providers are bound legally and ethically to comply fully and promptly is to transfer their records to other providers to whom the patients intend to transfer their care.

Related concerns

Third party interests

It has been legally recognized that, while the duty of confidentiality is of great importance in the provider-patient relation, it is not the only duty, and it is not necessarily a duty that outweighs all others. Further, there is latitude in how confidentiality serves patients' interests. Although patients may not have authorized disclosures by explicit requests, it may be legally implied from their relationships with providers that the providers are free to make particular disclosures with the patients' implied consent. For instance, when patients have voluntarily informed third parties that they are receiving care through the providers, and such third parties approach the providers for assurances that the patients are not suffering from infection or other harmful health conditions from which the patients are in fact not suffering, the providers may so inform the third parties without having to obtain the patients' explicit authorization.

Requests from third parties for health information about patients always present specialists with particular legal concerns. If they know that their patients have

informed third parties, such as their husbands or wives, that they are under the specialists' care, and the information requested can be answered in a supportive or reassuring way, specialists may feel that they have the patients' consent to reply directly. Indeed, their failure to reply directly may be harmful, in that it may suggest that patients suffer from conditions that have negative implications. For instance, if a spouse inquires whether testing of the patient has shown that he or she suffers from an infection or malignancy, and testing has shown none to be present, the specialist may feel free to say so. Refusal to answer or a response that is not appropriately reassuring may be taken by the third party as evidence of the patient's ill health. Further, a response that may reasonably give an impression that is incorrect and harmful to the patient may also in law be defamatory.

If providers are uncertain how replies may be understood, and when they know that patients possess infections, malignancies or other conditions the truthful disclosure of which may be a source of distress or disadvantage to them, providers are legally entitled to invoke the confidentiality of relationships with their patients. They may say that they are not free legally and/or ethically to disclose information arising from a professional relationship. In sensitive specialities, such as STD diagnosis and pregnancy termination, providers usually must decline to say whether or not a person is their patient. Requesting parties may be advised to request such information from the patients themselves, or to ask patients themselves to request the providers to give answers to those making enquiries. Any patients who authorize the release of information to third parties must be treated in accordance with the discussion above on authorized disclosures.

Third party peril

A legal limitation of confidentiality that courts have recognized is that the duty of confidentiality ends where public peril begins.²⁰ In many countries, this is recognized by legislation that requires health care providers who have become aware of patients' infections, by clinical diagnosis or otherwise, to so inform public health authorities. This is because of the legal limitation of patients' rights to privacy (see 1. above), the limitation relieving those bound to report of particular duties of confidentiality. Reporting parties remain bound by duties of general confidentiality outside the scope of their duty to report, and those who receive mandatory reports are bound to treat the information they receive about patients as confidential.

A further limitation of confidentiality arises when those who learn of information about patients have legal duties, or alternatively legal discretion, to disclose that information, in order to protect others who the information reasonably shows to be in peril of preventable harm. For instance, when a provider learns that a patient may spread a STD and is having unprotected sexual relations with a known partner, the provider has legal duties or powers to ensure that the partner has reasonable protection. The provider must inform the patient of risk that the patient's diagnosed condition presents to the partner, and ask the patient what protection of the partner the patient will assure. If the patient gives assurances that seem adequate in light, for instance, of the patient's understanding, maturity, lifestyle and demonstrated concern for well-being of the partner at risk, the provider will have discharged binding legal responsibilities.

In case of uncertainty, the provider may ask the patient to return promptly, accompanied by the partner, for relevant counselling, or to have the partner come alone or have his or her own provider confirm to the patient's provider that counselling has been requested. The patient should be informed that if the partner does not come for counselling, with the patient or alone, or the provider does not hear that the partner has learned of the appropriateness of counselling, the provider is legally obliged, even without the patient's consent, to inform the partner of the peril the provider has found to be present.

If the patient does not inform the partner of the risk of infection, and the provider is therefore legally obliged to act, the provider may not be free to explain to the partner in explicit terms that the patient is the source of danger. The provider must take reasonable care not to show that to be the case, although the partner may easily identify the patient as the source of risk. However, when the patient made aware of presenting the partner with risk refuses or fails to take reasonable precautions to protect the partner or to equip the partner to take reasonable precautions, the patient cannot legally invoke confidentiality to prevent the provider from indicating indirectly that the patient is a source of risk of infection to the partner. The law holds that, in the relationship between provider and patient, a provider who acquires information that a third party is in reasonably assessed danger from the patient, has a duty to act appropriately to protect that third party. Further, where the third party at risk cannot reasonably be identified by the provider, a duty arises to that third party to act for the protection of any third party reasonably found to be at risk, such as by notification of appropriate public health authorities or similar authorities that discharge policing functions for the community.

In addition to holding providers bound to act appropriately to protect third parties against preventable serious harms that their patients appear likely to cause, courts have held that providers not obliged so to act may be excused from legal liability if they exercise a discretion to act in protection of third parties. The legal doctrine of necessity may be invoked to relieve health care providers of legal liability when they take initiatives to protect others against their patients' tendencies to cause harm. However, while such initiatives may excuse health care providers from judicial sanctions, the initiatives are not necessarily justified in law. There is a legal distinction between justified and excusable behaviour. Justified behaviour is lawful, but excusable behaviour is excused legal punishment even though it is unlawful and wrong in principle. Professional licensing authorities and professional associations may consider legally excused initiatives improper and to require professional disciplinary sanctions. Further, lawyers may engage in professional misconduct if they advise health care providers to behave in ways that are not justifiable, though excusable. Accordingly, the form of advice lawyers give will be that such preventive initiatives proposed by providers are not legally justifiable, but that courts of law, as opposed perhaps to licensing authorities and professional associations, may find them excusable.

Competent delivery of services and the law of negligence

The law on competent delivery of services and negligence can have a distorting effect on health care practice, if providers believe that they have to treat patients in ways that defend themselves against risks of legal liability rather than in what they assess to be in the best interests of patients. In some countries, providers may decide,

for instance, to turn to caesarean delivery before properly assessing the safety to mother and child of natural delivery, and may feel bound to employ fetal monitors and induced delivery when no evidence of fetal distress is actually present. Providers' on-going professional education should curb tendencies to practice harmful or wasteful variants of defensive medicine.

In law, negligence is established when four elements are established by a complaining party.

- A legal duty of care must be owed by a provider to the complaining party. The range of legal duties is set by each legal system, some finding legal duties owed, for instance, to patients' family members, where others do not. Much of lawyers' work lies in establishing legal duties between complaining parties and those they want to make liable to pay them compensation.
- Breach of duty of care must be shown, meaning a provider's failure to meet the legally determined standard of care (see below).
- Damage must be shown, meaning a hardship or loss, perhaps of a future opportunity, that the law recognizes as an injury. For instance, courts usually recognize loss of future reproductive capacity as an injury. They have historically been reluctant to recognize unplanned birth of a healthy child as a form of legal injury, although many courts are now considering this compensable to the extent of costs of confinement and inconvenience, but not necessarily child rearing costs.
- Causation, meaning that the damage must be proven to have been caused by the breach of duty of care. Causation often requires evidence from expert witnesses (see below).

Central legal issues concerning competent delivery of sexual and reproductive health services are:

- the relation between legal and professional standards;
- standards for determining professional competence;
- delegated authority; and
- evidence for determining professional competency.

Relation between legal and professional standards

Courts are often inclined to defer to the standards of competence that health care professions require their members to observe, out of respect for the traditions of self-regulation that many societies maintain. However, many legal systems find that standards for delivery of services are matters of law as well as of professional discipline, because services are rendered under legal contracts whose terms, frequently implied rather than written, courts are obliged to interpret and enforce. Further, if professions themselves could exclusively determine the standards below which legal liability for negligence will arise, they might develop self-protective incentives to set standards modestly, at a lower level than would serve the public interest.

From their own expertise and experience, professions may develop practice standards by which their credentialing authorities will measure providers' eligibility for specialist recognition, and by which their disciplinary authorities will determine the competence with which individual procedures were performed. These may concern dexterity, protective and cautionary strategies in patient care and familiarity with new techniques and discrediting of once customary procedures. The legal significance of such practice standards, where they exist, is that providers who fail to satisfy them may be held in breach of their legal duty. Liability may arise because courts hold that providers undertake, by contract or otherwise, to perform according to that practice standard, or because courts adopt the standard as the legal measure of providers' duty of care. However, courts normally reserve the power to find that, while breach of the standard demonstrates legal liability, compliance with the standard does not necessarily satisfy legal tests, since the courts may find that the standard of practice the profession finds adequate is unacceptable to the wider community.

Professional standards of competence involve both professional skill and professional attitude, sometimes described as courtesy. Health care providers are required to be conscientious and sensitive not only in the conduct of procedures, but also in demonstration of respect for their patients and colleagues. Unprofessional behaviour includes such matters as neglect of patients' modesty, such as by remaining in the room while patients undress or dress themselves, smoking cigarettes while attending to them, and being distracted from care for them by attending to other personal or professional concerns. These insensitivities are difficult to regulate by law. Effective enforcement may be more readily achieved through professional discipline, including the disapproval of professional seniors and ineligibility for benefits such as promotions, due to the unsuitability of defaulting providers as role-models. The ethical component of professional competence may be influenced by reference to a wider literature than providers routinely consult, such as literature in bioethics. However, providers will be expected to be familiar with their own specialist literature, which increasingly includes contributions from bioethics. Specialists are legally obliged to keep up to date with developments in their field, which include ethical developments. For instance, providers of reproductive health care are expected to know about developments in emergency contraception, and providers of reproductive technologies are expected to be aware of controversies (whether or not regulated by law) concerning such matters as commercial surrogate motherhood, ovum recovery from fetuses, sperm recovery from recently deceased men, and post-menopausal gestation.

Many providers will recognize these latter concerns as controversial, but quite remote from their practice. More pressing are such issues as the prompt removal of contraceptive implants on request and, for instance, husbands' opposition to services their wives would like to receive. Providers' competency to exercise ethical judgement comes under more strict legal scrutiny when providers have monetary incentives to behave in ways open to ethical doubt. Legal doctrine and health professional discipline address the possibility that providers will favour their own advantage, in dealings with patients who depend on them, by reference to principles on conflict of interest. Some assessments are that such conflicts must always be avoided. Others are that a conflict can be satisfactorily resolved by disclosing the potential for conflict to a patient who has the option to seek services elsewhere where no such conflict exists. Whether resolution of conflict is through avoidance or due disclosure, a provider who does not achieve resolution will face legal and

disciplinary liability for professional incompetence, perhaps described as malpractice.

Standards for determining professional competence

In principle, each health care profession defines the services that its members profess themselves capable of delivering. Capability addresses both members' proficiency, including, for instance, dexterity and judgement in performance of professional acts, and the services the profession considers it ethical for its members to deliver. Professional ethics evolve over time, and practices unethical according to, for instance, the classical Hippocratic tradition, may now be considered ethical to be delivered by health care providers, and unethical for them to leave to patients themselves or to unskilled providers.²¹

Legal systems differ on the extent to which they regulate health professions. The historical development of some systems has resulted in their tolerance of both qualified and unqualified health care practice. Protection of potential patients is achieved principally by precluding unqualified providers from passing themselves off as qualified. For instance, even when they hold recognized doctorates, those not qualified as physicians are not permitted to describe themselves as "doctor" when offering health care. In general, the lay public is left considerable choice to receive care from qualified or unqualified providers, under the principle of the market place *caveat emptor* ("let the purchaser beware").

More commonly, laws preclude the performance of medical acts from being offered or undertaken except by those who are academically qualified and professionally licensed to practice medicine. Some laws permit, for instance, licensed nurses and paramedical personnel to perform limited medical acts. Exceptions are allowed for unqualified individuals to treat themselves in minor ways, and to give similarly superficial care to family members such as dependent children. Further, emergency care may be given by anyone who honestly believes another to be in immediate grave peril and who then takes reasonable initiatives for rescue.

Some overlap exists between qualified and unqualified health care practice concerning services that do not require skills developed through supervised training, but that depend on sensitivity and judgement in human interactions and familiarity with reliable literature relevant to the services in question. For instance, counselling concerning wise goals in sexual and reproductive health care may be undertaken not only by qualified health care professionals, but also by school teachers, ministers of religion, and, for instance, social workers. The availability in some countries of contraceptive pills without prescription, like the availability of condoms, justifies non-physicians advising their use.

Unqualified individuals lawfully offering services related to health care risk legal liability through recklessness in what they do, but are not held to a professional standard unless they hold themselves out as having skills beyond those ordinarily expected of non-professionals. They do not attract greater legal liability simply for having offered advice for a lengthy period of time, since their claim of experience is not necessarily a claim to expertise.

Qualified health care professionals claiming to act as such will legally be held to a professional standard of competence. General providers in their discipline, such as medicine and nursing, will be expected to maintain the standard of practice of other general providers, while those holding or claiming specialist status will be held to the standards that prevail within their speciality. An important element of professionalism, in both general and specialized practice, is to recognize the limits of one's skills and to make timely referral of patients to other, appropriate providers who are able to offer patients the care they need.

Although it is common to speak of "the" professional standard of care, courts often recognize that the standard includes a range of practices that are acceptable to satisfy the standard. The law acknowledges that standards evolve, and that at each end of the central body of practice there will be practices that are either somewhat antiquated or innovative. A respected minority of the profession may maintain earlier practices that are not discredited but that mainstream providers no longer follow. Similarly, a respected minority may find practices that are in advance of the mainstream to be preferable, and to incorporate them in their practice not as research but as routine care. The legal concept of standard professional practice therefore covers a spectrum, from reputable but largely abandoned care, through mainstream practice, to newly established practice that may in time become mainstream.

Outside the range of standard practice, however, will be antiquated, discredited care and treatment still at the stage of experimentation. For example, the use of general anaesthesia for early abortion was once common, but such procedures are now undertaken with no more than local anaesthesia, often on an outpatient basis. The continuing use of general anaesthesia warrants assessment by the profession, not only because of its drain on professional and funding resources, but particularly because of unnecessary risks posed to patients. Adequately informed patients may be willing to take the risks if they consider general anaesthesia preferable for them. The performance of abortion without anaesthesia, which has been interpreted as introducing a punitive or deterrent component to the procedure, requires professional assessment on grounds of patients' comfort, dignity and free and informed choice.

Before patients are offered reproductive health care, providers may be expected to identify the need for assessments that do not fall within the field of obstetrics and gynaecology. Providers who lack the capacity, for instance, for genetic diagnosis, prognosis and counselling are required to advise patients regarding the services that appropriate, reasonably accessible geneticists offer, access to such specialists and the implications of patients proceeding with their reproductive intentions in the absence of such services. This applies both to patients who intend to have children when they are unaware that the children would be at risk of harmful genetic inheritance, and patients seeking sterilization because they fear their children's harmful genetic inheritance, when with due counselling and care, the harm could be avoided or overcome.

Delegated authority

It has long been recognized in law that medical care often involves team work, and that providers frequently act by identifying and delegating tasks to those they supervise. This is the basis on which many functions discharged by nurses and other health care professionals are legally justified, and on which medical students

undertake medical acts and health care practice before they are qualified. Where the law reserves certain practices only to licensed physicians, or creates immunities from legal liability only for such physicians, it recognizes that physicians may act along extended lines of authority. Further, delegation may be general, to a form of care rather than specific to the care of a particular patient, such as when nurses act under medically directed standing orders.

For instance in Britain, when the Abortion Act 1967 amended the law, it maintained general criminal liability for performing abortion, and the immunity it created for acting in specified, liberal circumstances was expressed to protect only “a registered medical practitioner”. Nurses later objected to involvement in prostaglandin-induced procedures, which were developed after 1967. In these procedures, doctors inserted catheters for drug administration, but nurses administered the drugs and managed the subsequent expulsion of uterine contents, completing the abortion. The Royal College of Nursing feared that nurses instrumental in performing prostaglandin-induced abortions were not protected by the immunity from criminal liability legislated in the 1967 Act. However, the highest court interpreted the power of a registered medical practitioner to perform an abortion under protection of the Act to include procedures performed by delegation of authority. Accordingly, nurses and others acting under delegated authority were held to enjoy the same immunity as delegating physicians.²²

When physicians delegate authority to others, they remain obliged to conduct appropriate supervision, and are legally liable if their supervision falls below the legally regulated standard. Further, under many legal systems, even when physicians’ supervision satisfies the legal standard, they are vicariously liable to patients and others injured in the scope of activities performed by those to whom authority to act has been delegated.

Evidence for determining professional competency

Competency standards are determined by both courts of law, since standards are a matter of law on which courts rule, and by professional disciplinary tribunals. Providers are liable to be called on to answer for their clinical, institutional and economic practices before such tribunals. They are also often asked to serve as expert witnesses to assist courts and tribunals in the identification and measurement of competency standards by which all members of the profession are bound. The credentials that constitute expertise will usually be set by courts and tribunals themselves, usually paying respect to providers’ recognition and leadership within their own profession.

However experienced providers may be, they may feel reluctant to testify to professional standards of competency at hearings where fellow providers are defendants facing penalties. A so-called “conspiracy of silence” may develop within a profession that compromises patient-plaintiffs’ ability to acquire expert witnesses necessary for the due administration of justice. In the face of this, courts of law assessing patients’ claims for compensation may hear only insubstantial evidence that care was incompetent. However, they will allow an accused provider to present evidence from prominent authorities that the care delivered satisfied professional standards of competency, concerning proficiency of performance and/or ethical sensitivity.

Where courts of law are asked by public prosecutors to impose criminal penalties for wrong-doing and negligence, the prosecutor will usually be required to present compelling evidence that the defendant provider's proven behaviour fell short of the professional standard by presenting expert evidence of what that standard requires. In professional disciplinary tribunals, the profession will be expected similarly to demonstrate the standards it claims were violated.

Professional expert witnesses are not advocates for the parties that call them, and pay them fees. Their role is to assist courts or tribunals, and their only allegiance is to the integrity of their professionalism and expertise. They have no stake or interest in whether the parties that call them succeed or not.

Sexual misconduct

Nonconsensual sexual intercourse with patients is obviously a criminal offence and a compensable wrong committed against them, but the concern of competent delivery of health care services extends far beyond this self-evident truth. Many licensing authorities and professional associations consider consensual sexual behaviour with patients to be professional misconduct even though no crime may have been committed. Further, behaviour with sexual aspects falling far short of sexual intercourse may be held to constitute professional misconduct.²³ It may also be a ground for legal action, for instance in legal systems that recognize the deliberate or even the negligent infliction of emotional damage or breach of fiduciary duty to justify compensation. Health care providers' abuse of their power over patients for their personal sexual or other gratification usually persuades courts that a remedy should be available in law.

Conduct that has been considered sexual abuse of patients and professional misconduct typically involves male providers and female patients, but instances exist of the reverse and of health providers' sexual behaviour with patients of their own sex. Further, misconduct has been found when health care providers have engaged in sexual behaviours with their patients' spouses and other partners. Beyond conduct that unmistakably exploits patients' sexual, emotional or other vulnerability, conduct that humiliates, disparages or embarrasses patients on grounds of sex may be considered sexual misconduct. This includes making observations about a patient's sexual performance or attractiveness, whether of a negative or affirmative nature, and making sexual jokes with the patient. Such jokes need not make the patient the object of ridicule, but may be a misjudged attempt to make the patient feel comfortable, or to distract attention from an occasion of embarrassment. It also includes having a patient undress or dress in sight or even in the presence of the health care provider, the provider's colleagues, or other patients.

Health care providers in the field of sexual and reproductive health are expected to exercise a high level of caution and self-awareness concerning liability to suspicion of sexual misconduct because of the examinations they may conduct, the types of histories they may request from patients and the types of treatments they may administer and monitor. It may be expected that their practice would allow physical examinations of patients to be conducted by providers of the same sex, and that, particularly when male providers are examining female patients, and perhaps also when they are consulting with female patients, they will remain in the sight of a

female provider, within the limits of patients' confidentiality. Alternatively, patients may be invited to have a family member such as a mother or sister or a friend accompany them and be easily accessible, again subject to patients' requirements of confidentiality.

A common feature of health care providers' sexual abuse of patients is that the patients feel embarrassed and ashamed, and sometimes inclined to blame themselves for experiences they have suffered, so that they do not present complaints immediately, or at all. A response by some licensing authorities is to require licence holders who become aware of others' sexual misconduct to report the circumstances to the authorities, so that proper investigations and disciplinary proceedings can be initiated, and particularly so that patients can be offered appropriate counselling, care and rehabilitation. When sexual abuse is broadly defined to include sexually-sensitive discourtesies, professional colleagues may become aware of abuses that patients themselves do not recognize.

A policy of zero tolerance of sexual misconduct may be considered to justify sanctions against providers who failed to report the misconduct of others. The legal power that licensing authorities possess includes imposition of such sanctions as withdrawal or suspension of licensure for professional misconduct that is not itself a breach of law when committed by those outside the profession. Voluntary professional associations' legal powers to investigate and discipline members usually arises as an incident of the contractual relationship created by virtue of payment of membership fees. Under either legislated or contractual legal power, professional authorities and associations can offer the public assurances that their policy with regard to providers' sexual misconduct is strict and uncompromising.

A limitation of a zero tolerance policy is that it may not distinguish between abuse of patients and the attraction and affection that may genuinely arise between provider and patient that in other circumstances might include a sexual expression, and evolve through courtship into marriage. Professional institutions' interventions to regulate members may appear an unjustified intervention in patients' lives and choices. Nevertheless, even rejecting the view that patients' choices cannot be freely made in such unequal relationships that involve emotional dependency, providers are expected to recognize when their interest in patients transcends professionalism and is becoming personal, and to terminate the professional relationship and its emotional aspects before allowing any sexual or intimate expression of affection. Providers who are uncertain about the propriety of a relationship they anticipate and favour should be able to consult professional authorities and associations, and professional seniors and peers, without suspicions of professional misconduct arising.

Conscientious objection

By specific laws governing reproductive health services or general laws concerning human rights, sometimes embodied in countries' constitutional laws, many legal systems protect health care providers from legal obligations to perform procedures to which they have conscientious objections. In most legal systems, this right of protected conscience covers only conscience based on adherence to a religious faith, but some laws on freedom of political, philosophical or other expression may accommodate a right of nonparticipation in professional practice to which individuals object on grounds of more general conscience. In the field of reproductive health,

most conscientious objection is raised to participation in abortion procedures and contraceptive sterilization.

Laws on conscientious objection are normally inapplicable where patients are in emergency circumstances, such as when their lives or permanent health are at risk. This does not violate the conscience of providers in many cases involving abortion or sterilization, because of the ethical and religious principle of “double effect.”²⁴ This provides, in its simple form, that an action that has a good objective, such as preserving a patient’s life, may be performed despite the fact that the objective can be achieved only at the expense of an unavoidable harmful effect. The action itself must be either good or morally indifferent, the good effect must not arise by means of the harmful effect, and there must be proportionate justification for allowing the harmful effect to occur. For instance, an ectopic or tubal pregnancy that endangers a woman’s life can be removed without the procedure being regarded as an abortion, and a man’s testicular cancer can be treated by removal of the testicles without the procedure being regarded as a sterilization.

The legal burden of proving that a conscientious objection arises in good faith is usually to be discharged by the person claiming relief from an otherwise legally binding duty to act. This burden is sometimes discharged adequately by the claimant making a solemn declaration of religious or other conscience, and showing consistency of objection. The scope of relief from a duty on grounds of conscience is normally interpreted narrowly. Health care professionals who object, for instance, to performing abortions may be exempted from conducting procedures and perhaps from preparing patients immediately before their performance, but not from providing more general care, including for post-operative recovery and changing dressings. Further, only professionals who otherwise would be required to perform services directly on patients can invoke grounds of conscience for the purpose of exemption. Hospital service staff cannot refuse such functions as delivery of patients’ meals, arrangement and replacement of their bedding and booking of appointments on the ground of conscientious objection to the medical service the patient receives. It has been held, for instance, that a physician’s secretary has no conscientious right to refuse to type an abortion referral letter.²⁵

Institutions and clinics as such, even when established by religiously or otherwise committed agencies, cannot invoke conscientious objection, although they are often entitled to select the services they offer from those they leave unavailable to patients. When a hospital presents itself to the public as a facility on which members of the public can rely for medically indicated health services, it cannot endanger patients’ lives or health by refusing an indicated service. The duty of such facilities is to employ adequate staff to provide competent delivery of services to which some staff members may object on grounds of conscience, or to have standing arrangements under which patients are safely and conveniently referred to alternative facilities where such services are available.

In many countries, public hospitals are governmental facilities, and litigation brought against them may be resisted by their legal entitlement to governmental immunity. Immunities that protect government facilities before national courts when they deny patients care indicated for them, may render the state itself liable before international human rights tribunals.

Providers who invoke conscience to refuse to perform services on patients entitled to receive services from them are usually legally obliged to refer their patients to other appropriate providers, within their own facility or conveniently accessible elsewhere, who will provide the service. Under some religious doctrines, it may constitute a wrong not only to perform prohibited procedures but to have complicity in their performance through referral. Legal systems often afford priority to patients' rights of access to lawfully available therapeutic and preventive health care procedures over providers' personal conscientious objection. They interpret providers' conscientious exemption to apply only to actual performance of procedures, but not to justify refusal of appropriate referral. Failure or refusal of due referral has been found to constitute legal negligence or abandonment of patients.²⁶

In contrast, providers are usually free not to accept applicants for their care as non-emergency patients. They may decline on grounds of conscience, and in that case bear no legal duty to refer applicants elsewhere. However, they may be in breach of human rights laws if their exercise of conscience violates legal prohibitions of discrimination against persons seeking services on such grounds as their marital status, sexual orientation²⁷ or HIV positive status.²⁸

Further, licensing authorities and professional associations may require that more be done to assist applicants for services than is legally required. Authorities and associations may review the practice of providers who invoke conscience to decline to perform procedures in public facilities but who participate in such procedures in private practice. Since the duty of proving conscience falls on such providers, performance in private practice of procedures refused in public facilities will compromise ability to prove conscientious objection.

Related issues are whether a medical or other health care student with a conscientious objection to a reproductive health procedure such as abortion can refuse instruction and examination in performance of the procedure without forfeiting the right of qualification, and whether medical schools run by institutions with religious or other objections to health care procedures can decline to give instruction in them without forfeiting the right to accreditation and licensure of their graduates. Since the right of conscientious objection does not apply where patients' lives or permanent health are at risk, it appears that providers who may properly object to initiation of procedures on conscientious grounds in routine cases must nevertheless be capable of performing them in emergency, such as when it is necessary to complete an incomplete abortion, and be appropriately trained and qualified for this purpose.

Similarly, medical schools responsible for training graduates to serve needs of the public, including in conditions of emergency, may be required to instruct students in procedures they might properly refuse to perform in routine cases. Further, under religious teaching on the principle of double effect, procedures that achieve abortion only indirectly, such as treatment of ectopic pregnancy and of threatened spontaneous abortion, are not prohibited, and health care professionals must be competent in their performance.

Safety and efficacy of products

The law of product liability is not a direct concern to many providers such as obstetricians and gynaecologists as such, although any who develop new

pharmaceutical products or design new devices will become involved in such concerns as they move towards introduction and marketing. Similarly, providers proposing to develop new drugs or devices will be bound by relevant legal requirements to conduct research with human participants. The most immediate legal significance of drug and device safety is that providers are required, as part of their continuing competence to practice, to be aware of improvements in products available to patients, and of data and relevant anecdotal evidence of products failing to meet levels of efficacy and safety they were formerly believed to meet. Further, health care providers are expected to offer their patients the safest and most effective means of care of which patients can reasonably avail themselves, whether under public funding of services or private means, including under private health care insurance policies or organizations.

Legal systems approach product safety through principles either of liability based on proven fault, or alternatively of so-called “strict” or no-fault liability,²⁹ which requires a product manufacturer to become in effect the guarantor of its safety for the purpose for which it is designed and marketed. Whether liability is based on principles of fault or not, deficiencies leading to liability for products may arise from inadequate design, inadequate manufacture, for instance with defective materials or deviating from the design, or inadequate instruction or warning concerning proper use and limitations of the product.

The significance of this law for providers who are not researchers, designers, manufacturers or retailers of a product concerns their liability for recommending a specific product for the patient’s use. Even if they select and supply a product and charge a patient for it separately from services for the patient’s care, they will not be considered mere retailers of the product, but to be undertaking a professional service rather than a sale of goods transaction. When they employ devices for the purposes for which they are designed, they can claim legal indemnity for injuries to patients that follow from such use. Whether others can be found legally liable for negligence when supplying devices or drugs for the purposes for which their marketing and promotion are approved is a matter on which laws vary.

Providers accept responsibility for any accidental or deliberate uses they make of products that differ from their approved purposes. Although professional practice may be consistent with so-called “off-label” uses of drugs, which depart from the conditions for which they have been tested and approved, such practice provides no legal defence for off-label use that results in harm.

Providers are required under legal provisions on competence to pay regard to the information they receive from manufacturers of drugs and devices concerning contraindications for their use, and should make adverse incident reports to manufacturers concerning harmful outcomes of which manufacturers have not warned them. Providers must apply the information they receive from manufacturers with appropriate professional skill and judgement, and be alert to information in the general providers’ literature of scientific criticism of manufacturers’ trade information. They may also be required, for instance, to inspect devices and the packaging of drugs they supply to patients directly, in order to ensure that there are no defects apparent upon competent inspection that would render them unfit for use, such as passage of expiry dates for effectiveness of drugs.

Of particular concern are practices of providers and institutions, often driven by the needs of economy, to reuse devices advertised by the manufacturer and/or marketed by a retailer as being for single use only. As a matter of experience, many single use devices are known to be safe for a number of reuses, subject perhaps to effective sterilization. Manufacturers do not promote the devices as such, not simply to increase sales from single use but to avoid legal liability in testing and in, for instance, specifying safe techniques of sterilization and a number of reuses after which devices should be discarded. Nevertheless, providers and institutions bear legal liability for the harmful consequences that follow reuse.

Liability may be limited if providers offer patients the option to have first use or subsequent use of a single use device, perhaps adding the cost of the former to charges for services. Liability arising from subsequent use may be due to the transmission of infection following defective sterilization, associated perhaps with use of diluted solvents or error in sterilization procedures, or to mechanical malfunction of the device resulting from fatigue of its materials or from damage caused by sterilizing solvents, such as corrosion of rubberized valves. Even when patients give adequately informed consent for reuse of single use devices, and accept the irreducible minimum risks of their malfunction, they are not legally held to accept risks of negligent handling or inspection of devices.

Human rights and reproductive self-determination

The modern basis of human rights

All of the legal issues discussed above regarding domestic law arising from provider-patient relations fit within a framework of international human rights law. The legal duty to respect human rights has recently evolved to become a major component of international law, which historically was known as the Law of Nations. This body of law binds states and international institutions rather than individuals as such, but states are legally bound to ensure that their domestic practices conform to international human rights standards and that the conduct of individuals in violation of human rights will be investigated and remedied by state action. States must also take preventive action where human rights violations by individuals or private organizations may reasonably be anticipated.

Human rights law goes beyond the oversight of clinical management of patient care, since it addresses the responsibilities of states to ensure that individuals in need of health care services have reasonable access to physicians and others competent and equipped to deliver them. The wider framework of international law also governs the responsibilities of states to maintain public health, and to promote appropriate research into the advancement of sexual and reproductive health. For instance, while human rights obligations to promote or, at a minimum, permit access to the benefits of scientific progress tend to focus on biological, physiological and related sciences, they also apply to social sciences relevant to sexual and reproductive health.

The modern basis of commitments to human rights is the 1948 Universal Declaration of Human Rights. This was developed within the United Nations to add substance to its Charter, dating to 1945, which observed that a purpose of the new organization was “to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, [and] in the equal rights of men and women.” Legal force is given to the Universal Declaration through a series of leading treaties.

Treaties of legal force include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and regional treaties such as the European Convention on Human Rights, the American Convention on Human Rights and the African Charter on Human and Peoples’ Rights. In addition, several international treaties are directed to the relief of injustices individuals may suffer on account of an innate characteristic of theirs. These treaties include the International Convention on the Elimination of All Forms of Racial Discrimination, and the Convention on the Rights of the Child. These are applicable to, among other more obvious interests, the protection of reproductive and sexual health. Most directly relevant, however, is the Convention on the Elimination of All Forms of Discrimination Against Women (the Women’s Convention), which explicitly addresses human rights regarding family planning services, nutrition during pregnancy and information and education to decide the number and spacing of children.

The United Nations has given momentum to legal developments concerning sexual and reproductive health through its sponsorship of international conferences. Most immediately relevant are the 1994 International Conference on Population and

Development, held in Cairo, and the 1995 Fourth World Conference on Women, held in Beijing. The resulting Cairo Programme of Action and the Beijing Declaration and Platform for Action provide the basis for development of standards that provide substance to international human rights expressed in the sometimes abstract language of international human rights conventions.³⁰

International human rights treaties establish committees whose functions are to monitor states' compliance with the obligations states have accepted. Under the Women's Convention, the Committee on the Elimination of Discrimination Against Women (CEDAW) receives periodic reports that states must submit to show how they have brought their laws, policies and practices into compliance with the Women's Convention. To assist countries in their reporting obligations, CEDAW has developed a series of General Recommendations.³¹ These Recommendations develop the standards of performance applicable to measure compliance with human rights norms. General Recommendations are somewhat akin to regulations developed by administrative agencies under national legislation. Several interesting symposia have begun to focus on the factors that might be considered in developing a General Recommendation on women's right to health, including sexual and reproductive health.³²

In addition to General Recommendations, CEDAW agreed in 1995 to use the Cairo Programme in developing performance standards³³ to determine whether states are in compliance with their obligations under Article 12 of the Convention to

“take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning ... pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”

Applicable human rights

Rights to reproductive health and self-determination may be protected through several specific legally established human rights. Which rights are most relevantly invoked and how they are shown to have been violated depend on the particular facts of an alleged violation, and on the underlying causes of reproductive or sexual ill-health. The rights addressed below are not exhaustive, but indicative of rights that may be developed to advance reproductive interests. The Table following the notes to this Discussion Paper shows provisions of different international instruments that are relevant to the protection and promotion of reproductive interests.

Rights are interactive in that each depends in greater or lesser degree on observance of others. For instance, rights to information, central to legal principles of informed and free choice in health care, often depend on observance of the rights, particularly of children, to education and literacy. As human rights laws come to be applied more vigorously to reproductive interests, a variety of ways of applying rights will emerge to serve reproductive and sexual health.

The following discussion shows ways in which specific rights may be applied to protect reproductive interests. The discussion also addresses how the Cairo

Programme, Beijing Platform and the CEDAW General Recommendations have been used and can be further used to develop the standards by which to measure compliance with these rights.

The right to life and survival

The Cairo Programme reaffirms that “everyone has the right to life” (Principle 1). A strong case can be made to apply this right to the lives of the estimated 580,000 women each year world-wide who die of pregnancy-related causes, in order to hold governments accountable for their failure to achieve significant reductions in national rates of maternal mortality.³⁴ Governments agreed through the Cairo Programme and the Beijing Platform to reduce maternal mortality by one half of their 1990 levels by the year 2000, and by a further one half of the year 2000 levels by 2015 (Cairo para. 8.21 and Beijing para. 106(i)).

International human rights law requires states to protect women in motherhood. Article 25 of the Universal Declaration of Human Rights explains that “motherhood ... [is] entitled to special care and protection”. Article 10 of the International Covenant on Economic, Social and Cultural Rights requires states to accord “[s]pecial protection ... to mothers during a reasonable period before and after childbirth.” Article 12 of the Women’s Convention requires states to

“ensure to women appropriate services in connexion with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”

Article 11 of this Convention recognizes the right “to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.”

The root causes of maternal mortality are complex, ranging from lack of contraception and trained birth attendants to women’s unequal status in society that results in poor nutrition and schooling and in early marriage.³⁵ In order to apply human rights effectively to hold a government accountable for neglecting the high rate of maternal mortality in a community, the causes of maternal mortality in that community have to be understood. If the causes are multifaceted, which is often the case, then in addition to the rights discussed below, the right to life may be invoked to require remedy of causes. If, however, the predominant cause is lack of trained birth attendants, the right to the highest attainable standard of health might be more appropriately invoked to require governments to provide services. This may be so particularly in developing countries, where World Health Organization data indicate that only about 55% of women at delivery have a trained birth attendant, meaning a health worker who has received at least the minimum of training necessary to provide women support at these critical times.³⁶

Women’s lack of effective means of birth spacing and fertility control endangers their survival and health. All pregnancies and births carry some health risks, but these are higher when pregnancies are ill-timed (too early or too late in a woman’s reproductive life, or too closely spaced) or unwanted. Without obstetric care, women who give birth before age 18 are three times more likely to die in childbirth than women aged between 20 and 29 under similar circumstances; for women aged over

34, the risk of maternal mortality is five times as high.³⁷ Safe motherhood would be assisted through comprehensive reproductive health care, including contraceptive services,³⁸ and, on women's request, lawful, safely conducted terminations of ill-timed or high risk pregnancies. Further, evidence shows that if births were spaced and timed when women wanted them, the right to life of the child would also be promoted, since overall child mortality in many countries might be reduced by more than 20% when mothers survive childbirth.³⁹

The WHO estimates that approximately 20 million unsafe abortions occur every year, resulting in approximately 80,000 maternal deaths (and hundreds of thousands of disabilities).⁴⁰ Sexual abstinence is an obvious way to avoid unwanted pregnancy. However, since sex is a natural part of life and many women lack the power to determine when they have intercourse, contraception is a necessary alternative. Contraception, however, offers no guarantee against failure. For women who wish to terminate pregnancy, safe abortion and contraceptive after-care are necessary to reduce the risk of maternal death.⁴¹ For the first time at a UN Population Conference, the Cairo Programme called on governments to recognize unsafe abortion as a leading cause of maternal mortality and a "major public health concern" (para. 8.25). The call for safe abortion was underscored by the Beijing Platform (paras. 97, 106(j) and (k)), and fits within the established legal framework that requires governmental attention to advances in public health services.

The Cairo Programme recognizes that women's survival of pregnancy is an issue of women being "equal in dignity and rights" (Principle 1). If women are to be equal with men, governments have at least the same obligation to prevent maternal death as to prevent death from disease. Maternal mortality should not be aggregated with disease, of course, since pregnancy is not a disease, although its occurrence and childbirth may aggravate an existing disease. Equity requires more protection against the risk of maternal mortality than against disease, since maternity is the basis of family and community growth, and is often encouraged as a social benefit. Tolerance of high rates of maternal mortality shows the injustice of how little many societies, at all stages of economic development, value the lives of women.

The contrasting rates of maternal mortality between rich and poor countries show a greater disparity than exists for any other public health indicator. Almost 99% of maternal deaths occur in developing countries, and the life-time risk of maternal death is as high as 1 in 20 for women in parts of Africa, compared to 1 in 4,000 for women in North America.⁴² The magnitude of the differentials in maternal deaths between developing and developed countries is a challenge to the universality of human rights, even though the Cairo Programme and the Beijing Platform emphasize that "the human rights of women ... are an inalienable, integral and indivisible part of universal human rights"(Cairo Principle 4, Beijing para. 10).

Given the magnitude of maternal deaths, it is remarkable that so few legal claims have made their way to courts to require that governments take all appropriate measures to identify the causes of maternal mortality in their respective countries and take precautionary measures necessary to prevent further maternal deaths. It seems that there is only one reported case concerning a maternal death, which was before the European Commission of Human Rights. The case was held inadmissible for technical reasons. The Commission did take the opportunity, however, to emphasize

that Article 2 of the European Convention on Human Rights, which states that “everyone’s right to life shall be protected by law,” has been interpreted to require states to take steps not only to prevent intentional killing, but also to take measures necessary to protect life against unintentional loss.⁴³

The right to liberty and security of the person

States apply individuals’ right to liberty and security of the person to reproductive health and self-determination in a variety of ways. Through the Beijing Platform, governments recognize women’s interests in liberty by agreeing, for instance, to consider “reviewing laws containing punitive measures against women who have undergone illegal abortions” (para. 106(k)). Some courts have addressed abortion by finding restrictive criminal abortion provisions unconstitutional on the ground that they violate women’s right to liberty and security. For example, the Supreme Court of Canada declared a restrictive criminal abortion provision to violate women’s right to security of the person.⁴⁴ Several Constitutional Courts, including those of Austria⁴⁵, France⁴⁶, Italy⁴⁷ and the Netherlands⁴⁸, have found that liberal abortion laws, challenged by proponents of the interests of fetuses, are constitutional because they are expressions of women’s right to liberty.

Government regulation of population growth may violate the liberty and security of the person by compelled sterilization and abortion,⁴⁹ or, at the other extreme, by criminal sanctions against individuals’ resort to contraception, voluntary sterilization or abortion.⁵⁰ CEDAW’s General Recommendation 19 on violence against women calls on States Parties:

“to ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures such as illegal abortion because of lack of appropriate services in regard to fertility control.”⁵¹

The potential to suffer abuse of rights is often greater among women from minority and low-income communities, indicating the care to respect individuals’ human rights that must be applied in delivering family planning and other services in such communities. Control of reproduction in such communities in the United States, for instance, has been attempted through suspect means, such as courts offering low-income women offenders early release from imprisonment on probation if they accept long-acting contraceptive implants.⁵² Medical removal of implants that women accepted, even without being coerced or induced to accept them, may be difficult. One study in Bangladesh, for example, reported that 15% of women with contraceptive implants have to make at least three requests for removal⁵³. The Cairo Programme affirms and the Beijing Platform reaffirms that “the principle of informed free choice is essential to the long-term success of family planning programs [and that] any form of coercion has no part to play” (para. 7.12, Beijing paras. 106(g) and (h), 107(e)).

The right to liberty and security of the person has yet to be effectively applied to hold governments accountable for neglecting to enforce laws prohibiting the practice often referred to in the literature as female circumcision or female genital mutilation (FGM). In one form or another, FGM is practised in about 40 countries, mostly in

East and West Africa and parts of the Arabian Peninsula. Prevalence varies in these countries from 5% to almost 98%.⁵⁴ With immigration of populations from these regions, Europe and North America are now experiencing the reproductive and medical consequences of the practice, and also demands on health care professionals to perform it within immigrant families. World-wide, on average about 6,000 girls are circumcised every day.⁵⁵ Where practised, FGM is supposed to attenuate sexual desire, thus “saving” young girls from sexual temptation, and preserving their chastity and married fidelity.

Governments agreed to enforce the prohibition of FGM under the Cairo Programme and the Beijing Platform (Cairo paras. 4.22, 5.5, 7.40, Beijing paras. 124(i), 283(d)). The Cairo Programme urges governments “to prohibit [FGM] wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious organizations to eliminate such practices” (para. 4.22). The Beijing Platform underscores the importance of education, particularly of parents, to aid understanding of the harmful health consequences of the practice (para. 277(d)). Similarly, in its General Recommendation 14, CEDAW urges States Parties to “take appropriate and effective measures with a view to eradicating the practice of female circumcision”, including for instance, dissemination of information, provision of educational and training programs and support for women’s organizations working to eliminate harmful traditional practices.⁵⁶

Related to the right to liberty and security is the right to freedom from torture and from inhuman and degrading treatment. The Beijing Platform recognizes that women are raped and subjected to multiple forms of violence, including sexual torture, because of their low status in society and their sexual vulnerability, and calls on governments for effective preventive measures (paras. 135 and 107(q)). Consequences of rape and sexual violence account for about 5% of the global disease burden in women,⁵⁷ stimulating various health and professional organizations to address the problem.⁵⁸ International human rights tribunals have upheld criminal punishment of men who had raped or attempted to rape their wives.⁵⁹

The Beijing Platform condemns “torture, involuntary disappearance, sexual slavery, rape, sexual abuse and forced pregnancy” (para. 135). Forced pregnancy occurs when abortion following rape is legally denied, practically obstructed or unacceptable to victims themselves on religious or cultural grounds. The Cairo Programme urges governments

“to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation” (para. 4.10)

The Inter-American Commission on Human Rights’ Report on the Situation of Human Rights in Haiti under the Raoul Cedras Administration, for instance, similarly determined that rape and abuse of Haitian women were violations of their right to be free from torture and inhuman and degrading treatment, and of their right to liberty and security of the person.⁶⁰ In a case against Turkey, the European Court of Human Rights found that the rape and ill-treatment of a 17-year old woman of Kurdish

ethnicity by government security forces while she was in detention constituted torture and inhuman and degrading treatment.⁶¹

The right to the highest attainable standard of health

The Cairo Programme and the Beijing Platform provide substance to the right to the highest attainable standard of reproductive health from a woman's perspective. Both stress the importance of affordable, accessible and acceptable reproductive health services throughout the life cycle (Cairo paras. 7.5 and 7.23, Beijing paras. 92, 106(e)). "Acceptable" services require gender-sensitive standards for delivery of good quality services (Cairo para. 7.23, Beijing paras. 95, 103, 106(c) and (g)). Concerning the scope of reproductive health services, the Cairo Programme and the Beijing Platform state:

"reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and STDs." (para. 7.2, Beijing para. 94)

The Cairo Programme sets targets by which states agree to:

"make accessible through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015 (Cairo para. 7.6); [and] take steps to meet family planning needs of their populations as soon as possible and ... in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and to related reproductive health services which are not against the law." (para. 7.16)

The unmet need for family planning services is immense, and constitutes a primary challenge that many states face in meeting their obligation to respect human rights. Half of all pregnancies are unplanned and a quarter certainly unwanted.⁶²

Through the Cairo Programme and the Beijing Platform, governments commit themselves to act to prevent STDs including HIV/AIDS, and to provide services to treat and counsel those who are afflicted (Cairo paras. 7.27-7.33, 8.28-8.35; Beijing paras. 98, 108). Treatment of the afflicted requires their access to medical services, but governments have preventive health care responsibilities to equip their populations to maintain their health standards against the threat that STDs pose.

Treaty monitoring bodies build on commitments made in consequence of the Cairo and Beijing texts to develop performance standards to determine whether states have met their minimum core obligations to respect the right of individuals to the highest attainable standard of reproductive health throughout the life cycle.⁶³ Standards need to be developed on the basis of epidemiological, social science and related data.

The right to the benefits of scientific progress

The right to enjoy the benefits of scientific progress and its applications has yet to be effectively applied to require governments to give high priority to conducting reproductive health research or applying its findings. The right could be invoked, for instance, where women are denied access to antiprogestin drugs for non-surgical abortion or to emergency contraception that they want. The right is equally applicable to means to remedy or overcome pathological infertility.

The entitlement to this human right is enjoyed by both women and men. The Cairo Programme recognizes men's right to the benefits of scientific progress by calling on governments to give high priority to the development of alternative fertility-regulating methods to condoms, withdrawal and vasectomy (Cairo para. 12.14). The right could also be applied to require governments to improve the design and manufacture of condoms to increase protection against the spread of HIV/AIDS.

The Cairo Programme and Beijing Platform require governments to promote women's health research to ensure that women enjoy the benefits of scientific progress (Cairo paras. 12.10-12.26; Beijing paras. 104, 108(o),(p)). For example, the Beijing Platform calls on governments to

“support and initiate research which addresses women's needs and situations, including research on HIV infection and other STDs in women, on women-controlled methods of protection, such as non-spermicidal microbicides, and on male and female attitudes and practices” (para. 108(p)).

It similarly requires action-oriented research on affordable methods, controlled by women, to prevent HIV and other STDs, on strategies empowering women to protect themselves from STDs, including HIV/AIDS, and on methods of care, support and treatment of women, ensuring their involvement in all aspects of such research (para. 108(o)). CEDAW has also emphasized the need to avoid discrimination against women in national strategies for the prevention and control of HIV/AIDS. In its General Recommendation 15, it urges States Parties to implement programs to combat HIV/AIDS that “give special attention to the rights and needs of women ... and to the factors relating to the reproductive role of women and their subordinate position in some societies which make them especially vulnerable to HIV infection.”⁶⁴

The right is to the benefits of scientific *progress*. The Cairo and Beijing texts recognize that any compromise of women's liberty and security by inappropriate use or abuse of medical research or technology frustrates scientific progress (Cairo para. 2.10; Beijing para. 106(g) and (h)). The texts also recognize that relevant progress in science is not confined to the cellular level or laboratory, but includes the full breadth of applicable social sciences.

The right to the benefits of scientific progress is progressive in that governments are required to improve access to the benefits of scientific progress by reasonable steps. Governments are not required to ensure immediate access of all people at all times to the most advanced technology, but rather they are obligated to take reasonable steps to ensure access to cost-effective methods in such basic areas as contraception and prevention of STDs and infertility.

Rights to information and education

The right to receive and impart information

The texts from Cairo and Beijing call on governments to remove legal, medical, clinical and regulatory barriers to reproductive health information (Cairo paras. 7.3, 7.20; Beijing paras. 95, 103, 106(m), 107(e), 108(i), 223), and to improve its quality (Cairo para. 7.23, Beijing para. 103). The significance of information to reproductive health is reinforced by Article 10 (h) of the Women's Convention, which requires that women have access to "specific educational information to help to ensure the health and well-being of families, including information and advice on family planning." Nonetheless, in a number of countries it remains a criminal offence, sometimes described as a crime against morality, to spread information of contraceptive methods or to publicize where women can get pregnancy termination services.⁶⁵ The European Court of Human Rights held Ireland in violation of individuals' right to receive and impart information when the government tried to prevent circulation of information of abortion services legally available in Britain⁶⁶.

The right to education

The right to education is particularly important for the promotion and protection of health. Research has consistently shown that women's education strongly influences improved reproductive health, including infant survival and healthy growth of children.⁶⁷ Despite some progress towards literacy, a huge gap still exists world-wide between literacy rates of men and women. According to UN estimates, illiterate girls and women in the world in 1970 numbered 543 million, but by 1985 had increased to 597 million. Illiteracy in men increased from 348 million to only 352 million in the same period,⁶⁸ showing that women are still disproportionately disadvantaged. The Cairo Programme and the Beijing Platform call for universal primary education by the year 2015, and closing the gender gap in secondary, vocational and higher levels of education (Cairo para. 4.18; Beijing paras. 80 and 81).

The Programme and Platform both urge governments to address adolescent sexuality through educational programs in sexual and reproductive health, made available to and understandable by the young, and provision of contraceptive counselling and services, including services related to STDs (Cairo para. 7.47, Beijing paras. 74, 83(k) and (l) and 267). Reproductive health information in school curricula can be controversial, because sexual biology and behaviour may be explained in ways parents oppose, at a time they consider premature for their children, or with the effect of causing children to ask questions at home with which parents are uncomfortable. The European Court of Human Rights has required sensitivity to parents' views, but has upheld a compulsory sex-education course in a state's schools when "the curriculum is conveyed in an objective, critical and pluralistic manner [and does not] pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions."⁶⁹

The Cairo and Beijing documents encourage educational systems that eliminate all barriers that impede the schooling of married and/or pregnant girls and young mothers (Cairo para. 11.8, Beijing para. 277(a)). Such a barrier was removed in 1995, for instance, when the Botswana Court of Appeal ruled unconstitutional a college

regulation that discriminated against female students by requiring that they inform the college director of their pregnancy, and then become liable to suspension or expulsion.⁷⁰

Rights to family and private life

In some regions, infertility due in particular to reproductive tract infection jeopardizes rights to found a family and to the highest attainable standard of health. In some parts of Africa, this is the cause of up to 50% of infertility.⁷¹ Where such infection is identifiable, curable and preventable by reasonable means, governments appear obligated positively to provide related information, education and services to protect the founding of families. Amenability of this cause of infertility to successful, cost-effective care and prevention places governments under compelling duties to act, and shows their failure to act to be an inexcusable violation of human rights. An excuse may be found where governments prove personnel and resources to be unavailable, but the violation remains. Employment of suitable personnel or resources for alternative purposes requires governments to justify priorities that subordinate interests in reproductive health, for instance when they present their reports before human rights monitoring committees.

At times, rights may be in conflict. Minimum age of marriage laws prevent early foundation of families, but promote maternal survival and foundation of families later in the reproductive life span. Both the Cairo and Beijing texts require that governments and non-governmental organizations generate social support for the enforcement of laws on the minimum age of marriage, in particular by providing educational and employment alternatives to premature marriage (Cairo para. 4.21; Beijing paras. 93, 274(e) and 275(b)).

The Cairo Programme and the Beijing Platform invoke the right to private life against police and other public officers' investigatory intrusions, on suspicions for instance of self-induced or assisted abortion, in order to ensure women's autonomous and confidential choice in reproductive matters (Cairo paras. 7.3, 7.12, 7.17-7.20; Beijing paras. 103, 107(e), 108(m), 267). Claims by women to autonomous reproductive choices against their partners' attempted vetoes have been consistently upheld by national courts in countries of all regions of the world,⁷² and by the European Commission of Human Rights.⁷³ Moreover, national laws allowing women's resort to abortion on privacy grounds, including United States' law,⁷⁴ have been approved under international human rights instruments.⁷⁵

Rights to nondiscrimination

Sexual and gender nondiscrimination

The Women's Convention identifies the need to confront the social causes of women's health and wider inequality by addressing "all forms" of discrimination that women suffer. Legal prohibitions cover discrimination on grounds both of sex, which is a biological, chromosomal characteristic, and of gender, which is a social, cultural and psychological construct. The distinction is confused, for instance, in so-called "sex change" operations, which do not change biological sex but only an individual's social capacity for gender-related activity. Laws or school policies that end girls'

entitlements to education upon pregnancy illustrate discrimination on grounds of sex. The loss of opportunity is triggered only by female biology, since pregnant and nursing girls are no less educable than other girls or boys.

Laws or clinic policies that require women, but not men, to obtain the authorization of their partners before provision of reproductive health services illustrate gender discrimination. Society has characterized reproductive decisions as suitable to be made only by men. Similarly, to distinguish “women doctors” from doctors, and “male nurses” from nurses characterizes doctoring as naturally male-gendered, and nursing as naturally female-gendered. Higher legal minimum ages of marriage for males than for females are gendered, reflecting males’ social need of longer preparation to be family bread winners and protectors.

The need to eliminate all forms of sex and gender discrimination against women is a unifying and pervasive theme in the Cairo and Beijing texts. Particular contributions of these texts to sexual equality are that they urge states “to eliminate all forms of discrimination against the girl child and the root causes of son preference, which results in harmful and unethical practices regarding female infanticide and prenatal sex selection” (Cairo para. 4.16, Beijing para. 277(c)), and “to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles” (Cairo para. 4.25, Beijing para. 97).

Discrimination against women is so widespread in many national, institutional, religious, cultural and other practices that many who exercise leadership roles cannot perceive its breadth, or how affairs could be organized according to equality of the sexes. Their resistance to change, and vested interests in the male-dominated *status quo*, blind them to the injustices they perpetuate. The empowerment of women afforded by their claims to equal respect of their human rights, including to reproductive and sexual health, fundamentally challenges reactionary political, social, religious, professional and other institutions confident of their own virtue and unaccustomed to contradiction and legal accountability. They react to women’s reproductive choice and autonomy with frustration, hostility and condemnation, sometimes invoking moral values that male-dominated, often exclusively male, institutions have established.

Nondiscrimination on grounds of marital status

Article 23 of the International Covenant on Civil and Political Rights recognizes “the right of men and women ... to marry and found a family” as a reaction to genocidal policies conducted against racial minorities and mentally impaired persons, including their involuntary sterilization. It is unclear, however, whether this provision allows marriage to be made a legal precondition to the right to found a family, or whether the rights to marry and to found a family are independent of each other. Clearly, infants, children and adolescents incapable of marriage have a right to treatment of medical conditions that would impair their reproductive capacities, such as undescended testicles and diseased fallopian tubes, before their marriage becomes imminent.

The Women’s Convention indicates that rights to marriage and to foundation of families are severable. Article 1 defines discrimination against women to include limitations made on the basis of sex which compromise 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 light of the Convention’s protections of women’s reproductive choice and health, and protection in pregnancy, without regard to marriage, any refusal of reproductive health assistance and services on grounds of a patient’s unmarried status may be an offence against human rights.

Some laws distinguish between married and unmarried persons without regard to sex, such as in requiring spousal consent for sterilization of married persons. In practice, however, such laws are almost invariably applied to the disadvantage of women. For instance, wives will be denied sterilization and even contraceptive care unless their husbands’ authorization is given, but husbands are given vasectomies without having to show their wives’ approval. Moreover in some countries, contraceptive services are unavailable to unmarried persons. Since men can pass condoms among themselves, however, but women require medical screening to determine which form of chemical or other contraception is best suited to them, and to receive instruction on the use of means they prefer, denial of services to unmarried people unduly burdens women and prejudices their reproductive self-determination and sexual autonomy.

Sexual discrimination and stereotyping support popular assumptions in sexual relationships, in and out of marriage, that responsibility to guard against unwanted pregnancy rests with the female partner. If she is adolescent or unmarried, barriers to access to services on grounds of age and marital status will compound the injustice. Sexual equality requires that men accept responsibility with women to take measures against unwanted pregnancy. However, in many societies unmarried motherhood is stigmatizing in ways that unmarried fatherhood is not, and requirements of proof of virginity apply only to females eligible for marriage. Health care providers must be on guard against aggravating or perpetuating the human rights abuse of marital status discrimination.

Racial nondiscrimination

The interactions of gender, race and class impact on reproductive self-determination in many ways, including those that are well understood and those that are less immediately perceived.⁷⁶ In many countries, health protection and health status vary by race, indicating differential access among races to health care, information and education necessary for health protection. The potential for abuse of rights is often greater among ethnic minorities, which suggests that great care and sensitivity need to be applied in the delivery of reproductive health and related services in mixed-race communities. This is particularly the case with the introduction of permanent or long-acting contraceptive methods, such as Norplant or the emerging HCG vaccine, that can be applied without the free and informed consent necessary for other contraceptive methods. These methods may be offered or employed in ways that exploit vulnerability and subordinate status of racial minority populations.

Where the potential for abuse or neglect of rights is high among particular ethnic minorities, because of factors such as historical disadvantage, poverty or lack of education, approaches and procedures need to be maintained that reduce the risk of abuse. Approaches that hospitals and clinics might adopt include the appointment of a person from a vulnerable racial or ethnic community as a reproductive rights advocate or monitor, to review community members’ access to reproductive health

services and guard against racial discrimination in access to means of reproductive self-determination. At a governmental or public health level, similar means must be taken to ensure nondiscrimination on grounds of race in allocation of reproductive health resources among districts and regions of different predominant racial composition.

Age nondiscrimination

Discrimination on grounds of young age is comprehensively addressed through the Convention on the Rights of the Child, by which states agree “to ensure that no child is deprived of his or her right of access to...health care services” (Article 24(1)). However, the Cairo Programme recognizes that the “reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services” (Cairo para. 7.41). As a result, in many countries, rates of adolescent unmarried pregnancy are epidemic, and in others high rates appear endemic.⁷⁷

The Cairo and Beijing texts call for the removal of regulatory and social barriers to reproductive health information and care for adolescents (Cairo para. 7.45, Beijing paras. 106-108, 281). They recommend that countries ensure that the programs and attitudes of health care providers do not restrict adolescents’ access to appropriate services (Cairo para. 7.45, Beijing paras. 106-108), and that they protect and promote the rights of adolescents to reproductive health education, information and care in order to reduce STDs and the number of adolescent pregnancies (Cairo para. 7.46, Beijing paras. 83(k) and (l), 107(g), 281). An aggravating factor is that adolescent girls may be liable to sexual molestation by older men they cannot repel.

Adolescents suffer unjust discrimination when they are not free to seek reproductive health counselling and services with the same confidentiality that adults enjoy.⁷⁸ Courts have rejected laws and interpretations of laws that, on grounds of age, deny competent adolescents reproductive health services without parental consent. When minors are intellectually mature or emancipated, many courts will recognize their equal rights with adults to health care, and to confidentiality.⁷⁹ Signs of maturity in minors are their understanding of the need to protect their reproductive health, and, for instance, requesting contraceptive information and services when they are or are about to be voluntarily sexually active.

Stereotypes of aged people have been that they are not interested in sexual activity, and that it is inappropriate or even depraved for them to be interested, especially when unmarried. Sexual health is not confined to lower age-groups, however, and age-related decline in reproductive capacity or performance is not necessarily associated with decline in sexual interest. Advanced age-based discrimination in access to health services, including sexual health services, violates human rights provisions. Health care providers responsible for the well-being of elderly persons must be trained and willing to accommodate their sexual expression of affection, and not deny means or opportunities for such expression. Similarly, governmental provision of residential accommodation and other care for elderly persons should be sensitive to their rights both of security from the unwanted sexual intrusion of others, and also of consensual sexual intimacy.

Nondiscrimination on grounds of disability

Human rights conventions prohibit discrimination not only on specified grounds such as sex and age, but also on general grounds. The general prohibition includes discrimination on grounds of disability such as HIV infection, and physical and mental impairment. The Cairo and Beijing texts require governments to

- eliminate discrimination against persons infected with HIV, and against their families,
- strengthen services to detect HIV infection, making sure that they protect confidentiality, and
- devise special programs to provide care and the necessary emotional support to men and women affected by HIV/AIDS and to counsel their families and near relations (Cairo para. 8.34, Beijing para. 108).

The Cairo and Beijing texts recognize that HIV infection in women often reflects women's preconditioning disability that, as women, they lack social and legal power to control whether, when and with what protections they have sexual relations (Cairo paras. 7.34-7.40, Beijing para.99).

The need for sexual security and health of physically and especially mentally disabled persons has long been neglected and denied. Nondiscrimination rights of disabled persons, not only for their protection against sexual abuse but also for their achievement of sexual satisfaction and health, present new frontiers for advancement of human rights.

Nondiscrimination on grounds of sexual orientation

Overcoming nondiscrimination on grounds of sexual orientation is particularly challenging for health care providers. Historically, where male homosexual activity with consenting adult partners was criminal, health care providers' goals in treatment were confined to making such patients satisfied heterosexuals, less-than-satisfied heterosexuals or successfully suppressed homosexuals, but could not easily accommodate the treatment goal of making patients contented and healthy in their conduct of homosexual relationships. Decriminalization has presented the latter treatment goal as legally and ethically available. Laws criminalizing consenting homosexual relationships have been successfully challenged under international human rights laws as violating one's right to respect for private and family life,⁸⁰ as cases involving Northern Ireland,⁸¹ Ireland,⁸² Cyprus⁸³ and Australia⁸⁴ have shown.

Where criminal laws against adult homosexual activities remain, their meaning and application are subject to laws on medical necessity and nondiscrimination. Most laws accept as a legal defence the excuse of medical necessity, particularly to contain the spread of infection such as by HIV/AIDS. Health care providers who counsel and treat homosexual and bisexual patients in techniques of safer sex may be recognized not to be parties to any criminal offence that patients' behaviour may represent. Individuals' human rights to sexual health are not confined to their relationships with members of the other sex.

Nondiscrimination law is increasingly including sexual orientation as a prohibited ground of discrimination. Denying individuals in same sex relationships services necessary to protect their health that are provided to those in heterosexual relationships discriminates against these individuals on grounds of their sexual orientation, offending human rights law. Few countries, however, recognize same-sex relationships equally with heterosexual relationships, in order to award same-sex partners the equivalent of spousal rights for instance on death, disability or separation.

Since health care providers are legally entitled to decline to accept as patients individuals affected by conditions they cannot treat through their professional skills, they may be entitled to decline to afford medical assistance to women in same-sex relationships who seek artificial reproduction. For instance, women may seek anonymous sperm donations from men health care professionals have assessed to be suitable donors on grounds of their genetic, HIV/AIDS and other status. Where women's ability to conceive unassisted is not medically impaired, however, reproductive health professionals may decline to treat them. Nevertheless, human rights agencies may develop law and practice in this area, since health care, aimed at achieving physical, mental and social well-being, may be indicated in the absence of physical impairment, and health care must be available on a basis of non-discrimination on grounds of sexual orientation.⁸⁵

States' duties to implement human rights

Duties to give effect to human rights can be approached from many philosophical and legal frameworks. A useful framework has been developed under international human rights conventions⁸⁶ that obliges states that are parties to undertake three kinds of duties. These are to respect rights by not violating them, to protect rights by taking positive action against third party violators, and to fulfil rights by employing governmental means to afford individuals the full benefit of human rights. The duties affect reproductive rights in a variety of ways.

The duty to respect rights

The duty to respect individuals' rights to reproductive and sexual health obliges states and those they employ to be guarded when taking action that may restrict individuals' reproductive and sexual autonomy. For instance, it is widely recognized that lawfully married couples must not be impaired in their decisions to conceive and bear the children they want, even when such children are likely to be disabled or reared in deprivation.

State action becomes suspect when it obstructs individuals' use of their own means to satisfy their reproductive and sexual health goals, and when it intrudes on individuals' sexual or reproductive privacy. For instance, it has been seen that states cannot restrict women seeking reproductive health services, or clinics delivering them, because women do not have authorization of their husbands, or because they are unmarried. Similarly, states and their officers violate human rights by conducting virginity tests on detainees, charged, for instance, with political or criminal offences, or conducting tests as a condition of women's eligibility for admission to hospital,

educational opportunities or government employment⁸⁷. Privacy rights are also offended by governmental misuse of individuals' identifiable health information for instance on pregnancy, termination of pregnancy and STDs including HIV/AIDS.

States do not violate human rights through action that is justifiable to preserve individuals' human rights. Laws setting a legal minimum age of marriage limit the right to marry but are usually justified in order to save young women from the risks of premature childbearing. State action may accordingly be found not to violate human rights obligations. However, the burden falls on those employing state authority, whether through legislation, executive action or judicial action, to ensure conformity of their action with the human rights, concerning reproductive and sexual health and other interests, of those they intend to be affected by their action, and those they should reasonably anticipate being so affected.

The duty to protect rights

The duty to protect rights requires states to take action to prevent violations of rights committed by private persons and organizations. This is an area of growing concern to human rights tribunals, at both domestic and international levels, as states downsize governmental bureaucracies by giving over state functions to private agencies. Private individuals and institutions as such are not bound by international law, except in very extreme circumstances such as of war crimes and crimes against humanity. Thus, they are not accountable for their conduct in breach of international human rights conventions. However, states and their governments are legally bound under such conventions "to organize the governmental apparatus and, in general, all the structures through which public power is exercised so that they are capable of juridically ensuring the free and full enjoyment of human rights."⁸⁸

States cannot evade their human rights obligations by delegating powers to private sector agencies. States whose governments leave private violations of human rights unremedied or unaddressed are in breach of their own duty to protect human rights. For example, in a case involving the rape of a mentally impaired woman, the government denied liability for her consequent distress. The European Court of Human Rights held, however, that the state had "a degree of responsibility" because no means were provided for her assailant to be prosecuted or for the victim to be compensated.⁸⁹ The Court held that the state was required to take positive measures concerning events that occurred between private individuals where human rights had been violated. The state had failed in its legal duty to maximize protection of human rights through sanctions against individual violators and deterrence of potential violators.

States have been considered to have positive duties to provide protection against intentional killing⁹⁰ as well as unintentional death.⁹¹ The European Commission has considered the issue regarding a complaint that a governmental vaccination programme had resulted in damage and death to babies.⁹² In this case, it was found that appropriate and adequate measures to protect life had been taken. Had such measures not been taken, the state could have been found in breach of its human rights duty to safeguard life. Data on persistently high levels of maternal mortality put states on notice that they may be in breach of their human rights obligations to

protect life. States have duties to take appropriate and adequate measures, for instance, for women's access to skilled birth attendants.

The protective duty of states to restrain third parties' violations of human rights may require state action that may be interpreted as an element either of its protective duty or of its duty to fulfil rights. For example, where a private health care facility discriminates in its allocation of health benefits on the basis for instance of sex, age or race, governmental corrective action may be explained as protecting vulnerable groups against the human rights offence of discrimination, or as meeting the state's duty to fulfil human rights by ensuring fair access to private services.

The duty to fulfil rights

The duty to fulfil rights requires states to take appropriate legislative, administrative, judicial, budgetary, economic and other measures to achieve individuals' full realization of their human rights. Thus, governmental failure to ensure women's reasonable access to primary and reproductive health care, by women's own means or by governmental provision for those who lack means, places the state in breach of its duty. Studies showing for instance the unmet need for contraceptive services⁹³ provide measures of the extent of states' duties to fulfil human rights responsibilities regarding reproductive health care.

The duties of states to employ "all the structures through which public power is exercised"⁹⁴ to meet their responsibilities to protect human rights permit them to conscript private health care providers for this purpose. Where governments license health care providers, whether directly or by delegation to self-regulating professional licensing authorities, they may make it a condition of licensure that providers perform a portion of their licensed services under direction of the state, such as by serving for limited times in public hospitals or clinics.⁹⁵

Discharge of the duty to fulfil human rights sometimes requires states to balance competing human rights or to find a basis of maximum accommodation of the human rights of individuals that may be in conflict with each other. For instance, respect for individuals' religious convictions compels states to allow conscientious objection to participate in such procedures as artificial contraception and abortion, but human rights of women require that reasonable provision be made for their access to such services. Where local health services are available only through private facilities affiliated with a religious denomination opposed to delivering such services, for instance, states may be obliged to ensure their engagement and facilitation of providers who do not object to delivery of such care. Alternatively, states are bound to ensure that services be available through a public clinic or another arrangement that adequately respects the individual consciences of all local providers while ensuring patients' reasonable access to health care.

A legal basis of balance of rights is to ensure patients' access to care and individual providers' rights of conscience, but to recognize that institutions such as hospitals and clinics, being non-human agencies, have no human right of religious conviction or conscience, and cannot limit employed personnel to adherents to a single religious faith by discriminatory employment practices.

Enforcement of legal standards and human rights obligations

Overview

Legal systems frequently provide in theory a variety of means to enforce observance of legal principles. Indeed, historic theories of law claim that law is distinguishable from other systems of normative ordering by its means of enforcement, and that a rule unenforceable by a legal sanction is not a rule of law. In practice, however, means of law enforcement available in theory are frequently inoperative in practice. Such means are often inaccessible to individuals victimized by health care providers' disregard of legal principles, because they lack knowledge of relevant law and the means to gain advice of their legal entitlements and of means to compel their observance. Similarly, professional, governmental and other agencies may not monitor professional conduct, and legal systems may not compel or even expect health care providers to inform patients of legally substandard care or other breaches of patients' lawful entitlements.

Where health care professionals enjoy the privilege and public trust of maintaining self-discipline, the ethical principle of justice, to which the law claims primarily to devote itself, requires the profession to act as a moral agent and to require its members to observe the law. Where that public trust is inadequately respected and appears betrayed, societies may consider it appropriate to introduce legislation that will reinforce the requirement that health professionals maintain legal standards, perhaps by replacing or supplementing professional self-discipline that has failed the public by laxity or professional protectionism.

More serious outrages against patients, whether deliberate or negligent, may attract criminal proceedings initiated by public law enforcement officers, and punishment. In societies where patients have access to courts and lawyers, they may initiate non-criminal proceedings to obtain compensation for injuries suffered to their physical integrity and well-being, and perhaps also for the infliction of indignity. Non-criminal cases may also be managed without court proceedings through means of alternative dispute resolution, which may resolve patients' dissatisfaction by negotiated settlements reached with their health service providers, usually without the publicity that attends proceedings in courts of law.

States follow different legal traditions regarding the significance of international treaty law within national or domestic legal systems. Treaty law must usually be explicitly adopted by national legislation in order to have domestic application, although some states have provisions in their constitutional laws that make some treaties automatically incorporated ("self-executing"). Most states require their judges to interpret national law so as not to conflict with or violate law that exists at the international level. However, most national tribunals favour national laws over international treaty law in the face of unavoidable conflict.

International human rights law is normally taken to be different from treaty law that is negotiated for such purposes as trade and commerce. States negotiate the latter to enhance their own advantage, and to deal with others for mutual profit. In contrast, human rights treaties are concluded to enhance respect for human dignity, and to advance the standard of civilization. Because national courts presume their states'

participation in protection and enhancement of human dignity and civilization, national judges will more easily presume that the law they administer is consistent with international human rights law. They will accept arguments to favour national law that is inconsistent with provisions of international human rights treaties only when their states have explicitly limited adherence to those provisions, or when a provision is shown inconsistent with national law inspired by sacred texts.

National legal systems depend primarily on laws of national origin that give effect to the sovereign independence that all states enjoy under international law. Accordingly, lawyers' arguments that judges should reject national laws on the basis of international law, including international human rights law, will be invoked only as secondary or supporting arguments. That is, the protection and promotion of human rights fall first and foremost under national legal systems. Lawyers will argue first that national laws are to be understood as compatible with international human rights law. It is only if those systems are claimed to have failed in effectiveness that reference is made to international systems for the protection of human rights.

National enforcement

Regulatory and disciplinary approaches

Professional discipline may be imposed by associations of health care providers to which members belong voluntarily. Professional associations may afford their members the prestige of membership on the contractual understanding that members will submit to scrutiny of their practice and to the judgement of their professional peers. Members voluntarily accept their liability to censure and even expulsion for proven misconduct. Such discipline may be imposed for misconduct that is not itself a breach of the law, such as failure to respond promptly to professional association requests for information. Misconduct may also be demonstrated, however, by conduct that violates the law, such as treating patients in non-emergency cases without appropriate consent, and failure to maintain professional confidentiality. Members may also be required, for instance, to give an account of their invocation of conscience to decline to provide abortion services in public hospitals when performing the procedure in private clinics.

Whether or not providers are members of professional voluntary associations, their professional status often depends on licensure. Licensing authorities are usually constituted by governments with heavy reliance on members of the licensed profession itself, but with some governmentally-appointed lay members. Their legal mandate is usually to protect the public interest against unqualified practice, and against incompetent or unethical conduct by licensed providers. Professional licensure includes legal liability of providers to submit to the scrutiny of the licensing authority on the regulatory ground of fitness to practice, and the disciplinary ground of personal integrity. Failure to maintain legal standards of competence and, for instance, confidentiality may accordingly lead to regulatory or disciplinary proceedings.

Regulatory proceedings focus on a person's knowledge and capacity to fulfil the functions of the profession and on a provider's entitlement to retain or renew a license on grounds of fitness to practice. Disciplinary proceedings concern whether a licensed provider has observed the professional code of conduct, which will include

the duty to observe ethical standards and the law. Regulatory and disciplinary proceedings are to be conducted in accordance with principles of administrative law, which focus on fairness. They address the composition of the tribunal conducting the hearing, for instance to exclude the risk of bias or prejudice, the presentation of evidence and argument, and rights of recourse to courts of law on matters of law and procedure. They may include subsequent access to regular courts of law to appeal against tribunal decisions or to seek review of the propriety of the tribunal's conduct of the proceedings or, for instance, the sanctions imposed.

Legislative approaches

Where governmental reliance is not placed exclusively upon professional self-regulation through enforcement of a code of professional conduct, legislation may be enacted at different levels of detail that prescribes how providers are to demonstrate their observance of the law and how their practice will be scrutinized through professionally qualified or other inspectors.

Further, where observance of law is entrusted to professional self-regulatory and self-disciplinary authorities in general, particular practices that have been the subject of public concern or scandal may become subject to control by specific legislation. For instance, where undisclosed conflict of interest may arise through providers' ownership of clinical laboratories to which they refer their patients for costly tests, legislation may be enacted to prohibit such ownership or to require provider-owners to inform patients and provide alternative options. Where clinical services have been undertaken on patients of borderline mental capacity without guardians' approval, or, upon guardians' insistence but without patients' agreement, legislation may be enacted to regularize consent procedures, by requiring reference of each service proposed to an appropriate public officer or tribunal, or a court of law.

In countries where medically assisted reproduction is available, particularly by employment of recently developed biotechnologies, legislation may have been enacted that specifies the conditions and limitations under which such assistance may be requested, supplied and advertised. The legislation may be enforceable, for instance, through criminal proceedings, professional disciplinary proceedings or through licenses granted on approval by governmentally appointed authorities. Such authorities may specify conditions, undertake inspections and monitor the practice of individual license holders, and the evolving state of the art concerning the safety and efficacy of techniques and practices.

Criminal law approaches

Criminal law strategies to compel health care providers' observance of the law have been unusual, although legislation to control new reproductive technologies made available primarily by health care providers and human reproductive biologists increasingly include criminal sanctions. Where practice is permitted only under license, unlicensed practice is usually criminally punishable. However, criminal laws directed to society at large are obviously also applicable to health care providers. Accordingly, if their practices violate such general laws, they will be liable to criminal proceedings.

Criminal law tends to be a rather crude instrument that society may direct against the more severe violations of standards of social conduct and safety. It governs deliberate wrongs such as assaults, gross negligence causing bodily harm and recklessness in care of others when they are in peril. For instance, an anaesthetist has been convicted of manslaughter when death was caused by his inattention during surgery.⁹⁶ Criminal liability for assault normally arises when individuals are subject to physical interventions, such as medical examinations and treatments, that have not been legally authorized. Mentally competent individuals, both adults and mature adolescents who have not reached the age of legal majority, are usually considered competent to give legally effective consent for medical interventions on themselves. Parents can usually consent for examinations and treatments of their children when they are medically indicated, and often have legal duties to ensure that their children receive necessary medical care.

In many jurisdictions, parents and other guardians of children are not free to authorize medical treatments that are not intended to serve a therapeutic or preventive health care purpose. This may present difficulties when investigators propose non-therapeutic research procedures on children or mentally compromised adults. Circumcision of infant and young males on religious grounds is normally considered within parental power to approve, but female circumcision is considerably more contentious. In several countries, health professional rules of conduct prohibit the practice, and increasingly criminal law prohibitions are being enacted.

Similarly, professional and legal prohibitions are mounting against contraceptive sterilization procedures on young females and those who suffer mental impairment and are under parental or other guardianship. Where guardians are not legally empowered to authorize such procedures, providers who undertake them lack lawful consent, and are liable to criminal proceedings for assault. If providers are convinced that such procedures are of positive benefit to the females for whom they are proposed, for instance because they cannot cope with menstruation, they may afford evidence of their assessment to guardians who may then seek judicial approval of the procedures. If approval is granted, providers may undertake such procedures with legal security.

A special concern for gynaecologists, and urologists, is that some legal systems provide that sexual assault is more severely punishable than ordinary or common assault, and that the distinction between common and sexual assault is the objective or impersonal nature of the unauthorized touching. It is no defence to a charge of sexual assault that it was not motivated by any sexual purpose. Accordingly, if a gynaecologist lacks legal authorization when touching genitalia, criminal conviction and punishment are likely to be for sexual assault, which is more socially stigmatizing than conviction for the lesser offence of common assault, and may attract greater attention and sanction by medical association and licensing authority disciplinary tribunals.

Civil (non-criminal) law approaches

Where members of communities enjoy convenient and affordable access to lawyers and courts, health care providers have to be concerned that their failure to observe legal principles governing patient care will result in civil litigation for compensation.

Courts finding them liable will, at a minimum, require return of fees charged for services that were improperly delivered, and beyond this may award nominal damages. They will award substantial damages where patients suffered distress, physical and/or psychological harm and other injuries such as loss of employment or professional opportunities. In addition, courts may award further compensation where improper care was delivered with indifference or callousness towards patients' interests, or caused indignity and loss of patients' self-esteem.

The most direct basis of civil liability arises from professional malpractice or negligence. Treating patients without legal authorization is a legal wrong, frequently called battery or assault, which parallels criminal liability for assault and justifies an award of compensation to the patient even if the injury that resulted was minor. The touching itself is a wrong even if the procedure involved was competently undertaken. It is no defence to a civil charge of battery that it was skilfully performed.

It has been seen above that if a procedure is performed negligently, even with full legal authorization to undertake it, a practitioner will be liable if injury is caused. When a practitioner bears a legal duty of care, liability to pay compensation will arise if the duty is not performed according to the legally set standard of care, causing harm to a person to whom a duty of care is owed. In law, negligence is addressed as an incident, although health care providers sometimes react to an allegation of negligence as if it claims an enduring defective personality trait in the practitioner.

When a patient is injured from a procedure that bears an irreducible level of risk, the occurrence of the injury risked is not evidence that the provider who performed the procedure was negligent. However, the provider's explanation that the patient knowingly assumed that level of risk depends on the patient having been adequately informed of the risk, and having been competent and otherwise free to accept it. A patient who consents to performance of a procedure cannot succeed in a claim for battery if it results in injury, but may succeed in a claim for negligence by showing that the patient was not provided with adequate information about the irreducible level of risk inherent in the procedure. Injury may not have been due to any lack of skill or care by the provider in performing the procedure, but it may be shown to have been caused by defective disclosure of information because, had relevant information been given, the patient would have chosen not to have the procedure, and therefore not to have been exposed to its irreducible risk. The provider must avoid negligence not only in performance of the procedure, but also in ensuring that appropriate information is provided to assist the decision by or on behalf of the patient concerning what, if any, treatment to receive.

In some cases, providers or their clinics enter into contracts with patients, and terms are included (which courts may find implicit when they are not explicit) that guarantee certain outcomes, or that particular events will not occur. Such terms are binding, and their breach justifies compensation, even if there was no negligence and the promised outcome was impossible to achieve or the harm was unavoidable. Parties to contracts who give guarantees that are impossible to perform are nevertheless liable for breach of the guarantee.

Alternative dispute resolution

The capacity of legal systems to accommodate non-judicial resolution of civil disputes is receiving emphasis in modern literature. However, many legal systems have long shown historical, customary and communal methods of dispute resolution that avoid the costs and delay of the winner-take-all practices of dispute resolution that have come to characterize the judicial processes of many modern legal systems. Judicial proceedings reflect individualism and adversarial relationships between strangers. The alternative dispute resolution (ADR) system reflects how disagreements may be overcome when they arise between parties who expect to be in continuing relationship with each other, such as members of families and residents in the same communities.

The aim of ADR is that all parties to disputes achieve resolution by negotiation that leaves them all satisfied in the outcome. A focus may be on how injuries are best overcome rather than on identification of who is to blame, and on how hurt emotional feelings can be overcome and all parties to a dispute can regain their self-esteem and mutual esteem, and pay due respect to the feelings of other parties to the dispute.

Unlike in courts of law, important aspects of ADR may concern sincere apology, such as for oversights and lack of due respect to another party's dignity. In many legal systems, courts of law are the only resort for patients resentful that their emotional comfort and dignity were degraded by health care providers, perhaps acting as aloof and indifferent managers of sophisticated technologies and conduits of drugs that have unpronounceable names and uncertain effects. Litigation is used as a means to gain such providers' attention and respect, and to bring them down to patients' levels. Alternative dispute resolution may achieve the same results in a manner that is less public, less adversarial and less expensive, and that addresses the relationships among different parties in personal terms. They may prefer ADR to judicial processes that are impersonal, and require lawyers' denials of facts and responsibilities, and employment of the special language, descriptions and documents, frequently alien to the experience of both patients and providers, that characterize judicial proceedings.

International enforcement

Processes of international accountability

Governments may establish the merit of their administrations' respect for reproductive rights through policies advocated by their political institutions and to the satisfaction of their independent national courts. Experience demonstrates, however, that there must be international scrutiny of countries' observance of their commitments under international human rights law. Assessment of governmental action claimed to discharge duties to observe international human rights within a country is not within the exclusive jurisdiction over domestic matters that states claim as a legitimate aspect of their sovereignty and independence. The major achievement of international human rights law in the past half-century, reacting to how many German nationals were mistreated by their own state before 1945, is to demonstrate that nation states are not free to treat their own citizens and residents in any way they wish, without accountability to the international community. Individuals' human rights are of international and not exclusively domestic concern. Since governments are nationally and internationally accountable for their observance of the human rights of individuals and groups, attention is necessary to

legal and political processes to hold governments to account, to require responses to alleged violations, and to remedy violations.

The international legal order is clearly imperfect in its capacity for scrutiny and compulsion to hold governments strictly to account for their human rights records. The challenge must be faced of improving processes of accountability at domestic and international levels, by political, legal and other means. The Cairo Programme of Action was aware of prevailing inadequacies in international accountability for reproductive and sexual health. The Programme makes clear that advancement of reproductive health depends on momentum generated through the international human rights regimes. Development for this purpose can be driven in part by existing national human rights institutions and international treaty systems.

Reporting

Countries that are members of different international and regional human rights conventions are obligated to report on a periodic basis to each treaty monitoring body. For instance, through the Women's Convention, 161 states have committed themselves to report regularly to CEDAW on what they have done to:

“... take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning” Article 12(1);

and to ensure women's

“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.” (Article 16(e))

Enforcement of treaty obligations depends primarily on state action, but monitoring committees, like CEDAW, are mandated to be vigilant in their scrutiny of states' reports regarding evidence of defaults on responsibilities of states. For this purpose, CEDAW receives alternative reports or comments on state performance submitted by national and international nongovernmental organizations, which may incorporate significant findings of failures to protect and promote reproductive and sexual health. Such findings may result from medical or social science research. For example, studies that show high rates of wife beating have been used to put governments on notice of private violations that need to be prevented or remedied.⁹⁷

An increasingly important process for developing state accountability for reproductive rights is the publication of Concluding Observations by treaty monitoring bodies on reports submitted by states. For example, in 1996 the Human Rights Committee, established by the International Covenant on Civil and Political Rights to monitor state compliance with the Covenant, addressed the criminal abortion law of Peru. In its Concluding Observations, the Committee expressed its concern “that abortion gives rise to a criminal penalty even if a woman is pregnant as a result of rape and that clandestine abortions are the main cause of maternal mortality.”⁹⁸ The Committee found that the criminal law subjected women to inhuman treatment contrary to Article 7 of the Covenant. Moreover, the Committee explained that this aspect of the criminal law was possibly incompatible with Article

3 on equal entitlement of men and women to the enjoyment of the rights set forth in the Covenant, including Article 6 which protects the right to life.

The Committee recommended “that the necessary legal measures should be taken to ensure compliance with the obligations to respect and guarantee the rights recognized in the Covenant” and that “the provisions of the Civil and Penal Codes should be revised in the light of the obligations laid down in the Covenant”, particularly Article 3 requiring that countries ensure equal respect of men’s and women’s enjoyment of the rights set forth in the Covenant⁹⁹. As a result, Peru is responsible at least to require the medical profession to facilitate women’s access to safe abortion services to the extent that the law permits. Moreover, since prevailing law, which strictly penalizes abortion, results in inhuman treatment of women and undue maternal mortality, Peru is obliged to consider law reform to bring the law on abortion into compliance with human rights requirements. A new national policy would have to be expressed in new law, which more adequately balances limitations on abortion with women’s rights to safe and humane access to health services for preservation of life, health, and dignity.

CEDAW’s Concluding Observations on the Report of the Government of Hungary included the following points with regard to reproductive health and related matters:

the state of health of the female population was unsatisfactory when judged by international standards. In particular, the high cost of contraceptives prevented women from freely planning when to have children. The very high increase in the rate of abortions was of concern to the Committee.¹⁰⁰

As a result, CEDAW requested the government to offer sex education programs to all young people and to subsidize contraceptives in order to promote family planning and reduce the number of abortions.¹⁰¹ CEDAW also requested the government to take urgent legislative and concrete measures to provide female victims of violence with protection and appropriate services.¹⁰²

CEDAW further noted with concern the scale of the problem of prostitution, which affected girls and women in ethnic minorities in particular,¹⁰³ and urgently requested the government to take all necessary measures to rehabilitate and reintegrate prostitutes into society.¹⁰⁴

Individual complaints

Countries that have ratified other human rights conventions accept obligations to account to monitoring committees similar to CEDAW for the extent to which they have complied with their obligations. Further, processes exist under some conventions, such as the European Convention on Human Rights and the International Covenant on Civil and Political Rights, which enable private persons from consenting states to bring individual complaints against their states for violations. Accommodation of such individual petitions is now available under the Women’s Convention. A normal condition of international tribunals receiving individuals’ petitions, however, is that such individuals have exhausted all reasonable possibilities of achieving remedies before national tribunals of the state against which

the petition is presented. That is, a state must be afforded a reasonable opportunity to remedy a complaint before it can be considered at an international level.

Communications

The UN Special Rapporteur on Violence against Women receives communications about alleged instances of gender-specific violence against women that have not been effectively addressed through national legal systems. She then uses this information to open dialogue with governments about finding resolutions¹⁰⁵.

Violations and remedies

Violations of rights consist in failures to observe legally binding duties, whether due to deliberate refusal of observance, to unawareness of breach associated with lack of relevant information or, for instance, to oversight or interpretative blindness to the implications of available data. The origin of each violation is relevant to its appropriate remedy. The findings of social science research may draw out violations of rights disclosed by data, but may alternatively indicate interpretations that show states' conformity with human rights standards.

Violations of human rights have been divided into three categories,¹⁰⁶ which may be illustrated by reference to rights relating to reproduction and sexuality:

Category 1 violations result from direct action on the part of a state, such as mandating coercive sterilization and prohibiting use of contraceptive means;

Category 2 violations relate to a state's failure to meet the minimum core obligations of human rights protection, such as by refusing or neglecting action shown capable of reducing maternal mortality rates, and tolerating rape of female detainees in state institutions; and

Category 3 violations relate to patterns of discrimination, such as persistent and gross discrepancies in access to health services that cumulatively disadvantage the reproductive health of groups, such as unmarried adolescent girls.

Violations in each of these categories can be established by arguments of principle, such as against states' maintenance of strictly prohibitive abortion laws that are shown to cause inhuman treatment of women, but also empirically by evidence of individual outrages or from social science research. For instance, research can indicate the coercive conditioning of women's apparently voluntary requests for sterilization, such as when poor women can obtain employment only in toxic workplaces from which fertile women are barred under alleged fetal protection policies.¹⁰⁷ Similarly, such research can show actions capable of reducing infertility or maternal mortality rates that states are required to take, and expose patterns of discrimination suffered on the ground of sex or gender.

Critical principles governing modern legal systems are that "rights" without remedies are no rights at all, and that the duty of legal systems is to ensure that remedies are practically accessible, justly administered and effective to afford rights their full

substance. The purpose of remedies and sanctions for breaches of rights, particularly at the international level, is not primarily that offenders suffer sanctions, but that violations of rights will be prevented or deterred. Legal methods to make governments accountable are designed to expose governments in default of their legal responsibilities, to indicate by what standards and processes governments may conform to their legal duties, and to show their compliance with the responsibilities they have assumed. The primary role of national and international human rights agencies is not punitive, but supportive of states' intentions of compliance.

The duty to provide *effective* remedies for violations of reproductive rights can be informed by social science research. With greater understanding particularly of women's perspectives, legal systems will be better equipped to ensure the effectiveness of remedies required for violations of reproductive rights, of which women are more liable than men to be victims. For example, if a legal system does not take account of the social importance of confidentiality or virginity in a rape victim's life, the effectiveness of the remedy it provides might well be limited. Judicial processes might deter women's resort to them, and therefore prevent women's access to remedies, such as when court proceedings result in the public naming of victims of, for instance, rape, domestic violence, or innocent infection with disease.

Another example is that research into high rates of adolescent pregnancy can show how causes have to be properly identified in order for remedies to be effective. A study in the state of Washington, USA, for instance, showed that two-thirds of a sample of 535 young women became pregnant as a result of some form of sexual abuse by older men¹⁰⁸. These findings can be used to show that governments need to address the problem of sexual abuse of adolescent girls, in addition to providing contraceptive services, to satisfy their obligations to protect the right to security of these girls. The research demonstrated that many pregnancies were due not to any failure of the girls, but to failures to protect them against abuse.

Evidence for enforcement

Conscientious governments concerned to discharge their human rights obligations with regard to reproductive and sexual health may sponsor research in order to learn of the duties they have met and of the goals they have yet to achieve. Research may be undertaken either within government departments or through independent agencies such as universities or nongovernmental or other organizations. Experience shows, however, that when evidence of governmental failure to discharge duties is produced outside governmental sponsorship, governments approach it with caution, scepticism and not uncommonly hostility. Nongovernmental human rights organizations can be regarded, particularly by governments not accustomed to democratically elected opponents committed to different but not necessarily hostile visions of proper government, as anti-governmental. Reciprocally, claims supported by governmentally sponsored evidence that the human rights entitlements of individuals and groups have been satisfied will often be approached in much the same sceptical way by activists outside government who are committed to the highest levels of individual and group entitlement. Different attitudes and conclusions are often the raw material of conflict, and competition to achieve credibility in the

assessment of disinterested international agencies and tribunals is often resolved by the scientific calibre of the evidence that competing parties present.

The quality of evidence is of particular significance when it is proposed to be presented before international judicial or other fact-finding bodies whose decisions have legal and wider consequences. The conditions under which expert testimony and documents will be admitted differ among tribunals. Proceedings may follow, for instance, an adversarial model, in which advocates before passive tribunals present opposing arguments supported by witnesses and evidence. In contrast is an inquisitorial model, in which tribunal members are mandated actively to conduct questioning to reach a determination of truth from witnesses and evidence produced on their request, as well as from witnesses and evidence they consider relevant that is offered by interested parties.

When international treaty monitoring committees, such as CEDAW, are presented with evidence from nongovernmental organizations, such as national medical associations and national societies of obstetrics and gynaecology, that contradicts claims in governmental reports, governmental resources may be applied to question its credibility. Those who provide evidence for presentation before any such tribunal or committee must anticipate its rigorous, sceptical scrutiny, and prepare their findings accordingly.

A distinction in fact-gathering for human rights purposes is sometimes drawn between events-based data and standards-based data.¹⁰⁹ Events-based data record individual violations of human rights, such as a woman's forced abortion or sterilization. Standards-based data can show state compliance with, or violation of, specific rights, such as by persistently low or high rates of maternal morbidity and mortality. Meticulously documented events-based data may show that human rights abuses are not merely individual private incidents, for which states may not be accountable, or individual aberrations, for which states may propose excuses, but systematic. Events may reflect public policies of abusive action or abusive inaction in the face of known breaches of human rights, for which states are accountable. Carefully documented cases may direct attention beyond their specific facts to underlying conditions of abuse of reproductive rights.

Standards-based data are commonly used in international human rights monitoring, where states' obligations to maintain necessary programs, for instance to protect reproductive health at an adequate level, are a focus of scrutiny. Data of programme performance are interpretable by reference to international and other recognized standards.¹¹⁰ Separation of data according to sex is usually essential to prove the absence or presence of discrimination against women and, for instance concerning infant mortality, against girl children. Systematic discrimination for which states bear international legal liability can also be shown by data regarding the proportions of male and female employees in public facilities that offer reproductive health services. In many cultures, neither women nor men will become patients for services necessary to their health that are delivered by providers or their assistants who are not of the same sex as the patients. Those unable to receive care from providers of the same sex as themselves are accordingly denied care to which they are entitled.

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